STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455876	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	4650 S Panther Creek Dr The Woodlands, TX 77381

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observation, interview, and record review the facility failed to provide pharmaceutical services, which included procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 29 residents (Residents #2) reviewed for pharmacy services. The facility failed to ensure Midodrine (a blood pressure (BP) medication given to elevate hypotension (low blood pressure) was administered to Resident #2 as ordered by the physician. This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included: Record review of Resident #2's admission face sheet, undated, reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included: hypertension (elevated blood pressure), congestive heart failure (a chronic condition in which the heart not pumping blood as well as it should), respiratory failure, Percutaneous Endoscopic Gastrostomy (G-tube) (a flexible feeding tube placed through the abdominal wall to allow nutrition, fluids and medications to be put directly into the stomach), chronic atrial fibrillation (an irregular rapid heart ratee that causes poor blood flow). Record review of Resident #2's care plan revision updated 06/10/2024 reflected: Problem: Resident #2 had hypertension. Resident #2 was at risk for ineffective peripheral tissue perfusion (passage of fluid through the circulatory system); Goal: Resident will remain free of signs and symptoms of hypertension. Interventions: Give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a form of low blood pressure) and increased heart rate. Record review of Resident #2's care plan revision updated 06/10/2024 reflected: Focus: Resident #2 had coronary artery disease related to atrial fibrillation. Resident #2 was at risk for decreased cardiac output (heart does not pump enough blood to meet the body needs). (continued on next page)

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.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: The resident will be free from signs and symptoms of complications of cardiac problems. Interventions: Give all cardiac medications as ordered by the physician. Record review of Resident #2's July 2024 Medication Administration Record (MAR) dated 07/01/2024-7/31/2024 reflected, the resident was administered Midodrine 5 mg outside of physician set parameter of SBP over 130 on: 07/24/2024 at 8:00 AM with BP 139/67 by RN B 07/25/2024 at 8:00 AM with BP 133/62 and at 4:00 PM with BP 133/62 by RN A 07/26/2024 at 4:00 AM with BP 133/64 by RN A Record review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS) was not scored. The resident's cognitive skills for daily decision making was scored as three which indicted the resident's mental state was severely impaired. The resident was dependent on staff for her bed mobility, transfers, and dressing. The MDS identified Resident #2's active diagnosis was medically complex conditions. Record review of Resident #2's Physician Orders, dated 08/01/2024, revealed, Midodrine 5 mg. Give one tablet by G-tube three times a day. Hold for systolic blood pressure (SBP) (the top blood pressure number which measures the pressure in the arteries when the heart beats) greater than 130. Order start dated 07/12/2024. In an interview and record review on 08/01/2024 at 11:50 AM RN A stated he reviewed the physicians orders. RN A stated he checked the resident's blood pressure to assess if the blood pressure was outside of the ordered parameters. At this time RN A reviewed Resident #2's MAR. RN #2 stated the order was not to administer the medication if the resident's SBP was greater than 130. RN A stated the medication should not have been given because the resident's SBP was 133. RN A stated the purpose of the medication was to elevate the residents blood pressure. The RN stated the risk was causing the resident's blood pressure too high. The RN stated he did administer the medication according to the MAR. RN A stated if he had not given the medication, it the MAR would be documented with the number 4 to indicate the medication was held due to being outside ordered parameters. RN A stated he did not know why he gave it. In an interview on 08/01/2024 at 12:10 PM with the Pharmacist she stated Midodrine was to be given for low blood pressure. She stated the hold order for the SBP was to prevent the medication from going too high. The Pharmacist stated when the medication was given over the SBP parameters it was a risk of the blood pressure going too high for the resident. The Pharmacist stated she monitored the MARS monthly, if she found an error, she would bring it to the nurse's attention and sometimes write a recommendation and report it to the DON. Observation on 08/01/2024 at 12:15 PM revealed Resident #2 in bed. Resident #2's head of her bed was elevated with tube feeding (liquid form of food carried through the body) running on a pump. Resident #2 was nonverbal and unable to be interviewed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 08/01/24 at 12:37 PM the NP caring for Resident #2 stated the parameters to hold for SBP at 130 were ordered from the hospital. She stated the order was continued at the facility. The NP stated the resident had low blood pressure. The NP stated the medication was to elevate the resident's blood pressure. The risk was the blood pressure could get too high. In an interview and record review on 08/01/24 at 1:04 PM the DON stated her expectations was the medication was administered as ordered by the physician. Midodrine was given to elevate blood pressure. The DON stated the order was to hold when the SBP was over 130. She stated according to the blood pressures the medications were not to be given. The DON reviewed the electronic medication administration record. She stated the medication was documented as administered at those times by RN A and RN B. The DON stated the medication administration was monitor monthly by the ADON, DON and pharmacist. She stated if they identified a problem it was addressed with the staff. In an interview on 08/01/2024 at 1:42 the Administrator stated he was aware the medication was given to elevate low blood pressure. He stated the DON and ADON monitor MARS and physician's orders monthly. We have clinical meetings to discuss identified administration problems. The risk was the medication could cause the resident's blood pressure from going to high. We plan to educate to prevent this again. In an interview and record review on 08/01/2024 at 1:47 PM RN B reviewed Resident #2's MAR. She stated she followed steps to administer medications. She checked the resident's blood pressure. She reviewed the physician order. She stated she did not know why it was administered. She stated it should not have been given. The risk was the resident's blood pressure could go high. RN B stated she will go through the steps more carefully to prevent a mistake. Record review of the facility policy titled Medication Administration Date implemented, 10/24/2022, reflected, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . Policy Explanation and Compliance Guidelines: 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters .