STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676144	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Health & Rehabilitation Center - Wichi	910 Midwestern Pkwy Wichita Falls, TX 76302

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45437 Based on interviews and record reviews the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 1 of 1 Licensed Nurses (LVN A) reviewed for competent nursing, in that: LVN A was not supervised as per the Texas Board of Nursing agreed order. This deficient practice places residents at risk for being provided care by staff who do not have the skills to provide necessary . The Findings include: Record review of employee files on 02/27/2024 revealed that LVN A had nursing stipulations from the Texas Board of Nursing that were signed on December 13th, 2020, which revealed the following terms of the order: Findings: 7. On or about June 1, 2020 while employed as an LVN, and providing care for Patient Medical Record #2297001, Respondent failed to report out of range Prothrombin Time and International Normalized Ration lab results to the patients cardiologist who managed the patient's Coumadin dosage based on PT/INR lab results. Respondent's conduct places the patients at risk from the lack of medical treatment for elevated PT and INR lab results. 8. On or about June 8, 2018, while employed as an LVN, and providing care for Patient Medical Record #2297001, Respondent failed to timely provide the patient with the physician's new Coumadin order, including a new written order that the Coumadin should be held for 2 days and then restarted a 2mg daily, rather than continuing the current dosage of 3 mg. 9. On or about June 8, 2018, while employed as an LVN, and providing care for Patient Medical Record #2297001, Respondent falsely reported to the patient's cardiologist that the patient's Coumadin 3 mg daily, had been held for 2 days and then restarted at 2mg daily, per the physician's order. Respondent conducted a false report upon which the cardiologist relied for the medical management of the patient's Coumadin dosage. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employment Requirements: C. Indirect Supervision: Respondent shall be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse, if licensed as a Licensed Vocation Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as a respondent but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two years of experience in the same or similar practice setting to which the respondent is currently working. Respondent shall work only regularly assigned, identified, and predetermined units. Respondents shall not be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. Respondent shall not be self-employed or contract for services. Multiple employers are prohibited. D. Nursing performance evaluations: respondent shall call each employer to submit, on forms provided to the respondent by the board, periodic reports as to respondent's capability to practice nursing. These reports shall be completed by the individual who supervises the respondent, and these reports shall be submitted by the supervising individual to the office of the board at the end of each three month quarterly. For four quarters one year of employment as a nurse. Interview and Record on 02/27/2024 at 4:00 PM with the BOM revealed that a review of LVN A's Personnel Files reflected LVN A was hired on 11/14/2018 and received an annual background check. The last background check was pulled on November 2023, which notified the facility that LVN A had stipulations. The BOM stated that she became aware that LVN A had stipulations and was able to access the records online from the BON website. She stated that she brought the order and discussed them with the DON. She revealed that she did not discuss the stipulations with LVN A. She revealed that she did not complete any employment verification for the BON concerning LVN A, she did not realize she was supposed to. She stated this failure could cause the facility to employe nurses that are not following the BON orders to protect the residents from errors. The BOM revealed that she was responsible for employment verification. She revealed that the stipulations were not followed due to the facility not recognizing that they needed to. Interview on 03/01/2024 at 3:30 PM with the DON revealed that she was the only one responsible for supervising LVN A. She revealed that she supervised her but did not follow the BON stipulation to be readily available in the event that LVN A needed assistance while working. She stated she was unsure why they did not follow them. She revealed that the facility failed to complete the forms that the BON required from LVN A's employer. She revealed that she works days and the LVN A worked nights.

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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 - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45437 Based on interview, and record review the facility failed to have a system to account for the disposition and accurate accounting for controlled substances for 4 (Resident #'s 1, 2, 3 and 4) of 12 residents reviewed for pharmacy records, in that: . The ADON and DON failed to review the medication sheets for medication discrepancies. The facility failed to have 2 signatures on medication sheets when a controlled drug was wasted. These failures could place the residents at risk of a drug diversion which could result in delayed healing. Findings Include: During a record review on 2/27/2024 at 10:30 AM, the following medication sheets revealed the following information: - Resident #1's Controlled Substance Disposition Record. Order- Hydroco/APAP Tb 10-325Mg, take 1 tablet by mouth every 6 hours, as needed. 2/7/2024- no time entered- 1 wasted- LVN A signature, second signature missing. 2/10/2024- no time entered- 1 wasted- LVN A signature, second signature missing. 2/11/2024- no time entered- 3 wasted- LVN A signature, second signature missing. 2/12/2024- no time entered- 4 wasted- no nursing signature. - Resident #2's Controlled Substance Disposition Record. Order- Hydroco/APAP Tb 7-325Mg, take 1 tablet by mouth every 4 hours, as needed. 2/9/2024- 5pm- 1 wasted- LVN A signature, second signature missing. 2/9/2024- no time entered- 2 wasted- LVN A signature, second signature missing. 2/10/2024- no time entered- 2 wasted- LVN A signature, second signature missing. 2/11/2024- no time entered- 11 wasted- LVN A signature, second signature missing. - Resident #3's Controlled Substance Disposition Record (continued on next page)

