STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675356	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BASTROP NURSING CENTER	400 OLD AUSTIN HWY BASTROP, TX 78602

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 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were free from misappropriation of resident property for four of four residents reviewed for misappropriation. (Resident #1, Resident #2, Resident #3 and Resident #4) The facility failed to ensure Resident #1, Resident #2, Resident #3 and Resident #4's controlled medications were subject to drug diversion. This failure placed residents at risk for misappropriation and in danger of not receiving medications. Findings include: During observation of controlled medication counts on 7/29/20 at 2:10 PM it was revealed counting logs reflected numerous blanks on the pages for the months of May, June and July 2020. The count was performed by LVNs V and S. Record review of sign out sheets for controlled medications reflected the July sheet for halls F, A and B was observed to have 16 gaps where signatures were blank. The narcotics shift change count sheet for halls C, D and E was observed to have a large number of gaps, blank signature spots were noted on 17 lines. Review of the Face Sheet for Resident #1 reflected an [AGE] year old male was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS quarterly assessment for Resident #1 dated 7/02/20 reflected a BIMS score uncompleted and assessment as severely cognitively impaired. Medication review for Resident #1 reflected he received Antipsychotic medication 7 days of the review period and no Opioid pain medication (such as [MEDICATION NAME] tablets). Review of the Care Plan dated 6/27/20 for Resident #1 reflected ADL performance deficit related to muscle wasting, Dementia, resistance to showers, fall risk, Diabetes, depression, [MEDICAL CONDITION] disorder, and pain medication for generalized [MEDICAL CONDITION]. Review of progress notes for Resident #1 dated from 5/08/20 to 7/28/20 reflected he had received Tylenol 500 mg for pain every 6 hours. No mention of administering any doses of [MEDICATION NAME] 15 mg tablets (ordered q 1 hour as needed for pain) were found. Review of MARs for Resident #1 dated from 7/01/20 to 7/30/20 reflected no doses of [MEDICATION NAME] 15 mg tablets were given. Review of the Narcotic Sign out sheet for Resident #1 reflected from 7/02/20 to 7/03/20 a total of 8 doses were administered. The previous month from 6/09/20 t 6/13/20 LVN Q signed out a total of 17 doses of [MEDICATION NAME] 15 mg for Resident #1. On 6/10/20, 6/11/20 and 6/13/20 Resident #1 received 4 doses daily. Review of the Face Sheet for Resident #2 reflected a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS quarterly assessment for Resident #2 dated 7/24/20 reflected a BIMS score of 8 reflecting moderately impaired cognition. Her medication review reflected she received Antidepressant medication 7 days of the review period and Opioid pain medication 5 days of the review period. Review of the Care Plan dated 6/22/20 for Resident #2 reflected: Resident was dependent on staff for all needs, [MEDICAL CONDITION], Pacemaker, Impaired Cognition, [MEDICAL CONDITION], depression and anti-anxiety medication, and Pain meds for acute pain. Review of Medication Administration Records (MARs) for Resident #2 reflected she received [MEDICATION NAME] 5/325 mg once a day for pain. From 1/31/20 to 7/27/20 when the order was discontinued. Review of physician's orders [REDACTED].#2 had a PRN order for [MEDICATION NAME] every 6 hours which was discontinued on 7/17/20. Review of the sign out sheet for controlled medications for Resident #2 reflected she received two doses from LVN Q on 7/18/20, 7/19/20, 7/20/20, 7/21/20, 7/22/20 and 7/23/20. Review of the Face Sheet for Resident #4 reflected an [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS quarterly assessment for Resident #4 dated 6/07/20 reflected severe cognitive impairment. The assessment reflected he received anti-anxiety medication 7 days of the observed period, but no opioid pain medication. Review of the Care Plan for Resident #4 dated 6/26/20 reflected: he required frequent assistance and reminders for nutrition, was on Hospice services, was dependent on staff for emotional social needs, had Dementia, Behaviors, and communication problems. Review of Progress Notes for Resident #4 from 5/01/20 to 7/29/20 reflected regular administration of the pain medication [MEDICATION NAME] ([MEDICATION NAME]/Acetominophen 10-325 gm). The MAR indicated [REDACTED]. These four doses were signed out by different nurses and reflect Resident #4 received pain medication periodically. Review of the MAR indicated [REDACTED]. Review of the MAR indicated [REDACTED]. Review of the controlled medication sign out sheet for Resident #4's [MEDICATION NAME] tablets reflected a total of 43 doses were given from 4/06/20 to 7/03/20. The bulk of the signatures on the sign out sheet were attributed to LVN Q (and appear similar to her signatures identified by the DON on other sign out sheets). Review of physician's orders [REDACTED]. The orders were discontinued on 7/29/20. Review of the Misappropriation Incident Investigation dated 7/28/20 reflected the facility had suspended the employee (LVN Q) and insufficient evidence was found to conclude the medication had been taken by the employee. The investigation reflected LVN Q had made multiple documentation errors. In an interview on 7/29/20 at 2:10 pm LVN V stated the count of narcotics was to be performed every 8 hours or when keys were given to an oncoming nurse. In an interview on 7/29/20 at 2:10 PM LVN S stated count should be performed every 8 hours. In an interview on 7/29/20 at 2:15 PM the DON stated she was aware a lot of gaps were present on the controlled medication shift change signing sheet. She stated her investigation of the misappropriation allegation involving a suspended staff member (reported to the state on 7/25/20) was ongoing. The DON stated a terminated staff member (an ADON) was responsible for conducting the reviews of controlled counts and narcotic security. Observation of the controlled medication count on 7/29/20 at 2:22 PM for the CDE cart with LVN T and LVN R revealed no missing narcotics. No problems with security were observed. The narcotics shift change sheet for July 2020 was noted to have a large number of gaps, blank signature spots were noted on 17 lines. In an interview on 7/29/20 at 2:22 PM LVN T stated count of controlled medications was to occur on all shifts or every time keys were exchanged with another nurse. In an interview on 7/29/20 at 2:40 PM the Consulting Pharmacist stated she had not been in the facility since mid March with the start of the Covid-19 pandemic. The Pharmacist stated she had been remotely reviewing orders, medications and labs through computer records remotely. She stated she had received a phone call from the DON and was aware there had been a potential problem with narcotics. She stated she was in the process of getting authorization to enter the facility to conduct an investigation. In an interview on 7/30/20 at 9:20 AM the suspended LVN Q stated she had committed a number of documentation errors at the facility. She stated she was working a lot of overtime but acknowledged she made mistakes. LVN Q stated she was made aware of the errors in a meeting with the DON. She stated she did not understand why the ADON did not talk to her if she was aware of the documentation errors. LVN Q stated she failed to document medications on the MAR indicated [REDACTED]. She stated she did not take any of the medications herself. LVN Q stated she had reported herself to the Board of Nursing and would be involved in the TPAP program (Texas Peer Assistance Program for Nurses), which provides opportunities for recovery from chemical dependence or mental illness. LVN Q stated she did not believe any other nurses at the facility had made medication errors. LVN Q stated counting of controlled medications should have been performed every 8 hours. She stated she could recall shifts where she did not sign the controlled medication count but believed the count was correct. In an interview on 7/30/20 at 10:45 AM the DON stated she had discussed the failure to chart [MEDICATION NAME] administration for Resident #1 with LVN Q. She stated it was plain the MAR indicated [REDACTED]. The DON stated no drug test was requested of LVN Q. In an interview on 7/30/20 at 2:45 PM the Administrator stated her expectation of the facility employees was they would adhere to professional standards and facility policy. She stated LVN Q did not follow professional standards for documentation and monitoring of pain medication. Review of the Abuse & Neglect Prohibition Policy dated 07/2018 reflected misappropriation of Resident property was strictly

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 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) prohibited. Resident property was defined as any belongings, money or medication belonging to the individual resident. Review of the facility Substance Abuse Policy dated 06/2013 reflected the facility reserved the right to test or re-test any employee for reasonable cause. The policy reflected if controlled medications were missing or believed to be missing the employee responsible may be tested . Review of the Controlled Substance Medication Policy dated 06/2013 reflected the facility must account for all controlled medications in accordance with federal and state laws. The policy reflected all Controlled medications must be counted and reconciled at the beginning and end of each shift. The policy stated it was considered falsification to fill in blank holes on forms.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observation, interview and record review the facility failed to determine drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled for one of one drug record reviewed. The facility failed to review the controlled medication/drug sign out records. This failure placed residents at risk of drug diversion. Findings include: During observation of controlled medication counts on 7/29/20 at 2:10 PM it was revealed counting logs reflected numerous blanks on the pages for the months of May, June and July 2020. The count was performed by LVNs V and S. The July sheet for halls F, A and B was observed to have 16 gaps where signatures were blank. The narcotics shift change count sheet for halls C, D and E was observed to have a large number of gaps, blank signature spots were noted on 17 lines. In an interview on 7/29/20 at 2:10 PM LVN V stated the count of narcotics was to be performed every 8 hours (at end of shift) or when keys were given to an oncoming nurse. In an interview on 7/29/20 at 2:10 PM LEVIN S stated count should be performed every 8 hours at end of shift. In an interview on 7/29/20 at 2:15 PM the DON stated she was aware a lot of gaps were present on the controlled medication shift change signing sheet. Observation of the controlled medication count on 7/29/20 at 2:22 PM for the CDE cart with LVN T and LVN R revealed no missing narcotics. No problems with security were observed. The narcotics shift change sheet for July 2020 was noted to have a large number of gaps, blank signature spots were noted on 17 lines. In an interview on 7/29/20 at 2:22 PM LVN T stated count of controlled medications was to occur at the end of shift or every time keys were exchanged with another nurse. In an interview on 7/29/20 at 2:40 PM the Consulting Pharmacist stated she had not been in the facility since mid March with the start of the Covid-19 pandemic. The Pharmacist stated she had been remotely reviewing orders, medications and labs through computer records remotely. She stated she had received a phone call from the DON and was aware there had been a potential problem with narcotics. She stated she was in the process of getting authorization to enter the facility to conduct an investigation. In an interview on 7/30/20 at 9:20 am the suspended LVN Q stated she had committed a number of documentation errors at the facility. She stated she was working a lot of overtime but acknowledged she made mistakes. LVN Q stated she was made aware of the errors in a meeting with the DON. LVN Q stated she failed to document medications on the MAR indicated [REDACTED]. She stated she did not take any of the medications herself. LVN Q stated counting of controlled medications should have been performed every 8 hours. She stated she could recall shifts where she did not sign the controlled medication count but believed the count was correct. In an interview on 7/30/20 at 2:45 PM the Administrator stated her expectation of the facility employees was they would adhere to professional standards and facility policy. She stated LVN Q did not follow professional standards for documentation and monitoring of pain medication. She stated LVN Q was placed on administrative leave pending completion of her investigation into the misappropriation of medications. Review of the Controlled Substance Medication Policy dated 06/2013 reflected the facility must account for all controlled medications in accordance with federal and state laws. The policy reflected all Controlled medications must be counted and reconciled at the beginning and end of each shift. The policy stated it was considered falsification to fill in blank holes on forms.