STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676336	A. Building B. Wing	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Eagles Trace	14703 Eagle Vista Drive Bldg 601b Houston, TX 77077

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on interview, and record review, the facility failed to immediately assess the resident, consult with the physician, and immediately transport the resident to the hospital when a change in condition occurred for 1 of 1 resident (CR #6) was reviewed for a change of condition: 1. The facility failed to assessed CR #6 for more than 3.5 hours after the CA identified a change in resident's condition to include slurred speech and elevated blood pressure. 2. The facility failed to notified CR #6's physician for more than 4 hours after CA identified a change in condition. The noncompliance was identified as past noncompliance (PNC). The Immediate Jeopardy (IJ) began on 08/06/2023 and ended on 08/06/2023. The facility corrected the noncompliance before the investigation began. These failures resulted in an IJ on 11/17/2023. While the IJ was past non-compliance, this failure could affect all residents who dependent on staff to assess them and report changes in condition to physicians. Findings included: Review of the Face Sheet for CR #6 reflected an [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with the following diagnoses: dysarthria following other cerebrovascular disease, malignant neoplasm of connective and soft tissue of abdomen, secondary maligneoplasm of liver and intrahepatic bile duct, and chronic diastolic (congestive) heart failure. Review of Resident CR #6 Minimum Data Set (MDS) assessment, dated 09/07/2023, reflected a Brief Interview for Mental Status (BIMS) score of 08 out of 15. The MDS reflected CR #6's primary medical condition category that best describes the primary reason for admission: stroke. Review of CR #6 Care Plan dated 08/04/2023, reflected the following: Resident had a history of recent falls, was noted that resident was alert and oriented and able to make needs known. Resident required one-person extensive assistance with activities of daily living. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #6's nursing note dated 08/06/2023 at 05:27 PM written by Registered Nurse (RN) revealed: Resident was sent to the ER for evaluation following Medical Director's (MD) orders due to right side generalized weakness. BP vitals 173/93 (systolic/diastolic pressure in arteries), HR: 79, and BG 236. Witness #2 concerned of possible stroke or UTI and MD was notified hence the orders. Review of CR #6 hospital records dated 08/14/2023 revealed discharge diagnoses as: acute ischemic left middle cerebral artery stroke. Paroxysmal atrial fibrillation. Hypertension. History of stroke in adulthood. Diabetes mellitus, type 2, with complications. Obesity. Primary sarcoma of intraabdominal site. Hyponatremia. Cerebral infarction due to embolism of left middle cerebral artery. Record review of a timely of events from CM's interviews with CA dated 09/08/2023 revealed the morning of 08/06/2023 Care Associate (CA) assisted CR #6 in dining area and resident's speech was clear. RN checked CR #6 while visiting with Witness #1 with no concerns. After breakfast, CA reported to RN that CR #6 had an elevated BP. RN indicated she would recheck CR #6's BP. During transport to the dinning for lunch, RN asked CA to place TED hose (compression socks) on CR #6. CR #6 was checked after lunch with no concerns. At 1:00 PM, CA reported slurred speech to the RN after CR #6 dropped her glasses to the floor. Witness #2 reported CR #6 had difficulty finishing her sentences and did not seem like herself. RN assessed and CR #6 seemed fine. RN text MD with performing an assessment with Licensed Vocational Nurse (LVN). MD sent a text that CR #6 could be sent out for evaluation. EMS arrived and CR #6 was transported to the local ER. Record review of CR #6 Progress Note dated 09/12/2023 at 09:50 a.m. written by Social Worker (SW) revealed CR #6 discharged on [DATE] on stretcher with EMT in stable condition. Record review of the facility's provider investigation report dated 09/18/2023 signed by NHA revealed on 8/6/23, RN provided a delay in care, and a delay in notifying MD for CR #6 change in condition. There was also no documentation pertaining to reported elevated BP by CA. The RN also did not complete any documentation/assessment of the change in condition for CR #6 having had a difficulty forming words at 01:00 PM reported to RN by CA. The NHA, DON and CM meet with the CR #6's family informing that an investigation that was done. It was found that RN did not assess CR #6 properly and was terminated. Resident return to facility on 08/28/2023 after having a stay at an acute care facility from 8/14/2023 to 08/28/2023. Record review of RN's Counseling Reason dated 9/19/2023 at 09:52 AM revealed RN's work performance and behavior did not meet expectation and did not exhibit the facility's Mission, Vision, and Values. The events of 08/06/2023 revealed that RN presented a delay in care, delay in notifying the doctor, she did not provide clinical/nursing assessment. No documentation pertaining to reported elevated blood pressure escalated to her by CA. No documentation /assessment of the change in condition in resident having difficulty forming words at 1 pm reported to her by CA. RN did not report events to Manager on Call, instead called the NHA. The policy to notify provider for change of condition was not performed by RN The series of events by RN lead to a delay in care to the resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record of policy Physician Notification of Change in Condition, origination date of 5/2023 revealed, Policy: When there is a sudden change of condition, the clinical team is responsible to perform a complete assessment, to include obtaining a full set of vital signs and the concern and notify the provider /attending physician. Procedure: 1. Significant changes in resident medical or psychosocial condition may include but are not limited to: Change in Vital Signs. 