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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 - Few	Order- Hydroco/APAP Tb 10-325Mg, take 1 tablet by mouth every 6 hours, as needed. No date (in between 2/6/2024 dates)- no time entered- 1 wasted- LVN A signature, second signature missing. 2/6/2024- no time entered- 1 wasted- LVN A signature, second signature missing. 2/9/2024- no time entered- 1 wasted- LVN A signature, second signature missing. 2/10/2024- 6:45pm- 1 wasted- no signature. 2/11/2024- 12:45am- LVN A signature, second signature missing. - Resident #3's Controlled Substance Disposition Record. Order- Hydroco/APAP Tb 10-325Mg, take 1 tablet by mouth every 4 hours, as needed. 2/1/2024- 3 wasted- no time entered- 1 wasted- LVN A signature, second signature missing. 2/2/2024- 1 wasted- no time entered- 1 wasted- LVN A signature, second signature missing. - Resident #4's Controlled Substance Disposition Record. Order- APAP/Codeine Tablet 300-30Mg, take 1 tablet by mouth every 6 hours, as needed. 1/18/2024- time not legible- 1 given- No nursing signature. 1/19/2024- 6AM- 1 given- No nursing signature. 1/28/2024- no time entered- 1 wasted- LVN A signature, second signature missing. 1/29/2024- no time entered- 1 wasted- LVN A signature, second signature missing. 1/30/2024- no time entered- 2 wasted- no time entered- 1 wasted- LVN A signature, second signature missing. During a record review on 2/27/2024 at 2:30 PM, the following statement revealed the following information: DON notes from 02/14/2024 at 10:54AM- I met with LVN A and HR. The narcotic sheet was reviewed with LVN A where she wasted several narcotic. She admitted that all of the wasted entries were, in fact hers. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/27/2024 at 10:30 AM the DON revealed that she had not been checking the medication sheet in its entirety. She stated that they had just been checking the last line, which was the count number and total. She stated that all nursing staff complete in-service that when a medication is wasted, there must be 2 signatures to waste the medication. She stated that once she realized it was not being completed, she reported it to state. She revaled that after her investigation and record review, all of the medications that were wasted were from 1 nurse, which was LVN A. She revealed that she had interviewed LVN A and LVN A reported that the medications were wasted by her, she failed to have another nurse verify that it was wasted by her. She reported that she had completed a full staff in-service on wasting controlled medications and following the facilities policies and procedures. In an interview on 02/27/2024 at 5:11 PM the ADON revealed that the wasted med sheets should have been reviewed better and that the facility expectations are that they should be reviewed at shift change She stated that they should have been completing 2 signatures for the wasted medications. She said that this could result in a medication diversion. Record review if the facility's policy titled Medication Administration not dated, revealed the following: Process for wasting narcotics: - a narcotic should only be wasted if it has been dropped on the floor, resident refused medication, etc. - It is required to have a witnessing nurse when wasting narcotics. You must waste the med together, and both nurses sign in narcotic log. - When wasting a medication, it should be crushed and put in the sharp's container. - The supervisor should then be notified. Every Med cart must be counted each time the keys switch hands. Ensure that the number of meds on the narcotic log matches the number of meds in the card/bottle. PRN's should be given by the charge nurse. Their narcotic log should match the MAR. Record review of the facility's policy entitled; Controlled Substances not dated, revealed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purchase, storage, distribution of controlled drugs will be done in accordance with all federal and state laws and standards of professional practice, to maintain optimal quality control over high-risk substances and to prevent divergence. The facility will adhere to the controlled substance act. All scheduled two drugs are kept secured under a double lock. A transaction record for all controlled substances will be maintained. All controlled drugs will be maintained for the period required by law can be readily retrievable. A separate record will be maintained for each drug covered by scheduled II, III, IV of the Control Substance Act. The record will contain the prescription number, name, and the strength of the drug, date received by the facility, date and time administered, name of the resident, dose, physician's name, signature of the person administering the dose, an original amount dispensed with the balance of verifiable by drug inventory at every shift.

