STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455856	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Healthcare	169 S Oak St Van, TX 75790

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(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 - Some	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** 47204 Based on observation, interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of 3 of 4 residents reviewed for pharmacy services (Residents #16, #24, #26). The facility failed to ensure medications were available in the form ordered by the physician for Residents #16 and #24. The facility failed to ensure a physician's order to discontinue an oral diabetic medication and replace it with another medication was carried out resulting in the discontinued medication being given for 3 (three) months after it was discontinued, and the replacement medication not being initiated for Resident #16. The facility failed to ensure LVN D administered insulin to Resident #26 in a safe, therapeutic manner. These failures could place residents at risk for not receiving the intended therapeutic response of prescribed medications and not having accurate records of medication administration which could result in diminished health and well-being. Findings included: 1.A review of Resident #16's face sheet indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included dementia, cerebral infarction (stroke), and Diabetes Mellitus (a long-tern condition in which the body has trouble controlling blood sugar and using it for energy). During an observation of medication administration and interview on 10/22/2024 at 08:20 AM, MA H was observed to administer 1 (one) tablet of Vitamin D3 2000mg to Resident #16. MA H said the physician's order was for 2 tablets of Vitamin D3 1000mg. MA H said he did not have any Vitamin D3 1000mg tablets and said the 1 tablet of Vitamin D3 2000mg was the same thing. MA H did not consult the charge nurse about not having the prescribed 1000mg Vitamin D3 tablets nor did he seek the nurse's guidance for determining the number of tablets to give of the substituted medication. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this same observation of medication administration, MA H said he did not have the physician ordered Glipizide 2.5mg tablets (for treatment of Diabetes). He told LVN D who said she would look for the medication. The ADON came to the medication cart and pulled out a card of Glyburide 2.5mg tablets. MA H said the order was for Glipizide. The ADON put the Glyburide tablets back in the cart and said she would notify the pharmacy. Shortly after, the ADON returned to the cart and said the order for Glyburide was discontinued on 07/19/2024 and a new order for Glipizide was written the same day. The ADON said pharmacy would deliver the Glipizide that evening. A review of Resident #16's October 2024 physician orders indicated an order dated 06/19/2024 for Resident #16 to be given 2 (two) Vitamin D3 25mcg (1000 UT) capsules one time a day. The same physician orders also indicated an order dated 07/19/2024 to discontinue Glyburide 2.5 mg 1 tablet daily and start Glipizide 2.5mg 1 tablet daily. A review of the October 2024 MAR indicated Resident #16 was to receive Glipizide 2.5mg 1 tablet daily. A review of the MARs from 07/20/2024 through 10/21/2024 indicated Resident had received Glipizide 2.5mg daily. A review of Resident #16's medication labeled Glyburide 2,5mg tablets was noted filled by the pharmacy on 09/27/2024 and had 15 tablets missing from the card. A review indicated the following: *07/20/2024 a card containing 30 tablets each of Glyburide 2.5mg was delivered to the facility. *08/29/2024 a card containing 30 tablets each of Glyburide 2.5mg was delivered to the facility. *09/27/2024 a card containing 25 tablets of Glyburide 2.5mg was delivered to the facility. *09/30/2024- 5 tablets of Glyburide 2.5mg was delivered on 09/30/2024. Further review revealed there was no evidence the medication, Glipizide 2.5mg tablets, had ever been delivered to the facility. 2.A review of Resident #24's face sheet indicated he was [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included myasthenia gravis (a weakness and fatigue of muscles under voluntary control), sciatica (pain radiating along the sciatic nerve which runs down one or both legs from the lower back), vertebral low back pain, and chronic pain syndrome. During an observation of medication administration and interview on 10/22/2024 at 08:40 AM, MA H was observed to administer 1 (one) tablet of Vitamin C 500mg to Resident #24. MA H said the physician's order was for 2 (two) tablets of Vitamin C 250mg. MA H said he did not have any Vitamin C 250mg tablets and said the 1 (one)tablet of Vitamin C 500mg was the same thing and proceeded to administer the 1 (one) tablet of vitamin C. MA H did not consult the charge nurse about not having the prescribed 250mg Vitamin C tablets nor did he seek the nurse's guidance for determining the number of tablets to give of the substituted medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this same observation of medication administration, MA H said the physician's order was for 2 capsules of Gabapentin 100mg but the label on the bottle containing Gabapentin 100mg capsules said give 1 tablet. He asked the charge nurse, LVN D, about the conflicting labels. LVN D located a card of Gabapentin 100mg capsules with a label that matched the physician's order for 2 capsules to be given. MA H said he did not know if Resident #24 had been getting 1 (one) or 2 (two) capsules. A review of Resident #24's October 2024 physician's orders and MAR indicated an order dated 08/07/2024 to administer 2 Vitamin C 250mg tablets once a day. The same physician orders indicated an order dated 09/20/2024 for Resident #24 to be given 2 (two) Gabapentin 100mg capsules 3 (three) times daily. 3. A review of Resident #26's face sheet indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus. During an observation of Resident #26's insulin administration on 10/22/2024 at 11:30 AM, LVN D was observed to administer a subcutaneous injection of 15 units of insulin to Resident #26's right upper abdominal quadrant. Resident #26 was overheard to ask LVN D if she was going to rub it. LVN D replied she was and proceeded to massage the injection site. During an interview with LVN D on 10/22/2024 at 11:50 AM, LVN said massaging the site of an insulin injection was proper technique, then said, she was not supposed to massage the site of an insulin injection but because Resident #24 asked her to, she did. During an interview with the DON on 10/23/2024 at 01:45 PM, he said medication aides were not supposed to calculate drug dosages. He said MA H should not have made the decision to give different vitamins of different strengths without discussing it with the charge nurse and having the charge nurse determine the amount of each vitamin to give to meet the physician's order. The DON said Resident #24 probably brought the bottle of gabapentin capsules from home when he admitted to the facility and the bottle should not have been in the cart. He said someone should have noticed the discrepancy between the drugs, Glipizide and Glyburide. The DON said massaging the site of an insulin injection was not proper technique. The DON said he expected the medication aides to let the nurse know when medications were not available or when orders needed clarification. He said he expected medication aides to follow the rules of medication administration to ensure residents receive the right medication and he expected nurses to use proper technique when administering injections. A review of the facility's policy titled Pharmacy Services indicated the following: The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents. Medications must be ordered and reordered on a timely basis so that no resident misses a dose. The facility will ensure drug administration processes are followed to ensure that: drugs to be administered are checked against the physician's orders. A review of the Texas Administrative Code:Title 26: Part 1: Chapter 557: Rule 557.105 indicated the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A medication aide permitted under this chapter may not: (5) calculate residents' or client's medication dosages for administration . A review of the facility's policy titled Subcutaneous Injection Administration indicated the following: Procedure: 19. Cover site (injection) site with alcohol wipe. Massage site gently to distribute drug and facilitate absorption, except when giving heparin or insulin. A review of Lippincott's 2004Atlas of Medication Administration indicated the following: .For a subcutaneous injection, the site is gently massaged after the medication has been given, except in the case of heparin and insulin because massaging the site can increase the rate of absorption of these agents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 5 Residents (Residents #3, #7, #21) reviewed for medical records accuracy. The facility failed to ensure Resident #3's physician orders included orders for dialysis and the care of the dialysis access device. The facility failed to ensure Resident #7's physician orders included clear and precise instructions for the administration of an antidepressant medication. The facility failed to insure Resident #21's physician orders included the amount of an ordered liquid nutritional supplement to be given. These deficient practices could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. Findings included: 1.A review of Resident #3's face sheet dated 10/25/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease (a condition in which the kidneys lose the ability to remove wastes and balance fluids) and Dependence on Renal Dialysis (a person requires regular dialysis to remove excess water and wastes to sustain their life). A review of Resident #3's quarterly MDS assessment (Section O:J1) dated 08/17/2024 indicated she had received dialysis during the observation period. The same MDS noted Resident #3 to have