2. If after the nurse evaluates/assesses a resident and a change in condition is noted, the nurse will promptly notify provider and provides recent vital signs, and physical assessment. 3. Review identified change(s) with resident and document evaluation/assessment in electronic medical record. Procedure: 6. Nurse documents assessment of change of condition, time & conversation of physician & responsible party conversation and transcribes any new orders received in resident's electronic medical record (EMR). Record of policy Physician Notification for Change in Condition - SOP. Origination date of 8/2020. Purpose: Regulatory Requirements mandate that the resident's provider and healthcare representative will be notified of changes in a resident's condition that affect health. When there is a change of condition, the clinician is responsible to perform a complete assessment of vital signs and assessment of the basic problem, and to notify the provider. The following are examples of times when the provider must be immediately notified of a change in condition. After the provider is notified and the resident is stabilized the clinical team are responsible to notify the healthcare representative of the change in condition. Signs and symptoms of an impending stroke. Sudden decline in cognitive status and vital signs outside of parameter. Documents and follow up: Notifying clinician documents in electronic medical records: assessment completed of change of condition. Record review policy Abuse Prevention originated date 12/2006. Neglect. The failure of facility, its employees or service provider to provide goods and/or services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment, rehabilitation, care, attention, food, clothing, shelter, supervision, or medical services by a caregiver. Neglect could include instances where competent resident's wishes are not honored, restricting contact with family, ignoring the resident's need for verbal and emotional contact. Interview on 11/03/2023 at 12:34 PM NHA stated that on 08/06/2023 CA was assisting CR #6 did not have clear speech and did not eat breakfast. She stated at 01:00 PM, CA reported to RN that CR #6 had difficulty with word finding and to have an elevated BP. The RN did not check on resident at this time but did report she had checked on resident before lunch and did not notice any changes. At 02:00 PM Witness #2 reported to CA that resident had slurred speech. She stated that CA told witness #2 that RN had been made aware. She stated the RN reported she assess resident after Witness #2 reported that resident appeared frustrated, and that resident's son was finishing the resident's sentences. She stated the RN notified MD at approximately 03:43 PM to inform MD that Witness #2 was upset with resident's change in condition. She stated the MD called back within 15 minutes of notification and informed the RN to send resident out to the hospital. She stated that CR #6 was transported to the ER at 04:43 PM and was later admitted with a diagnosis of acute ischemic left middle cerebral artery stroke. She stated at the time of transport, resident's BP was 173/93. Interview on 11/03/2023 at 01:15 PM Witness #3 stated that Resident #3 was doing fine. He stated that the facility was short staffed. He stated he had to visit with the resident everyday all day long to ensure that the resident was receiving adequate care. He stated he had not issue to no concerns to presently report. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 11/03/2023 at 01:23 PM Resident #2 stated said he had no issues with care or delay in care. no staff were abusive to him. that he was on his way to watch a moving and was in a hurry. Interview on 11/03/2023 at 01:29 PM Resident #4 stated he believed he was doing fine and had no issues with care or a lack of care. Interview on 11/03/2023 at 01:34 PM Resident #1 stated he had no issues with care or a lack of care. Interview on 11/03/2023 at 02:56 PM DON stated on 10/31/2023 between 11:30 AM and 12:30 PM CR #6 ate lunch with Witness #1 with no reports of concern. She stated on or about the same time Witness #2 called to speak to resident and reported to Witness #1 that resident was not easily understood as speech was slurred. She stated that CA checked on resident between 12:00 PM and 1:00 PM and resident had slurred speech and an elevated BP. She stated that CA immediately reported the resident's change of condition to the RN who told CA she would be to assess CR #6 shortly. She stated at 02:00 PM witness #2 arrived at the facility and report to both CA and RN that CR was not looking good and had slurred speech. She stated RN told witness #2 that when she finished with another resident, she would be in to assess CR. She stated RN spoke with resident but did not take resident's vitals. She stated that Witness #2 told RN that CR had previous stroke history. She stated that RN felt that the CR was stable. She stated that witness #2 was adamant that MD come to the facility and assess CR. She stated (exact time unknown) RN sent a message regarding CR's change in condition. She stated at that time, the Administrator called her stating RN had called MD regarding CR's slurred speech and positioning in chair. She stated that she told Administrator if RN had not heard back from the MD or if MD cannot triage CR in-house, to send CR to the hospital. She stated that there was a lap in time between the MD was contacted and when CR was sent to the hospital. She stated that RN failure to take heed to witness #2's keen history of CR's previous stroke history and did not possess a sense of urgency to CR's change in condition. She stated that RN could not provide her a reason for not assessing CR #6. She stated that as an experienced RN with several years of experience RN had not followed protocol for assessing and reporting to the MD a change in resident's condition. Interview on 11/03/2023 at 05:00 PM MD stated he had