| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676389 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Matador Health and Rehabilitation Center | 805 Harrison St<br>Matador, TX 79244 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161<br><br>Based on interview and record review the facility failed to provide pharmaceutical services to include the accurate dispensing and administering of drugs to meet the needs for 1 of 5 residents (Resident #1) reviewed for physician orders.<br><br>The facility failed to accurately enter physician orders for Seroquel(anti-psychotic medication) and Trazodone(insomnia medication) for Resident #1.<br><br>The deficient practice could place residents at risk of not receiving medications as prescribed and/or deterioration in their condition.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet dated 08/28/24 revealed an [AGE] year old male was originally admitted to the facility on [DATE] and was sent to the hospital and readmitted on [DATE] with diagnoses to include but not limited to Alzheimer's disease(memory loss), atherosclerotic heart disease of native coronary artery(narrowing of arteries), vascular dementia, unspecified severity, without behavioral disturbance(breakdown of thought process), psychotic disturbance, mood disturbance and anxiety, delusional disorder, psychotic disorder with delusions due to known physiological condition, mood disorder due to know physiological condition with major depressive like episode and Vascular dementia, unspecified severity, with other behavioral disturbance(breakdown of thought process causing disruptive behavior).<br><br>Record review of Resident #1's last completed Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 03 out of 15 indicating that he had severe impairment. Resident #1's functionality was independent from sitting to lying down, sitting to standing and chair/bed transfer with setup assistance with eating, oral hygiene, and upper and lower body dressing. Resident #1 had occasional bowel and urinary incontinence.<br><br>Record review of Resident #1's care plan start date 08/08/2022 revised on 08/20/2024 revealed that Resident #1 had a history of depression and took antidepressants with interventions to encourage and assist resident to attend activities and provide medication as ordered. Care plan also indicated Resident #1 had a diagnosis of Alzheimer's/Dementia with interventions to encourage and allow resident to verbalize needs and concerns and provide medications as ordered. The care plan did not address Resident #1's insomnia or antipsychotic medication.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's discharge orders from the Rehab Hospital dated 08/15/2024, indicated Resident #1 was admitted on [DATE] and released back to the facility on [DATE] and revealed the following orders:<br><br>Quetiapine ER (Seroquel XR) Give 100 mg (2tablets) by mouth at bedtime DO NOT CRUSH. Start date/Time: 07/31/2024 at 9:00 PM and Stop Date/Time: 09/28/2024 9:00 PM Active Days: 16<br><br>Trazodone (Desyrel) Give 50 mg (1 tablet) by mouth at bedtime PRN for Insomnia<br><br>Start date/Time: 07/31/2024 at 9:02 PM and Stop Date/Time: 09/28/2024 9:02 PM Active Days: 16<br><br>Record review of Resident #1's orders listed as Discontinued Orders entered on 08/15/2024 and discontinued on 08/18/2024 revealed the following:<br><br>Seroquel Oral Tablet 50 MG-Give 2 tablet by mouth two times a day related to psychotic disorder with delusions due to known physiological condition.<br><br>Trazodone HCI Oral Tablet 50 mg-Give 1 tablet by mouth at bedtime for Insomnia.<br><br>Record review of Resident #1's orders listed as Active Orders entered on 08/18/2024 revealed the following:<br><br>Seroquel XR Oral Tablet Extended Release 24-hour 50 mg (Quetiapine Fumarate) Give 2 tablet by mouth at bedtime related to Psychotic disorder with delusions due to known physiological condition.<br><br>Trazodone HCI Oral Tablet 50 mg (Trazodone HCI) Give 1 tablet by mouth every 23 hours as needed for insomnia (Use only at bedtime).<br><br>Record review of the MAR dated August 2024 revealed that Resident #1 took Seroquel Oral Tablet 50 mg (Quetiapine fumarate) Give 2 tablet by mouth two times a day. Resident #1 was given the medication on 08/15 at 8:00 PM, 08/16 and 08/17 at 8:00 AM and 8:00 PM, and 08/18 at 8:00 AM. The MAR also revealed that Resident #1 was given Trazodone HCI Oral Tablet 50mg-Give 1 tablet by mouth at bedtime for insomnia on 08/15, 8/16, and 08/17/2024.<br><br>Interview on 08/28/2024 at 11:45 AM, Resident #1 stated that he was doing well and that they fixed his medications. Resident #1 stated he did not know what medications he was taking but he did not feel drunk anymore.<br><br>Interview on 08/28/2024 at 12:45 PM, LVN C stated the nurses were responsible for putting in the orders when a new admission was admitted to the facility. LVN C stated that she was told that when Resident #1 was sent to the hospital that they were looking at lowering his medication and was wondering about the medications. LVN C stated she looked at the discharge orders from the Rehab Hospital from 08/15/2024 and noticed that the orders that were put in the system did not match the discharge orders from the Rehab Hospital. LVN C stated she contacted her DON immediately and put the correct orders in the system on 08/18/2024. LVN C stated that the LVN that put the orders in wrong was no longer employed at the facility. LVN C stated that a possible negative outcome for not having the correct orders would be that it could cause the resident harm.<br><br>(continued on next page) |

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|---|---|---|---|
| | 676389 | A. Building<br>B. Wing | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 08/28/2024 at 1:38 PM, LVN A stated that the nurse on duty at the time of a resident's admission was responsible for entering the orders from the doctor/hospital.<br><br>LVN A stated that a possible negative outcome for putting orders in wrong would be that a death could occur if too much medication was given.<br><br>Interview and observation on 08/28/2024 at 1:51 PM, LVN B opened the medication cart where Resident #1's medication was stored. LVN B stated that when the new medications that were ordered were the same medication but a different dose, a label was put on the blister pack that identified the new order in the system. LVN B pulled out the labels that were used to put on the blister packs that identified new orders. LVN B stated that a possible negative outcome for putting orders in wrong would be that a resident's side effects could get worse, or they could become lethargic and hurt themselves.<br><br>Interview on 08/28/2024 at 2:45 PM, the DON stated that Resident #1 was already taking Seroquel and Trazodone so when he returned to the facility, they were able to use the medication on hand. The DON stated that a possible negative outcome for not having correct documentation for orders would be that a resident could die or become injured due to confusion.<br><br>Record Review of Medication Administration Policy (no date) revealed the following:<br><br>. Follow the six rights of medication administration(Right Patient, Right Drug, Right Dose, Right Route, Right Time, Right Documentation) .<br><br>. Read the label 3 times as your prepare a medication, carefully checking the drug label against the Medication Administration Record (MAR, med card or physician orders) . |