a BIMS score of 15 indicating her cognition was intact. A review of Resident #3's care plan dated 10/22/2024 indicated she was receiving dialysis and included interventions to address it. A review of Resident #3's physician orders indicated there were no orders for dialysis treatment nor a protective dressing to the shunt site. During an observation and interview with Resident #3 on 10/21/2024 at 10:30 AM, she said she went to dialysis 3 (three) days a week. While she was speaking, resident #3 pulled up the sleeve on her left arm and pointed to the dialysis shunt (access device) site area. The shunt site was clean and dry. There was no dressing or band aide covering the site. Resident #3 said the dialysis center puts a dressing on the site after the dialysis is complete. She said the dressing usually comes off by itself or becomes loose and she removes it. She said the facility did not put any covering over the site. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/2024 at 01:00 PM, LVN D said Resident #3 went to the dialysis center on Tuesday, Thursday, and Saturday every week. She said she would verify orders for dialysis and care of the shunt site by reviewing the physician's orders. LVN D said she could not find any orders for dialysis nor shunt site care. A review of the facility's policy titled Dialysis indicated the following: 1.Review and confirm the physician's order for dialysis. 7.The (access) site will be assessed .every shift. 10.If the dressing should become wet or be removed, put a clean band aid over the site 2.A review of Resident #7's face sheet dated 10/22/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Anxiety, unspecified somatoform disorder (extreme focus on physical symptoms such as pain, weakness, shortness of breath), schizoaffective disorder, bipolar type, and schizoaffective disorder, depressive type (major mood disorder , either depression or mania, that occur at the same time as symptoms of schizophrenia are present). A review of Resident #7's admission MDS assessment dated [DATE] noted Resident #7 had a BIMS score of 10 indicating her cognition was moderately impaired. The same MDS indicated Resident #7 had received antidepressant medication during the observation period. A review of Resident #7's physician orders indicated the following: *Dated 04/22/2022 Venlafaxine 150mg to be given once a day with 75mg to equal 225mg. *Dated 07/27/2024 Effexor 150mg to be given once a day (Venlafaxine is the generic form of Effexor). A review of a PMHNP (Psychiatric Mental Health Nurse Practitioner) record for Resident #7 dated 07/19/2024 noted a plan to increase Effexor to 150mg daily. The same record noted Resident #7 was currently receiving Venlafaxine (Effexor) 75 mg with 150mg to equal 225mg. A review of a PMHNP record dated 07/23/2024 noted Resident #7's current medications included Venlafaxine 75mg 1 (one) time a day with 150mg to equal 225mg and Effexor 150mg 1 (one) time a day. The same record included notation saying Effexor had been increased to 150mg a day on 07/19/2024. A review of the October 2024 MAR for Resident #7 indicated the following: * 1 (one) capsule of Venlafaxine 150mg to be administered with 75mg to equal 225mg every day. * Effexor (venlafaxine) 150 mg to be administered one time a day. Further review of the October 2024 MAR indicated both orders had been signed by staff, indicating Resident #7 had received 375mg of Venlafaxine every day since 07/27/2024. Observation of the medication cart on 10/23/2024 at 2:05 PM noted Resident #7 had 2 (two) medication cards containing Venlafaxine. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Card 1-Venlafaxine capsule 75mg: Give 1 (one) capsule by mouth once daily with 150mg for total dose of 225mg per day. * Card 2-Venlafaxine 150mg: Give 1 (one) capsule daily with 75mg for total dose of 225mg per day. During an interview with Resident #7 on 10/22/2024 at 10:15 AM, she did not know what medications she took or why. Resident was noted to be calm and showed no signs of mental upset. During an interview with the ADON, DON, and RN G present on 10/23/2024 at 02:10 PM, the ADON said she understood Resident # 3 was supposed to be given a total of Venlafaxine 375mg daily. The DON said he understood Resident #3 was to receive 225mg of Venlafaxine daily. He said the orders should have been written so that whoever was administering meds would know to give a 150mg capsule and a 75mg capsule and there would be a space to sign for the administration of each capsule. He said he did not know why the PMHNP would document to increase the dose of Venlafaxine to 150mg when Resident #7 was receiving 225mg of Venlafaxine at the time she prescribed the increase. RN G said the orders were not clear and should be clarified. During an interview with the DON on 10/23/2024 at 02:35 PM, he said he found where Resident's order for 75mg Venlafaxine was discontinued on 02/22/2024 and the order for Venlafaxine 150mg daily continued. He said the instructions to give with 75mg to equal 225mg should have been