been the MD at the facility for [AGE] years. He stated on 08/06/23 he received a text message from RN that CR #6 had a change in condition with signs and symptoms of slurred speech which indicated that CR #6 may had experienced a stroke. He stated he could not recall the specific time of day that he received the message from RN. He stated he ordered RN to send CR #6 to the hospital. He stated it was confirmed by the hospital that CR #6 had experienced a stroke. Interview on 11/07/2023 at 04:43 PM CA stated that on 08/06/2023 during breakfast Witness # 1 ate breakfast with the CR #6 in the dining room. She stated after breakfast, exact time unknown she took the resident back to her room and performed vitals checks. She stated that the resident's BP was elevated, and she wrote down the BP and gave it to RN. She stated that Witness #2 came in at 2:00 PM and reported that the resident had slugged speech and was unable to finish her sentences. She stated again she reported the resident's BP reading and slurred speech to the RN also explaining Witness #2 was concerned. She stated RN came to assess the resident after Witness #2 insisted CR #6 be assessed. She stated thereafter she did not assist resident because the resident as transferred to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	It was determined these failures placed CR #6 in an Immediate Jeopardy (IJ) situation on 08/06/2023. The NHA was notified and provided with the IJ template on 11/16/2023 at 02:28 PM. The facility took the following action to correct the non-compliance on 08/07/23. Record review of the facility's Inservice Chain of Command meeting dated 08/07/2023 revealed 13 staff and on 08/15/2023 revealed 14 staff were trained on Care protocol in an emergency situation: After the nurse evaluates/assesses the resident and a change in condition is noted, the nurse will promptly notify the provider and provide the provider with the resident's vital signs, physical assessment, lab results, etc. The nurse will notify the resident's responsible party (if appropriate) of the findings and any new orders and document. Chain of command when reporting: In the event of a change in condition, the team member is to immediately notify the nurse of the findings. If the nurse is unavailable, the team member should then, immediately notify the clinical manager. In the event the clinical manager is unavailable, the team member should then notify the on-call manager. Record review of the facility's Inservice meeting dated 08/07/2023 revealed 13 staff were trained on Change in Condition/Provider Notification and Quality Insurance Performance Plan. A review of all change in conditions in daily clinical meeting, check documentation completed, who noted the change in condition, timely notification to the provider, and follow-up with family/POA/resident. Record review of RN's Notice of Employee Separation dated 08/10/2023. She was terminated for unsatisfactory performance. It was determined that her actions constituted a violation of facility values, standards of conduct and other polices. Record review of the facility's Inservice meeting dated 08/15/2023 revealed 14 staff were trained on Change in Condition/Provider Notification. Quality Insurance Performance Plan. A review of all change in conditions in daily clinical meeting, check documentation completed, who noted the change in condition, timely notification to the provider, and follow-up with family/POA/resident. Record review of the facility's Quality Insurance Performance Plan begun on 10/01/2323 after all education was initiated. The Staff Development Coordinator conduct random weekly audits of 3-staff members that consisted of RNs/LVNs and CAs on what they would have done in a situation where there was a change in condition. Interview on 11/17/2023 at 01:55 PM LVN B stated she received training on reporting changes of condition, reporting change in condition: chain of command, abuse prevention, and abuse reporting. in-service medication administration and watched pass meds. Last weekend. And one during the week Interview on 11/17/2023 at 02:14 PM RN B stated she received training on reporting changes of condition, reporting change in condition: chain of command, abuse prevention, and abuse reporting. Attempts to contact RN were made on 11/03/2023 at 12:04 PM, 11/07/2023 at 03:59 PM, 11/07/2023 at 04:24 PM, and 11/16/2023 at 11:18 AM no answer and voice mail messages left.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety 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** 44669 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs to meet the needs for 5 of 5 Residents (#1, #2, #3, #4 and CR #5) reviewed for pharmacy services in that: Medication Aide (MA) failed to follow medication administration policies resulting in Resident #1, #2, #3, #4 and CR #5 receiving double doses of medication. MA failed to follow the posted medication administration schedule for Resident #1, #2, #3, #4 and CR #5. MA failed to document the start date for Resident #1, #2, #3, #4 and CR #5's medications. MA failed to monitor medication administration as CR#5 was discovered deceased with medications in his mouth. These failures could place all residents at risk of drug diversion, health decline, and/or death. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the investigation began. These failures resulted in an IJ on [DATE]. While the IJ was past non-compliance, this failure could affect all residents who dependent on staff to administer medication. Findings included: Review of the Face Sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of essential (primary) hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery without angina pectoris (thickening of heart arteries), insomnia, unspecified pain, peptic ulcer (sore on lining of stomach, intestines, or esophagus), acute or chronic, without hemorrhage or perforation. Record review of Resident #2's Face Sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Parkinson's disease (nerve disorder), hereditary and idiopathic neuropathy (disfunction of motor nerves), urge incontinence (frequent urination), atrial fibrillation (irregular heartbeat), and atherosclerotic heart disease of native coronary artery without angina pectoris (fat build up in arteries causing difficult blood passage). Record review of Resident #3's Face Sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Poly osteoarthritis (5 or more locations of arthritis), hyperlipidemia (hardening of arteries), gastro-esophageal reflux disease without esophagitis (stomach acid flows into the food pipe) , dizziness and giddiness, and repeated falls. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's Face Sheet reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of heart failure, hypertensive heart disease with heart failure paroxysmal atrial fibrillation (rapid heart rate associated with blood clots), gout (inflammation and crystallization of joints), and chronic obstructive pulmonary disease (airflow blockage). Record review of CR #5's Face Sheet reflected an [AGE] year-old male admitted to the facility admitted to the facility on [DATE] and deceased on [DATE] with diagnoses of acute on chronic systolic (congestive) heart failure, hypertensive heart disease with heart failure (high blood pressure). Review of Resident #1's Care Plan dated [DATE], reflected the following: Resident had a history of oxygen therapy, pacemaker/defibrillator, and diabetes. Resident received diuretics and to be monitored for dry mouth, constipation, low BP, and increased heart rate, spontaneous nose and diabetic bleeds, bleeding of gums, blood in sweat and urine, lethargy, paleness, and cold and clammy skin. Resident received psychotropics and to be monitored for sleepiness, drooling, increased confusion, restlessness, and change in posture, actions and expressions. Record review of Resident #2's Care Plan dated [DATE], reflected the following: Resident had a history seizure and required seizure precautions, shortness of breath, and complications with cardiac status. Resident was on anticoagulant therapy and needed assistance with bleeding precautions, administer medications per order, monitor for side effects to medications: blood shot eyes, red enlarged tongue. Resident took psychotropic drugs and was to be monitored for sleepiness, drooling, increased confusion, restlessness, and change in posture, actions and expressions and monitor resident's sleep patterns and report insomnia. Record review of Resident #3's Care Plan dated [DATE], reflected that resident had a history of seizures and required seizure precautions, with shortness of breath, and complications with cardiac status. Administer medications per orders. Resident on anticoagulant monitor for blood in my urine and stool, black stools, blood shot eyes, enlarged red tongue and monitor resident's sleep pattern and report insomnia. Record review of Resident #4's Care Plan dated [DATE], reflected that resident had a pacemaker, history with complications with cardiac status. Resident was on anticoagulant therapy and needed assistance with bleeding precautions, administer medications per order, monitor for side effects to medications: blood shot eyes and red enlarged tongue. Record review of CR #5's Care Plan dated [DATE], reflected that resident had a fatigue defibrillator. Monitor resident for side effect and interactions of medications and report spontaneous nose bleeds, bleeding of gums or blood in urine to nurse promptly. Administer medications per orders and monitor resident's sleep pattern and report insomnia. Review of Resident #1's MDS assessment, dated [DATE], reflected a BIMS score of 08 out of 15. The MDS reflected Resident's 1's primary medical condition category that best describes the primary reason for admission: Debility, cardiorespiratory condition. Review of Resident #2's MDS assessment, dated [DATE] reflected a BIMS score of 08 out of 15. The MDS reflected Resident #2's primary medical condition/reason for admission: Progressive neurological condition. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's MDS assessment, dated [DATE] reflected a BIMS score of 04 out of 15. The MDS reflected Resident #3's primary medical condition/reason for admission: Medically complex condition. Review of Resident #4's MDS assessment, dated [DATE] reflected a BIMS score of 11 out of 15. The MDS reflected Resident #4's primary medical condition/reason for admission: stroke. Review of CR #5's MDS assessment, dated [DATE] reflected a BIMS score of 15 out of 15. The MDS reflected CR #5's primary medical condition/reason for admission: Debility, cardiorespiratory condition. Review of Resident #1's Incident Report dated [DATE] written by DON revealed that at approximately 10:30 p.m. MA reports to LVN A that she administered prescribed 9:00 p.m. medications to resident at 10:00 p.m. However, this resulted in a medication error because resident had received his medication prior by LVNA. Review of Resident #2's Incident Report dated [DATE] written by DON revealed that at approximately 10:30 p.m. MA reports to LVN A that she administered prescribed 9:00 p.m. medications to resident at 10:00 p.m. However, this resulted in a medication error because resident had received his medication prior by LVNA. Review of Resident #3's Incident Report dated [DATE] written by DON revealed that at approximately 10:30 p.m. MA reports to LVN A that she administered prescribed 9:00 p.m. medications to resident at 10:00 p.m. However, this resulted in a medication error because resident had received his medication prior by LVNA. Review of Resident #4's Incident Report dated [DATE] written by DON revealed that at approximately 10:30 p.m. MA reports to LVN A that she administered prescribed 9:00 p.m. medications to resident at 10:00 p.m. However, this resulted in a medication error because resident had received his medication prior by LVNA. Review of Resident CR #5's Incident Report dated [DATE] written by DON revealed that at approximately 10:30 p.m. MA reports to LVN