

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Parklane West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Towers Park LN San Antonio, TX 78209	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447</p> <p>Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #1) of 5 residents reviewed for pharmacy services.</p> <p>The facility failed to transcribe Resident #1's discharge orders and failed to follow-up to ensure Resident #1's hospital discharge orders were implemented timely, which caused him to miss getting his medications for four (4) to five (5) days.</p> <p>This failure could cause a delay in appropriate medical care and worsening in symptoms, condition, or illness.</p> <p>The findings included:</p> <p>Record review of Resident #1's Admission Record, dated 07/30/2024, indicated he was a [AGE] year-old male admitted on [DATE].</p> <p>Record review of Resident #1's Medical Diagnosis list in the facility's EMR included: COVID-19 (An illness that can affect a person's lungs and airways caused by a virus called the Coronavirus), Pneumonia due to Coronavirus Disease 2019 (a lung infection caused by the coronavirus), muscle weakness, unsteadiness on feet, need for assistance with personal care, type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), paroxysmal atrial fibrillation (a rapid, erratic heart rate begins suddenly and then stops on its own within 7 days), and hypothyroidism (when the thyroid does not produce enough hormones).</p> <p>Record review of Resident #1's BIMS (Brief Interview for Mental Status) indicated Resident #1's mental status was moderately impaired (BIMS score 12).</p> <p>Record review on 07/30/2024 of Resident #1's hospital records uploaded to his facility EMR did not reveal a discharge medication list.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of an email dated 07/24/2024 at 11:18 p.m. sent by [local hospital] staff member to the ADON included Resident #1's Discharge Medication List dated 07/24/2024 indicated This med [medication] list indicates the medications you should continue taking and new medications you should start taking. The list included:</p> <ul style="list-style-type: none"> - Amoxicillin/Clavulanate Potassium (Augmentin; a combination antibiotic used to treat various bacterial infections) 875 MG, oral, twice a day through 07/27/2024 - Apixaban (Eliquis; used to prevent serious blood clots) 5 MG, oral, twice a day - Aspirin EC (Ecotrin; used to prevent heart problems) 81 MG, oral, daily - Guaifenesin/DM 100-10 MG/5ML (Robitussin-DM 100-10 MG/5ML; used to thin mucus and relieve coughing) 200 MG, oral, every 4 hours as needed - Levothyroxine Sodium (used to treat underactive thyroid) 175 MCG, oral, daily - Losartan Potassium (used to treat high blood pressure) 25 MG, oral, daily - Metformin HCl (used to lower the amount of sugar the body makes or absorbs) 500 MG, oral, daily - Metoprolol Succinate (Toprol XL; used to treat chest pain, heart failure, and high blood pressure) 25 MG, oral, daily - Rosuvastatin Calcium (used to lower cholesterol and fats in blood) 5 MG, oral, at bedtime <p>Record review of Resident #1's Order Summary Report, active orders, dated 07/30/2024, reflected:</p> <ul style="list-style-type: none"> - Blood sugar checks QAM (every morning) and HSQ (every evening) in the morning for BS (blood sugar) monitoring, order date 07/29/2024 and start date 07/30/2024. Ordered five (5) days after admission and started six (6) days after admission. - Document Temp (temperature) / O2 sats (oxygen saturation) and monitor for the following symptoms: Fever, Cough, New shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, congestion, runny nose. GI (Gastrointestinal) symptoms: Diarrhea/Nausea/Vomiting every shift, order and start date 07/24/2024. Ordered and started the day of admission. - Monitor for signs and symptoms of hypo/hyperglycemia (low or high blood pressure) hunger, thirst, sweating, dizziness, changes in vision, headache, irritability, nausea, fatigue, frequent urination q (every) shift, order and start date 07/24/2024. Ordered and started the day of admission. - Amoxicillin-Pot Clavulanate Oral Tablet 875-125 MG, give 1 tablet by mouth every 12 hours for UTI (urinary tract infection), order and start date 07/29/2024. Ordered and started five (5) days after admission and three (3) days after expected end date for treatment per the hospital discharge medication list. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Apixaban Oral Tablet 5 MG, give 1 tablet by mouth two times a day for Afib (atrial fibrillation), order and start date 07/29/2024. Ordered and started five (5) days after admission.