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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 - Few	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** 45437 Based on interview and record review the facility failed to maintain clinical records that were complete and/or accurate for 2 of 4 (Resident #2 and Resident #3) residents reviewed for clinical records in that: The facility failed to document in Resident #2's MAR when they administered Hydroco/APAP on 02/02/2024 through 02/07/2024. The facility failed to document in Resident #3's MAR when they administered Hydroco/APAP on 02/03/2024 through 02/11/2024. This failure could place residents at risk for having records that were inaccurate/incomplete Finding included: Record review of Resident #2's Face Sheet, dated 2/27/2024, revealed a [AGE] year-old female, admitted to the facility on [DATE] with an admitting diagnosis of Fracture of the shaft of the humorous (break in the upper arm bone). Record review of a Resident #2's Discharge MDS assessment, dated 02/26/2024, revealed the following: Section C (BIMS)- Resident had a BIMS score of 15, which indicated she was cognitively intact. Section N (Medications)- Resident was receiving opioids. Record review of Resident #2's MAR dated 02/27/2024 revealed the following: Order for Hydroco/APAP Tab 7.5-325. Directions: Take 1 tab by mouth every 4 hours as needed. Administered on the following: 02/03/2024 x1 administered. 02/07/2024 x1 administered. Record review of Resident #2's Controlled Substance Disposition Record revealed the following that was not documented on the MAR: Order for Hydroco/APAP Tab 7.5-325. Directions: Take 1 tab by mouth every 4 hours as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administered on the following: 02/02/2024 x2 administered. 02/03/2024 x4 administered. 02/04/2024 x 3 administered. 02/05/2024 x 5 administered. 02/06/2024 x 6 administered. 02/07/2024- x2 administered. Record review of Resident #3's Face Sheet, dated 2/27/2024, revealed a [AGE] year-old male, admitted to the facility on [DATE] with an admitting diagnosis of lower abdominal pain (pain in the stomach areas), spinal stenosis (abnormal narrowing of the spinal canal that results in pain, numbness and pressure). Record review of a Resident #3's Admission MDS assessment, dated 01/26/2024, revealed the following: Section C (BIMS)- Resident had a BIMS score of 09, which indicated severed cognitive impairment. Section J (Pain Interview)- Resident answered 10 for a pain intensity scale of 0-10, with 10 being the worst, Section N (Medications)- Resident was receiving opioids. Record review of Resident #3's MAR dated 02/27/2024 revealed the following: Order for Hydroco/APAP Tab 10-325. Directions: Take 1 tab by mouth every 6 hours as needed. Administered on the following: 02/08/2024 x1 administered. Record review of Resident #2's Controlled Substance Disposition Record revealed the following that was not documented on the MAR: Order for Hydroco/APAP Tab 10-325. Directions: Take 1 tab by mouth every 6 hours as needed. Administered on the following: (continued on next page)

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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 - Few	02/03/2024 x3 administered. 02/04/2024 x4 administered. 02/05/2024 x 3 administered. 02/05/2024 x 4 administered. 02/06/2024 x 5 administered. 02/07/2024 x 3 administered. 02/08/2024 x 4 administered. 02/09/2024 x 4 administered. 02/10/2024 x 3 administered. 02/11/2024 x 3 administered. In an interview on 2/27/2024 at 10:30 AM, the DON revealed her expectations are for nursing staff to sign the drugs out on the Controlled Substance Disposition Record and document the administration on the MAR. She revealed that failure could place the resident at risk for a drug diversion or a duplicate medication being administered. She stated that she had trained nursing staff to always document electronically. She revealed that it was her responsibility to ensure that medication sheets and records on Controlled Medications were done accurately. She revealed that she reviews the medication sheets for accuracy but did not compare it to the EMAR. Record review of the facility's policy covering Medication Administration, not dated, revealed the following: - PRN's should be given by the charge nurse. The Narcotic log should match the MAR.