A that she administered prescribed 9:00 p.m. medications to resident at 10:00 p.m. However, this resulted in a medication error because resident had received his medication prior by LVNA. Record review of Resident #1's [DATE] MAR reflected on [DATE] during 09:00 p.m. medication pass LVN A administered the following medications: Refresh Tears 0.5 % eye drops 1- drop both eyes for dry eye syndrome of bilateral lachrymal glands. Hydralazine 50 MG 1-tablet oral for atherosclerotic heart disease of native coronary artery without angina pectoris with bp ,d+[DATE] and heart rate 70. Trazodone 50 MG tablet (,d+[DATE] tab) oral for insomnia, unspecified. Record review of Resident #2's [DATE] MAR reflected on [DATE] during 09:00 p.m. medication pass LVN A administered the following medications: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Tamsulosin 0.4 MG 1-capsule oral for urge incontinence. Lisinopril 20 MG 1-tablet oral for hypertensive heart disease without heart failure. atorvastatin 10 MG 1-tablet oral for hyperlipidemia, unspecified. Metoprolol tartrate 25 MG 1-tablet (oral for unspecified atrial fibrillation. DonepeziL 10 MG 1-tablet oral for unspecified dementia with behavioral disturbances. Eliquis 5 MG 1-tablet oral for long term (current) use of anticoagulants. Valproic acid 250 MG 1-capsule oral for unspecified mood effective disorder. Myrbetriq 50 MG 1-tablet, extended release 24 hour oral for major depressive disorder, single episode, severe without psychotic features. Record review of Resident #3's [DATE] MAR reflected on [DATE] during 09:00 p.m. medication pass LVN A administered the following medications: Memantine 10 MG1-tablet oral for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Eliquis 2.5 MG 1-tablet oral for atrial fibrillation. CarvediloL 12.5 MG tablet (1) for hypertensive stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. Record review of Resident #4's [DATE] MAR reflected on [DATE] during 09:00 p.m. medication pass LVN A administered the following medications: Budesonide-formoterol HFA 160 mcg-4.5 mcg/actuation aerosol inhaler (2 puffs) HFA (hydrofluoroalkane) aerosol with adapter (gram) for chronic obstructive pulmonary disease, unspecified. Flomax 0.4 MG 1-capsule oral for benign prostatic hyperplasia with lower urinary tract symptoms. Colace 100 MG capsule (1) oral for constipation, unspecified. Oxcarbazepine 300 MG tab capsule for trigeminal neuralgia. Record review of CR #5's [DATE] MAR reflected on [DATE] during 09:00 p.m. medication pass LVN A administered the following medications: Carvedilol 3.125 MG oral 1-tab for hypertensive heart disease with heart failure with a recorded BP of , d+[DATE] and pulse of 72. Ranolazine ER 1,000 MG tablet, extended release, 1-tab, for hypertensive heart disease with heart failure. Atorvastatin 80 MG 1-tab oral for hyperlipidemia, unspecified. (continued on next page)

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	676336	A. Building B. Wing	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Eagles Trace	14703 Eagle Vista Drive Bldg 601b Houston, TX 77077

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	ClopidogreL 75 MG 1-tab oral for atherosclerotic heart disease of native coronary artery without angina pectoris. Tamsulosin 0.4 MG capsule (1 cap) oral for benign prostatic hyperplasia without lower urinary tract symptoms. Benzonatate 100 MG capsule oral for cough. Remeron 15 MG tablet (1 tab) oral for muscle weakness (generalized)/weight loss. Interview on [DATE] at 01:15 PM Witness #3 stated that Resident #3 received a double dose of medication on [DATE]. He stated he was concerned that the resident as she was on anticoagulant blood thinners. He stated he expressed his frustration and displeased concerns with the NHA and the DON about the lack of competences in the staff who over medicated the resident. He stated the incident occurred because the facility was short staffed. He fears if a mistake was made again, the results may not be as favorable for the resident. Interview on [DATE] at 01:23 PM Resident #2 stated he had no issues from the double dose of medication. Interview on [DATE] at 01:29 PM Resident #4 stated that he could not recall receiving a double dose of medication and believes he was doing fine. Interview on [DATE] at 01:34 PM Resident #1 stated he had no issues from the double dose of medication. Interview on [DATE] at 01:43 PM DON stated that on [DATE] she received a telephone call from LVN A of drug diversion. She stated that CMA took a picture of Resident #1, #2, #3, #4 and #CR #5's MARs with her cellphone around 08:00 p.m. on [DATE]. She stated on or about 09:00 p.m. LVN A passed medication to Resident #1, #2, #3, #4, and CR #5. She stated sometime between 10:,d+[DATE]:30 p.m. CMA went to pass Resident #6 meds with the resident informed the CMA that she had already received her meds for the evening. She stated that CMA spoke to LVN A and confirmed LVN A had passed the 6 residents' medication at 09:00 p.m. She stated that LVN A called MD who requested a list of all the medications that were passed and ordered the staff to do follow-up vital checks and monitor the 5 residents for any adverse effects and bruises and bleeding. She stated that Residents #1, #2, #3, and #4 were all in stable conditions after follow-up checks by CMA and LVN A. She stated upon follow-up check of CR #5 LVN A found the resident non-responsive with no pulse, no BP, and partially undissolved medication in his mouth. She stated that CR #5 had been on a decline since admission. She stated he had weight loss, poor appetite, increased behaviors of agitation resulting in redirection, falls, and restlessness. She stated the family was scheduled to consult with hospice on [DATE]. She stated that the facility resolved the issue by terminating the CMA. She stated that the policy and procedures for med administration and reporting medication errors were reviewed by the NHA, ADON and herself and found to be effect when followed. She stated all CMAs, LVNs, and RNs