</p> <p>- Aspirin 81 Oral Tablet Delayed Release, give 1 tablet by mouth one time a day for heart health, order date 07/29/2024 and start date 07/30/2024. Ordered five (5) days after admission and started six (6) days after admission.</p> <p>- Atorvastatin Calcium 10 MG Tablet, give 1 tablet by mouth at bedtime for HLD (hyperlipidemia; high fat levels in the blood), order and start date 07/29/2024. Ordered and started five (5) days after admission.</p> <p>- Levothyroxine Sodium Oral Tablet 175 MCG, give 1 tablet by mouth in the morning for hypothyroidism, order date 07/29/2024 and start date 07/30/2024. Ordered five (5) days after admission and started six (6) days after admission.</p> <p>- Losartan Potassium Oral Tablet 25 MG, give 1 tablet by mouth one time a day for Hypertension, order date 07/29/2024 and start date 07/30/2024. The order included to hold if SBP (systolic blood pressure) was less than 110 or if DBP (diastolic blood pressure) was less than 60. Ordered five (5) days after admission and started six (6) days after admission.</p> <p>- Metformin HCl Oral Tablet 500 MG, give 1 tablet by mouth one time a day for DM (diabetes mellitus), order date 07/29/2024 and start date 07/30/2024. Ordered five (5) days after admission and started six (6) days after admission.</p> <p>- Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG, give 1 tablet by mouth one time a day for hypertension, order date 07/29/2024 and start date 07/30/2024. The order included to hold if SBP (systolic blood pressure) was less than 110, if DBP (diastolic blood pressure) was less than 60, or if HR (heart rate or pulse) was less than 60. Ordered five (5) days after admission and started six (6) days after admission.</p> <p>Record review of Resident #1's July 2024 CMA (Certified Medication Assistant) MAR (Medication Administration Record), accessed on 07/30/2024 at 03:10 p.m., indicated:</p> <p>- Aspirin 81 Oral Tablet was first administered on 07/30/2024.</p> <p>- Atorvastatin Calcium 10 MG Tablet was first administered on 07/29/2024.</p> <p>- Levothyroxine Sodium Oral Tablet 175 MCG was first administered on 07/30/2024.</p> <p>- Losartan Potassium Oral Tablet 25 MG was first administered on 07/30/2024 with blood pressure level documented as 124/83.</p> <p>- Metformin HCl Oral Tablet 500 MG was first administered on 07/30/2024.</p> <p>- Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG was first administered on 07/30/2024 with blood pressure level documented as 124/83 and pulse documented as 84.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/31/2024 at 01:25 p.m., Resident #1 stated that he felt that the facility took a while to get his medications but that he was receiving them now. Resident #1 stated that he didn't know why there was a delay with his medications and that he had told them that he was missing his medications, but he felt it was a different group he told each time and that they didn't seem to coordinate with each other. Resident #1 stated he did not experience any side effects or complications due to the delay in receiving his medications.</p> <p>During an interview on 07/31/2024 at 01:46 p.m., LVN A stated that the process for admitting a new resident when they came to the facility without a hospital admission packet would be to obtain the hospital floor number (phone number for the nurses' station at the hospital which the resident came from) and to request that they fax the resident's discharge medication list. LVN A stated he was not working the night of Resident #1's admission, but he was made aware that the resident did not receive medications for several days. LVN A stated that the procedural mistake was that the hospital was not called again the next day if the admitting nurse did not receive the discharge medication list on the night of admission.</p> <p>During an interview on 07/31/2024 at 02:51 p.m., the ADON stated Resident #1 arrived from the hospital during the evening shift (of 07/24/2024) and did not arrive with a medication list from the hospital. The ADON stated she was aware that LVN B had called the nurse at the hospital multiple times, but since he had been unsuccessful, she also called the house supervisor for the hospital to obtain the finalized discharge medication list. The ADON stated that the hospital staff tried to fax the medication list a couple of times, but it didn't go through. Around 08:00 p.m., she reached out to the DON about not obtaining the medication list. The DON recommended requesting the house supervisor to email the medication list to her (the ADON). The ADON stated she received the email with the finalized discharge medication list around 11:00 p.m. The ADON stated she forwarded the medication list to the DON and that she assumed the DON would take the next steps from there. The