STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675579	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Harbor Healthcare and Rehabilitation	6700 Heritage Parkway Rockwall, TX 75087

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of five residents reviewed for medications. The facility failed to ensure Resident #1 was provided his medications and not the medications of Resident #2, when he went on therapeutic leave on 06/02/24. This failure placed residents at risk of consuming unprescribed medications, harm, and hospitalization . The findings included: Record review of Resident #1's face sheet, printed on 06/25/24, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of atherosclerosis of native arteries of extremities with gangrene, right leg (narrowing and hardening of the arteries that supply the legs and feet), muscle weakness, muscle wasting and atrophy (loss of muscle tissue), and abnormalities of gait and mobility. Record review of Resident #1's quarterly MDS assessment, dated 06/03/24, reflected Resident #1 had a BIMS score of 09, which indicated Resident #1 had a moderate cognitive impairment. Record review of Resident #1's care plan, revised on 06/03/24, reflected the following: Focus: [Resident #1] Has hypertension . INTERVENTIONS: Give anti-hypertensive medications as ordered . FOCUS: [Resident #1] Has Diabetes Mellitus . INTERVENTIONS: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness . FOCUS: Anti-anxiety medication uses r/t anxiety disorder INTERVENTIONS . Give anti-anxiety medications ordered by physician . FOCUS: Antidepressant medication use r/t Depression . INTERVENTIONS . Give antidepressant medications ordered by physician. Monitor/document side 1effects and effectiveness .FOCUS . [Resident #1] Has acute/chronic pain . INTERVENTIONS . Administer analgesia medication as per orders . (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the physician orders tab of Resident #1's electronic health record revealed the following evening orders: - Atorvastatin Calcium Oral Tablet 40 MG - Give 1 tablet by mouth at bedtime related to HYPERLIPIDEMIA, UNSPECIFIED, start date of 04/17/23 - Melatonin Oral Tablet 3 MG - Give 3 mg by mouth at bedtime for insomnia, start date of 04/18/23 - traZODone HCl Oral Tablet 50 MG - Give 2 tablet by mouth at bedtime related to UNSPECIFIED MOOD [AFFECTIVE] DISORDER (F39);SLEEP DISORDER, UNSPECIFIED (G47.9);ANXIETY DISORDER, UNSPECIFIED, start date of 10/13/24 - Brilinta Oral Tablet 90 MG (Ticagrelor)- Give 1 tablet by mouth two times a day for Atrial Thromboembolism, start date of 04/18/23 - Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) - Give 250 mg by mouth two times a day related to UNSPECIFIED MOOD [AFFECTIVE] DISORDER (F39), start date of 09/06/23 - Famotidine Tablet 20 MG - Give 1 tablet by mouth two times a day for GERD, start date of 07/15/23 - Gabapentin Oral Capsule 100 MG -Give 1 capsule by mouth two times a day for pain, start date of 03/28/23 - Lovaza Oral Capsule 1 GM (Omega-3-acid Ethyl [NAME]) - Give 2 capsule by mouth two times a day for supplement, start date of 06/09/23 - Metoprolol Tartrate Tablet 25 MG - Give 0.5 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold B/P less than 100/60 or HR less than 60, start date of 04/18/23 - Sacubitril-Valsartan Oral Tablet 49-51 MG (Sacubitril-Valsartan) - Give 0.5 tablet by mouth two times a day for HTN HOLD IF SBP less than 110, start date of 04/19/23 Record review of Resident #2's face sheet, printed on 06/26/24, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, cognitive communication deficit, pain in unspecified shoulder and hypotension. Record review of the physician orders tab of Resident #2's electronic health record revealed the following evening orders: - Neurontin Oral Capsule 300 MG - Give 300 mg by mouth at bedtime related to CHRONIC PAIN SYNDROME, start date of 05/01/24 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Senna-Docusate Sodium Tablet 8.6-50 MG - Give 1 tablet by mouth at bedtime for constipation, start date of 08/14/22 -Zoloft Oral Tablet 25 MG (Sertraline HCl) - Give 3 tablet by mouth at bedtime for Dysthymia, start date of 05/08/24 -Depakote Oral Tablet Delayed Release125 MG (Divalproex Sodium) - Give 1 tablet by mouth two times a day for Anxiety and agitation, start date of 05/08/24 - Memantine HCl Tablet 5 MG - Give 1 tablet by mouth two times a day related to ALZHEIMER'S DISEASE, start date of 08/14/22 - Gabapentin Capsule 100 MG - Give 1 capsule by mouth three times a day for neuropathic pain, start date of 08/14/22 - Midodrine HCl Tablet 5 MG - Give 2 tablet by mouth three times a day for hypotension 1 hour before Dialysis Hold for BP of greater than 120/90, start date of 08/16/22 - Renvela Oral Tablet 800 MG (Sevelamer Carbonate) - Give 1 tablet by mouth with meals for related to END STAGE RENAL DISEASE, start date of 03/07/24 In a telephone interview on 06/24/24 at 3:49 p.m., Resident #1's family member stated on 06/02/24, Resident #1 was provided the incorrect medications by LVN A when he went on therapeutic leave. The family member stated they received several calls after he left from LVN A, stating Resident #1 was given another residents medications and not to take the medications provided. The family member stated Resident #1 was not provided