were in-serviced by the ADON on med administration, medication error reporting, abuse and neglect reporting, and following floor assignments. She stated that the facility has never had any issues with staff following the medication administration, floor assignments policies in the past. She stated that the ADON and herself had implemented an on-going audit/monitoring system reviewing MARs, and observed MAs medication administration for a 3-month period and on-going as needed to ensure that the med administration and floor assignment process and procedures were followed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 03:35 p.m. NHA stated that on [DATE], LVN A notified the DON that a medication error occurred, and 5 residents may have received a second dose of their evening medications administered by the CMA. She stated that the DON informed staff to take vitals and monitor residents for adverse signs and symptoms. She stated that MD was immediately notified, and orders were provided to hold meds and monitor. She stated when LVN A went to perform a check on CR #5 he was found to be unresponsive and ultimately pronounced deceased . She stated that CR #5 had a pacemaker. She stated that resident's family had a consult with hospice providers prior to his passing. She stated they immediately began an investigation. She stated that CMA was suspended on [DATE] and terminated from employment on [DATE]. She stated to resolve the drug diversion the DON, ADON and herself reviewed the med administration and reporting medication errors which they found to be effect when followed. She stated all CMAs, LVNs, and RNs were in-serviced by the ADON on med administration, medication error reporting, abuse and neglect reporting, and following floor assignments. She stated that the DON and ADON had implemented an on-going audit/monitoring system reviewing MARs, observed medication administration by MAs constantly for a 3-month period and on-going as needed to ensure that the med administration and floor assignment process and procedures were followed. Interview on [DATE] at 05:00 PM MD stated he had been the MD for the facility for [AGE] years. He stated on [DATE] he received a text message from the DON stating that Resident #1, #2, #3, #4 and #CR #5 had received double doses of medication and MA B would be calling him. MD stated he instructed the facility to do immediate assessments on the 5 residents to ensure that their vitals were within range and that the resident had no adverse effects from the double doses. He stated that LVN A, and CMA began vital checks on the 5 residents. He stated he received another call back from LVN A that CR #5 was deceased and that partially consumed medication remained in his mouth. MD stated that CR #5's mediations: ranolazine, clopidogrel and benzoate were all low doses of .25 and the max doses were 3.5. He stated that the medication should not have cause the death of CR #5. He stated CR #5's cause of death was cardiac arrest. Interview on [DATE] at 02:23 PM Witness #4 stated that he learned that CR #5 received a double dose of his medication and was then found deceased . He stated that facility told him they were performing an investigation and he was waiting on the time frame from when the resident was given the medication until he passed. He stated that he had not made up his mind if he would be requesting an autopsy and he was not interested in doing that. He stated that the MD informed the facility the quantity of the medications that CR #5 received would not have killed the resident. Interview on [DATE] at 10:45 a.m. LVN A stated that on [DATE] she was scheduled from 03:00 p.m. to 11:30 p.m. and assigned to pass medication to 9 residents. She stated at 09:00 p.m. she began and completed passing medication to the 9 residents. She stated at 10:30 p.m. she saw CMA on the same hall coming out of Resident #6's room and heading into another resident's room passing medication. She stated she stopped CMA and asked what she was doing on hall and who told her to pass meds there. She stated that CMA told her, Everyone and threw her hands in the air, They told me to pass meds. She stated CMA did not given any one staff person's name as to who instructed her to pass meds on that same hall as her. She stated CMA told her she had not looked at the posted schedule. She stated she told CMA if she had looked, she would have seen that she was not assigned to that hall and informed her that meds were already passed to the resident there. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She stated CMA told her that Resident #6 had just told her she had already received her meds. She stated that she immediate began comparing the MARs of the residents she passed meds to pictures CMA had on her phone of the resident's MARs. She stated it was confirmed that CMA had given a second dose of medication to Resident #1, #2, #3, #4, and CR #5. She stated CMA had taking photos of the resident's MARs sometime around 08:00 p.m. earlier in the evening with her cellphone and was working from the photos to pass medication. She stated she then called and informed the DON of the drug diversion. She stated that the DON instructed her to call the MD, immediately begin assessments on the 5 residents, and writing everything down to determine if any adverse effects occur from the double doses. She stated the MD was contacted and called back ordering residents be monitored and vitals checked. She stated Residents #1, #2, #3, and #4 were assessed and vitals checked with no adverse effects. She stated at 10:,d+[DATE]pm she entered CR #5's room she found him to have no rise in his chest and his mouth was jarred and she saw what appeared to be white and red colored medication still in the resident's mouth. She performed vitals and found the resident nonresponsive with no BP and no pulse. She stated resident received somewhere between 6 and 7 medications during med pass. She stated when she saw the resident during her 09:00 p.m. med pass, he in his bed alert with a