ADON stated that she would have typically completed a chart review the next day (Thursday, 07/25/2024), which was part of her process following a new admission, but she was scheduled off the next two days (Thursday and Friday, 07/25/2024 and 07/26/2024) due to being scheduled as the weekend supervisor which required working doubles on Saturday and Sunday (07/27/2024 and 07/28/2024). The ADON stated she did come in on her scheduled off days (Thursday and Friday, 07/25/2024 and 07/26/2024) for a few hours but did not follow up with the admission, which was what she would have typically done as part of her process following an admission. The ADON stated she was not sure what happened after she had forwarded the documentation from the hospital to the DON. The ADON stated that her understanding was that the DON was going to take over the next steps with the medication list that night. The ADON stated that the DON was expected to be out of town on Thursday, 07/25/2024, and scheduled off on Friday, 07/26/2024. The ADON stated the DON worked remotely a lot of the time. The ADON stated that due to her belief that the DON took over with the medication list, and because she did not receive any concerns from the staff [nursing staff working Thursday through Sunday (07/25/2024 through 07/28/2024), 6 shifts], she had thought everything was good. The ADON stated that on Monday, 07/29/2024, a nurse notified her that Resident #1 did not have any medications ordered. The ADON stated that she notified the DON and Resident #1's physician. Resident #1's physician requested lab work following the report. The ADON stated Resident #1 had been assessed and his vitals had been reviewed since the medication error was identified but no adverse effects had been found. The ADON stated she had been notified the RP (Responsible Party) had sent an email with concerns, but the email had been forwarded to the wrong [first name of the ADON] resulting in her not receiving it until after the error was identified.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/01/2024 at 03:00 p.m., LVN B stated he was the receiving and admitting nurse for Resident #1. LVN B stated that when Resident #1 arrived for admission, the admitting paperwork only consisted of one page and the transport services staff stated that the one document was all that they received from the hospital. LVN B stated that he called the hospital and requested the discharge paperwork to be faxed over but after several attempts he discovered that the 1st, 2nd, and 3rd floor fax machines were having connection issues. LVN B stated he notified the ADON of the status and passed it over to her due to it being passed his end of shift. LVN B stated the ADON told him that she would email the discharge medication list to the DON and that the DON would email it to the night shift (next shift). He stated the on-call physician was notified when Resident #1 arrived for admission that the discharge medication list was missing, and that they were having difficulties getting the medication list routed to them. LVN B did not state that the physician made any actions following his notification of a lack of medication list. LVN B stated he ended up leaving that night around 11:38 p.m. or a little over an hour and half after the end of his scheduled shift. He stated that he gave a verbal report to the oncoming night shift nurse, reported to her that Resident #1 had pending medications. He stated that he also reported or documented about Resident #1's pending medications on the 24-hour report and on the facility's encrypted administration group chat, which went to every nurse, the DON, both ADONs, and the coordinator for admissions and discharges. LVN B stated that the DON was involved in his chat with the ADON and was constantly monitoring stuff but from home, not within the facility. LVN B stated he did not work again until Saturday (3 days later) and at that time, did not follow up because he did not see how it would not have been resolved over the last two (2) days. LVN B stated that due to residents having medications on either the CMA MAR, the regular MAR, or both; he did not notice that Resident #1 did not have medications ordered on either. LVN B stated it was not unusual to not have a resident listed on the CMA MAR, if all their orders were on the MAR, or for a resident to have all their medications on the CMA MAR and not have any medications on the MAR. LVN B stated that though he distributed both the CMA MAR medications and the MAR medications over the weekend, he was moving non-stop and didn't notice that Resident #1 was on neither MAR, thus not receiving any medications. LVN B stated that no one had mentioned to him that Resident #1 did not have medications orders, it was not brought to his attention.