his insulin as well. The family member stated the medications were not double checked at the facility because they were in a rush. The family member stated Resident #1 did not take any of the medications provided to Resident #1 when he left the facility. In an interview on 06/25/24 at 1:16 p.m., Resident #1 stated he did not recall an instance where he was provided another residents medications or that he received a call stating he was provided another residents medications. Resident #1 stated he had no concerns regarding his medications. In an interview on 06/25/24 at 2:50 p.m., LVN A stated she was Resident #1's nurse when he went on therapeutic leave on 06/02/24. LVN A stated she recalled having to call Resident #1's family member to report the incorrect medications. LVN A stated MA B prepared the medications for Resident #1's leave, which she provided to the resident as his family member signed him out of the facility. She stated roughly 30 minutes after his departure, MA B notified her that she had prepared Resident #2's medication for Resident #1 in error. LVN A stated she immediately began to call Resident #1 and his family member to report the error. LVN A stated when she was able to speak with Resident #1's family member, she was able to confirm he did not take the medications. LVN A stated she offered to prepare Resident #1's evening medications, but the family member declined to pick them up. LVN A stated if Resident #1 would have taken the medications, they could have had adverse effects to the resident. LVN A stated she reported the situation to LVN C, who was the supervisor, and he took over the situation. LVN A stated by her next shift, which was the following weekend, she was in serviced on medication administration and leave of absence medication procedures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 06/26/24 at 10:51 a.m., MA B stated LVN A notified her on the morning of 06/02/24 to prepare the evening medications for Resident #1, but she heard Resident #2, whose names were similar. MA B stated she prepared the medications, gave them to LVN A a little after lunch and continued to administer medications to her assigned halls. MA B stated roughly 30 minutes later she saw Resident #2 in the facility, and she immediately realized her error and reported to LVN A. MA B stated LVN A stated she would call Resident #1's family and report to the supervisor. MA B stated she was not certain how the medications would have affected Resident #1, but she knew Resident #2 had a kidney medication that Resident #1 was not on, so she believed it could have harmed him. MA B stated she had an one-on-one in-service with the DON when she returned to work regarding medication administration, the 10 rights of medication administration and leave of absence medication procedures. Telephone interviews were attempted with the weekend supervisor, LVN C on 06/26/24 at 11:00 a.m., 11:23 a.m., 1:28 p.m., and 3:30 p.m., but were unsuccessful. In an interview on 06/26/24 at 1:33 p.m., the DON stated Resident #1's family member reported the incident to him roughly a week and a half prior to the investigation. The DON stated Resident #1's family member saw him in the facility the week of Father's Day and told him she wanted to speak with him, but she did not have time to speak at that moment. The DON stated about a week later he saw the family member again in the facility and she reported the wrong medications were provided on 06/02/24. The DON stated the family member had the medications with her and he was able to confirm they were the medication of Resident #2, and the medications were destroyed. The DON stated he conducted one-on-one in services with LVN A, MA B, and LVN C regarding incident reporting, medication administration, the 10 rights of medication administration, leave of absence medication procedures and documentation. The DON stated he also in serviced all nursing staff on the 10 rights of medication administration, incident reporting and leave of absence medication procedures. In an interview on 06/26/24 at 2:47 p.m., the ADMIN stated he was aware of the medication mix-up with Resident #1. He stated after the family member reported the incident to the DON, he investigated and found there was a miscommunication between LVN A and MA B. The ADMIN stated staff were able to identify the error and avoid a medication diversion. The ADMIN stated the DON immediately re-trained the involved staff and in-serviced all nursing staff on medication administration, the 10 rights of medication administration, incident reporting, leave of absence medication procedures and documentation to ensure the situation did not occur again. The ADMIN stated the medications could have harmed Resident #1 if had taken them. Record review of Inservice documentation dated 6/22/24 through 6/24/24, revealed all nursing staff, including LVN A, MA B, and LVN C were in serviced on the 10 rights of medication administration, leave of absence medication procedures and incident reporting. Record review of the facility's policy entitled Medication Administration, revised in 02/2007, read in part: POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician . 2. Medications must be administered in accordance with the written orders of the attending physician .