good BP. She stated that she walked out the room, told the CMA B to assist her with end-of-life care and she called the MD and DON to relay CR #6's condition. She stated that RN B came to the room and too found the resident had no vitals and pronounced the resident deceased . She stated the CR #6's family came sometime after midnight. She stated CMA had screenshot the MARs because as they pass meds, the internet goes in and out in parts of the building and they are logged off the system. She stated they then have to go back by the nurse's station for the internet to pick back up and they are able to sign back in. She stated it was an inconvenient but not impossible. She stated management was aware of the issue and it was being addressed as far as she knows. She stated it was not an approved practice for staff to take pictures of the MAR with their phone to pass meds. She stated that she was a contact employee and [DATE] was her last scheduled shift with the facility and at 12:00 a.m. the electronic medical record system locked her out and she was unable to add notes to the system. She stated she had to handwrite her assessments from that evening and gave them to the DON. It was determined that the drug diversion/double dose of medication placed Resident #1, #2, #3, #4, CR #5 in an Immediate Jeopardy (IJ) situation on [DATE]. The NHA was notified and provided with the IJ template on [DATE] at 02:28 PM. The facility took the following action to correct the non-compliance on [DATE]: Record review of Resident #1's Nursing Note dated [DATE] written by NP revealed resident seen following-up with medication review as unfortunately resident had receive 2 doses of his 9 PM meds which were trazodone and hydralazine. Resident was seen earlier today in bed however at baseline resident usually does sleep later during the day. Reading his newspaper without any difficulties and denies any complication. Notes: Medication reconciled, and resident was monitored closely. At that time vital signs were normal, and he was eating without any difficulties. Resident continued with all of his medications as ordered. Follow-up in the a.m. Follow-up: 2 - 3 days. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Nursing Note dated [DATE] written by NP revealed resident seen following up with overall status due to resident receiving a double dose of his p.m. meds 48 hours ago. Resident is up in his wheelchair without any complication. Noted eating without any difficulty. Notes: No adverse effects noted with medication error per staff. Resident is on hospice and will continue his hospice orders as written. Vital signs reviewed with staff and all within normal limits. We will continue to monitor closely. Notes: Not experiencing any adverse effects of the medication ever. Resident monitored closely and resident at baseline stayed in bed the majority of his day. Eat well and was without pain. Record review of Resident #2's Nursing Note dated [DATE] written by NP revealed resident seen following up with medication review. Unfortunately, there was a possible med error in which resident received 2 doses of his neck medication. At that time resident noted with difficulties but was wanting to sleep after his breakfast. Notes: Due to the med error, Eliquis was held that a.m. and p.m. donepezil, metoprolol, lisinopril, valproic acid and Myrbetriq's were held times 1 dose since resident received double dose in the [DATE] PM. Also, will be ordering a CBC, CMP along with valproic acid level. Staff ensured that resident received gabapentin only at midnight thus medication request he will that was double dose was his 9:00 meds. Resident monitored closely and vital signs were stable. Follow-up: 2 - 3 days. Record review of Resident #3's NP Nursing Note dated [DATE] revealed resident seen following up with medication review. Evidently staff and did give resident her 9:00 p.m. meds twice [DATE]: Namenda, Coreg and Eliquis were given. Resident was up in wheelchair doing therapy without any difficulty. Witness #3 reports of no complication. Resident was in good spirits. Notes: Again, resident without any complication after medication error. Eliquis was held. Follow Up: 2 - 3 days. Record review of Resident #3's NP Nursing Note dated [DATE] revealed resident seen following up with medication error per staff as it was noted that resident received a double dose of her 9:00 PM meds on [DATE]. Resident was seen up in her wheelchair without any complication. Eating much better. Witness #3 at bedside and also was accompanying resident throughout her stay during the day. Notes: No adverse effects noted. Vital signs reviewed with staff extensively and all are within normal limits. Follow-up: prn. Record review of Resident #4's NP Nursing Note dated [DATE] revealed resident received a double dose last night of budesonide, Eliquis, Colace, Flomax, Norco, nystatin, and oxcarbazepine. Eliquis was held this [DATE] a.m. Resident had no complications with the extra dose of medication given. Resident was stable and will resume all his meds this [DATE] p.m. Hospice notified, and resident continued to be monitored by the hospice team and continue with comfort and palliative care. Follow-up: 2 - 3 days. Record review of Resident #4's NP Nursing Note dated [DATE] revealed resident seen following double dose of his p.m. meds 48 hours ago. Resident was up in his wheelchair without any complication. Noted eating without any difficulties. No adverse effects noted with medication error per staff. Resident was on hospice and continued his hospice orders as written. Vital signs reviewed with staff and all within normal limits and resident was monitored closely. Follow-up: prn. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident CR #5's handwritten Nursing Note dated [DATE] at 07:19 p.m. created by the LVN A. Resident returned from appointment with Witness #1. Assisted to dining room to eat with poor appetite. Resident put to bed 30 minutes later and tried to climb out of bed. Resident remained confused. LVN A walked resident around hall to calm. NP notified, incident report created, and resident monitored. Record review of Resident CR #5's handwritten Nursing Note dated [DATE] created by the LVN A revealed resident seen by cardiologist early in day with no new orders given. Resident viewed sitting up in his wheelchair the remaining of the day. At 10:50 p.m., LVA A entered resident's room to find resident without pulse, BP, or respiration. Resident code: DNR. The CMA last observed resident between 10:00 p.m. and 10:15 p.m. when he received his medications. RN B pronounced CR #5 deceased on [DATE] at 11:30 p.m. DON, MD, and family contacted. Record review of CR #5's Nursing Note dated [DATE] at 01:21 a.m. created by the DON. Resident had a change in condition. Refer to handwritten LVN A notes. Record review of CR #5's Nursing Note late entry dated [DATE] at 04:30 a.m. created by the LVN A. Head to toe assessment completed and vitals taken. No chest rise and respiration was zero. DON, MD, and family arrived. Family left before mortician picked up CR #5's remains at 03:14 a.m. Record review of CR #5's Nursing Note dated [DATE] at 04:54 p.m. created by the NHA. Family informed by NHA and DON facility performing an investigation due to medication error reported by LVN A after CR #5 received a double dose of medication on [DATE]. Review of Progress Note dated [DATE] written by MD B revealed Resident #1's Medical History: Bisacodyl 10 MG Suppository 1 suppository as needed, rectal once a day. Acetaminophen 650 MG Suppository 1 suppository as needed rectal every 6-hrs. Levsin (Hyoscyamine Sulfate) 0.125 MG tablet 1 tablet as needed orally every 4-hrs. Ondansetron Hydrochloric acid (HCl) 4 MG tablet 1 tablet orally every 4-hrs as needed. Morphine Sulfate (Concentrate) 20 MG/ML solution 1 ML as needed orally every 4-hrs. LORazepam 0.5 MG tablet 1 tablet orally every 6-hrs as needed. Taking Dutasteride 0.5 MG capsule 1 capsule orally once a day. Colace (Docusate Sodium) 100 MG capsule 1 capsule as needed orally once a day. Budesonide-Formoterol Fumarate ,d+[DATE].5 microgram/actuation (mcg/act) Aerosol 2 puffs Inhalation Twice a day. GenTeal Tears 0XXX,d+[DATE].3 % Solution as directed Ophthalmic. Miralax 17 GM Packet 1 packet mixed with 8 ounces of fluid Orally once a day. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	OXcarbazepine 150 MG Tablet 2 tablets at breakfast, lunch and bedtime, 1 tab before dinner oral as directed. Allopurinol 100 MG Tablet take 2 tablets by mouth daily oral. Eliquis (apixaban) 5 MG tablet 1 (one) tablet by mouth 2 times daily oral. Tamsulosin HCl 0.4 MG capsule take 1 capsule by mouth at bedtime oral. Ppantoprazole sodium 40 MG tablet delayed release take 1 tablet by mouth every day oral. HYDROcodone-Acetaminophen ,d+[DATE] MG tablet 1 tablet scheduled 5 x day and quaque (q) 6 needed as orally every 6 hrs. Review of Progress Note dated [DATE] written by MD B revealed Resident #2's Medical History: HYDROcodone-Acetaminophen ,d+[DATE] MG Tablet 1 tablet as needed orally every 12-hrs. Salonpas Lidocaine Plus (Lidocaine HCl-Benzyl Alcohol) ,d+[DATE] % cream patch externally daily. Melatonin 3 MG Tablet 1 tablet at bedtime orally once a day. Gabapentin 600 MG Tablet 2 tablet Orally nightly. Pepcid (Famotidine) 20 MG tablet 1 tablet orally once a day. Carbidopa-Levodopa ,d+[DATE] MG tablet 1 tablet orally 3 times a day. Taking Eliquis (Apixaban) 5 MG Tablet 1 tablet orally 2 times a day. Donepezil HCl 10 MG Tablet 2 tablet at bedtime orally once a day. Multi Complete (Multiple Vitamins-Minerals) - Capsule as directed orally. Metoprolol Tartrate 25 MG Tablet 1 tablet with food orally twice a day. Aspir-81 81 MG tablet delayed release 1 tablet Orally Once a day. Cholecalciferol 25 MCG (1000 international units) (UT) capsule 1 capsule orally once a day. Tylenol (Acetaminophen) 325 MG capsule 1 capsule as needed orally every 6-hrs. Preparation H (Phenylephrine-Mineral Oil-Pet) 0XXX[DATE].9 % ointment as directed rectal. Atorvastatin Calcium 10 MG tablet 1 tablet orally once a day. MiraLax (Polyethylene Glycol 3350) 17 GM/SCOOP powder 1 scoop mixed with 8 ounces of fluid orally once a day. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Lisinopril 20 MG tablet 1 tablet orally once a day. Tamsulosin HCl 0.4 MG capsule 1 capsule orally twice a day. Azelastine HCl 137 MCG/SPRAY Solution 1 puff in each nostril nasally twice a day. Abilify (ARIPiprazole) 20 MG tablet 1 tablet orally once a day Lexapro (Escitalopram Oxalate) 20 MG Tablet 1 tablet orally once a day. Valproic Acid 250 MG capsule 1 capsule orally nightly. Myrbetriq (Mirabegron ER) 50 MG Tablet extended release 24-hr 1 tablet rally take in evening. Review of Progress Note dated [DATE] written by MD B revealed Resident #3's Medical History: Medical History: traMADol HCl 50 MG Tablet 1 tablet as needed orally once a day. Sennosides Docusate Sodium 8XXX,d+[DATE] MG Tablet 1 tablet orally once a day. Memantine HCl 10 MG Tablet 1 Tablet orally twice a day. Ferrex 150 (Polysaccharide Iron Complex) 150 MG Capsule 1 capsule orally twice a day. Carvedilol 12.5 MG Tablet 1 Tablet orally twice a day. Hydroxyurea 500 mg Capsule 1 tablet orally daily. Esomeprazole Magnesium 20 MG Capsule Delayed Release take 1 capsule orally daily. Losartan Potassium 100 mg Tablet 1 tablet Orally Daily. Apixaban 5 MG Tablet 1 tablet orally twice a day. amLODIPine Besylate 5 MG Tablet 1 tablet orally once a day. Escitalopram Oxalate 20 MG Tablet 1 tablet orally daily. Solifenacin Succinate 5 MG Tablet 1 tablet orally once a day. Review of Progress Note dated [DATE] written by MD B revealed Resident #4's Medical History: Bisacodyl 10 MG Suppository 1 suppository as needed rectal once a day. Acetaminophen 650 MG Suppository 1 suppository as needed rectal every 6-hrs. Levsin (Hyoscyamine Sulfate) 0.125 MG Tablet 1 tablet as needed orally every 4-hrs. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ondansetron HCl 4 MG Tablet 1 tablet orally every 4-hrs as needed. Morphine Sulfate (Concentrate [TRUNCATED]