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/01/2024 at 04:16 p.m., the NP stated he had seen Resident #1 on Friday, 07/26/2024 and early in the week of 07/29/2024. The NP stated that Resident #1 was COVID positive but doing okay. The NP stated the medical team had communicated with the discharging hospital prior to Resident #1's discharge to the nursing facility and had received his labs. The NP stated LVN B had notified him upon admission that Resident #1 admitted without a discharge medication list. The NP stated he received another call from the ADON on Tuesday, 07/30/2024 to notify him that she was working on the error. The NP stated that he felt the facility staff could have done more, that they could have gotten more attention on it and done work on it over the weekend. The NP stated he had not received any reports of any issues that were caused by the delay in medications. The NP stated that the facility and resident were fortunate that Resident #1 was stable. The NP stated that the 4-day day (if given on day of discharge from the hospital) in Resident #1's Amoxicillin/Clavulanate Potassium was not detrimental and was mostly prescribed as a preventative measure but could have caused harm. The 4-day gap in Apixaban (Eliquis) could have been significant if Resident #1's blood pressure and pulse were not so stable. The NP stated that the 5-day delay in Resident #1's Aspirin EC 81 MG would have been beneficial for Resident #1 due him having had COVID and could have been serious. The 5-day gap in receiving the Levothyroxine Sodium was okay to have been missed due to the medication's slow breakdown in the body, so Resident #1 would have been fine missing it up to two weeks. The 5-day gap in receiving the Losartan Potassium could have been detrimental, but Resident #1's blood pressures were surprisingly okay during the time that the medication was missed. The 5-day gap in receiving Metformin did not reveal any physical signs for the short-term and Resident #1's labs were not outstanding during this time. The 5-day gap in receiving Metoprolol Succinate did not appear to cause harm with Resident #1 having had his blood pressure and pulse monitored which were okay. The 5-day delay in receiving the Rosuvastatin Calcium which was changed to Atorvastatin Sodium did not cause harm since the delay was a short period of time and this medication was prescribed for managing long-term heart disease.</p> <p>During an interview on 08/01/2024 at 04:50 p.m., the DON stated that Resident #1 was admitted on Wednesday, and she was notified via an encrypted thread (text message chain) set up to go to the facility administration. The DON stated that as far as she knew, the ADON had reported to her that she (the ADON) was having problems getting the discharge medications list that night. The DON stated that she had seen in the EMR that Resident #1 was admitted on Wednesday night and that his diet and code status were entered but that was about all she checked. The DON stated that she did not touch the chart after that and had left to go out of town on Thursday morning. The DON denied receiving an email from the hospital and stated that she may have received something from the ADON, but the ADON was still at the facility late. The DON stated that she did not receive any notifications from Thursday to over the weekend from staff regarding concerns about Resident #1's medications. The DON stated that Resident #1 having missed his prescribed Amoxicillin/Clavulanate Potassium for four (4) days could have made him sick and that there was no excuse for the error. The DON stated that Resident #1 having missed his Apixaban for four (4) days could have resulted in Resident #1 having atrial fibrillation. The DON stated that Resident #1's missed five (5) doses of Aspirin were prophylactic (a measure or substance intended to prevent or protect against undesired effects), meaning it was prescribed as a preventative medication. The DON stated that Resident #1's five (5) missed doses of Metformin does not seem to have been impactful since Resident #1's blood sugars don't indicate that missing the medication changed his blood sugars. The DON stated that Resident #1's vitals seem to indicate that missing five (5) doses of his Metoprolol Succinate was not impactful since Resident #1's vitals were okay. The DON stated that she wouldn't be able to say that Resident #1 missing his statin (Rosuvastatin Calcium and then prescribed Atorvastatin Sodium) was impactful but would say that Resident #1 should have gotten his medications.</p> <p>(continued on next page)</p>		

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