removed from the instructions. He said the PMHNP would be at the facility shortly and he would ask about the noted instructions to increase the Effexor dose to 150mg daily. The DON also said part of the confusion could be due to the use of the generic drug name used in some orders and the brand name used in other orders even though both names refer to the same drug. During an interview with the PMHNP on 10/23/2024 at 03:10 PM, the PMHNP said she increased the Venlafaxine dose by an additional 150 mg to total 300mg daily. The DON was overheard to ask the PMHNP if it would be better to write the order to give 2 Venlafaxine 150mg capsules at which the PMHNP said that was ok. The PMHP said the pharmacist should have addressed this. During an interview on 10/23/2024 at 04:05 PM, the DON said he did not know why the issue with the Venlafaxine orders had not been addressed. He said he did not know why the card of Venlafaxine 75mg capsules were not removed from the cart when it was discontinued. He said he did not know why the discrepancies between the PMHNP records, physician orders, MAR records, and labels on the medication containers had not been noticed and addressed. The DON said there was a risk of overdosing and/or underdosing of medication due to unclear orders. He said he expected the nurses and med aides to notify him of all unclear orders. 3.A review of Resident #21's face sheet dated 10/22/2024 indicated she was a [AGE] year-oldfemale who admitted to the facility on ,d+[DATE] with diagnoses which included dementia and protein calorie malnutrition. A review of Resident #21's MDS dated [DATE] noted her to be rarely understood by others. A review of Resident#21's care plan dated October 2024 indicated she was at risk for weight changes and malnutrition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #21's weight records from April 2024 through October 2024 indicated Resident #21 had a mild weight loss of approximately 4.5 pounds over the last 6 months. A review of the physician's orders dated 10/22/2024 indicated Resident #21 was to receive Med Pass 2.0 (a liquid nutritional supplement that provides 120 calories and 5 grams of protein in each 2 oz. serving) 2 (two) times daily for weight loss. The order did not specify the amount of the supplement to be given with each administration. A review of the October 2024 MAR indicated Resident #21 was provided Med Pass 2.0 twice daily. There was no documentation to reflect how much supplement was provided nor how much Resident #21 consumed. During an interview on 10/23/2024 at 02:20 PM, MA J accessed Resident #21's MAR and said the order did not say how much Med Pass 2.0 to give Resident #21. MA J said whenever she saw Med Pass 2.0 on the MAR, she gave about half of a disposable cup she was holding in her hand. The cup was a 6oz cup. She said she had not consulted the charge nurse nor the DON about the incomplete order. She said Med Pass 2. 0 was given to residents who were losing weight. During an interview with the DON on 10/23/2024 at 04:00 PM, he said he was not aware the order for Med Pass 2.0 did not specify the amount to be given. He said he expected the medication aides to notify the charge nurse, ADON, or himself when orders needed clarification. A review of the facility's policy titled Pharmacy Services indicated the following: The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.The pharmacist must report any irregularities to the medical director, attending physician and the director of nursing .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42190 Based observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident (Resident #29) reviewed for infection control. The facility failed to keep the urine drainage bag off the floor. This failure could place residents at risk of cross-contamination and development of infections. Finding include: During observation on 10/21/2024 at 11:27AM, Resident #29's urine catheter bag was hung on the trash can beside his bed. The bottom of the urine catheter bag was observed to be laying on the floor. During observation on 10/23/2024 at 2:29PM, Resident #29 urine catheter bag was hung on a trash can beside his bed. The bottom of the urine catheter bag was observed to be laying on the floor. During an interview on 10/23/2024 at 2:36PM, CNA-E said, the urine catheter bag was hung wrong and it should not be touching the floor. She said it should not be hung from the trash can, it should be hung from the bed and should be below Resident #29 feet. CNA-E said the urine catheter bag should have been place in a covering bag. During an interview and observation with the DON on 10/23/2024 at 2:40PM, the DON said the urine catheter bag should have been placed in a covering bag. He said he did not know why the urine catheter bag was not in a covering bag. He said the facility just purchased new covering bags. Record review of an undated policy titled, Anchoring - Catheter Bags, indicated: To ensure that all catheter bags are anchored appropriately, they do not touch the ground .