

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Traymore Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4315 Hopkins Ave Dallas, TX 75209	

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 - Few</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** 28637</p> <p>Based on observation, 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 1 (Resident #1) of 9 residents reviewed for pharmacy services.</p> <p>1. The facility failed to ensure Resident #1's medications (Memantine HCL and Carbidopa-Levodopa) were correctly ordered and transcribed on his MAR upon admission on 7/17/24.</p> <p>2. The facility failed to ensure Resident #1 did not miss four doses of Ryтары (Carbidopa-Levodopa) 48. 75-195 mg 3 capsules each dose between 7/17/24 and 07/18/24 and when Resident #1 received double his dose of Memantine HCL ER 28 mg from 7/20/24 to 7/29/24.</p> <p>This failure placed residents at risk of not receiving their medications as ordered by a physician and worsening of their condition.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record dated 8/22/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] for a short-term stay.</p> <p>Record review of Resident #1's Admission MDS assessment dated [DATE] revealed his cognition was not assessed, he required set up assistance for transfers and supervision for toileting and hygiene. His diagnoses included Parkinson's disease (disorder of central nervous system affecting movement), hypertension (high blood pressure); and non-Alzheimer's Dementia (condition that can affect memory and impaired thinking).</p> <p>Record review of Resident #1's Nursing Admission assessment dated [DATE] revealed it was completed with the assistance of Resident #1's family member. The Assessment reflected Resident #1 was not always able to communicate his wants and needs; his short and long-term memory was OK; he had no impairment of his range of motion. He had decreased strength, poor safety awareness, poor balance, and was one-person assist with transfers. He had a dressing to his knee on admission due to a wound from a previous fall, and had a history of falls at home.</p> <p>Record review of Resident #1's physician's orders reflected the following entries:</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 - Few</p>	<p>-Order dated 7/17/24 for Memantine HCL ER (used to treat dementia) Oral capsule Extended Release 24 Hour 28 mg one capsule by mouth at bedtime.</p> <p>-A revised order dated 7/17/24 reflected Memantine HCL 10 mg tablet 1 tablet by mouth twice daily for cognitive function-order source: Pharmacy.</p> <p>-Order dated 7/19/24 for Memantine HCL ER Oral capsule Extended Release 24 Hour 28 mg one capsule by mouth two times a day for dementia.</p> <p>-Order dated 7/17/24 Carbidopa-Levodopa ER (used to treat Parkinson's disease) Oral Capsule Extended Release 48.75-195 mg Give three capsules by mouth four times daily-shown as discontinued 7/17/24.</p> <p>Order dated 7/18/24 for Carbidopa-Levodopa ER (used to treat Parkinson's disease) Oral Capsule Extended Release 48.75-195 mg Give three capsules by mouth four times daily.</p> <p>Record review of Resident #1's MAR dated 7/1/24 through 7/31/24 reflected the following entries:</p> <p>Memantine HCL 10 mg tablet give one tablet by mouth two times a day for cognitive function. Order start date 7/18/24. The medication was signed as administered on 7/18/24 at 9 AM and 6 PM and on 7/18/24 at 9 AM .</p> <p>Memantine HCL ER Oral Capsule Extended Release 24 hour 28 mg Give one capsule by mouth two times a day for dementia. Order start date 7/19/24. The medication was signed as administered on the following dates and times:</p> <p>7/19/24: 5 PM</p> <p>7/20/24: 9 AM and 5 PM</p> <p>7/21/24: 9 AM and 5 PM</p> <p>7/22/24: 9 AM and 5 PM</p> <p>7/23/24: 9 AM and 5 PM</p> <p>7/24/24: 9 AM and 5 PM</p> <p>7/25/24: 9 AM and 5 PM</p> <p>7/26/24: 9 AM and 5 PM</p> <p>7/27/24: 9 AM and 5 PM</p> <p>7/28/24: 9 AM and 5 PM</p> <p>7/29/24: 9 AM and 5 PM</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 - Few</p>	<p>During an interview on 8/23/24 at 11:22 AM, the Medical Director stated she had heard from the DON and been made aware of the dosing issue with Resident #1's Memantine in that it was an extended-release dose and should have been administered only once a day. The Medical Director was unable to recall on what day she was made aware by the DON. She stated they usually gave the lower dose two times a day at the facility, and she had overlooked the transcription error as well. She stated the risk of double dosing a resident was you were not supposed to overdose anyone. The Medical Director stated, for that particular medication, she would not think it would cause significant issues for the timeframe involved. She stated other medications such as anti-anxiety medications would cause more serious issues. She stated she was aware Resident #1 missed 4 doses of his Carbidopa-Levodopa. She stated, having Parkinson's and being on respite care, I really can't say there was too much risk. They usually don't do well if they miss too many doses. They might not feel great and can feel a little tight but not necessarily increased fall risks. She stated she did not believe Resident #1 missing his initial doses at the facility contributed to his falls. The Medical Director stated she had not had any other issues with pharmacy services at the facility and the staff were usually pretty good at letting her know of any concerns. She stated respite residents typically came with their own medications from home.</p> <p>In an interview on 8/23/24 at 12:01 PM, LVN D stated she had cared for Resident #1 during his respite stay at the facility. LVN D denied noting any decline in Resident #1's cognition or strength while he was at the facility. She stated she was not aware of any medication issues on her shifts.</p> <p>In an observation and interview on 8/23/24 at 12:19 PM, Resident #2 was sitting up in his room watching television. He stated he remembered Resident #1 very well and described him as a very nice guy. He stated they often talked about his previous profession, and he would chat with his family as well. Resident #2 stated he remembered him slipping out of bed on a couple of occasions. Resident #2 stated he had never had any issues with his medications while staying at the facility and felt the staff did a good job.</p> <p>In an interview on 8/23/24 at 12:41 PM, the facility's Pharmacy Consultant stated she had been informed about Resident #1's medication issues. She stated she performed the monthly drug regimen reviews for the facility but would not have done one for Resident #1 as he was only there two weeks. She stated the typical dose of Memantine for residents was 10 MG twice a day and she understood he had received two doses of the 28 MG extended-release doses twice a day instead due to a transcription error. The Pharmacy Consultant stated she did not believe there was any real risk to the dose he had received, or it would have been very minimal. The Pharmacy Consultant looked up Resident #1's doses of Carbidopa-Levodopa when asked about missing the 4 doses. She stated there was still minimal to no risk as the medications were long acting and had a half-life on 12-24 hours meaning there would still be medication in his system. She stated the longer a patient was on the medication, the more of it would still be in his system. She did not know how long Resident #1 had been taking the medication. She stated he may have felt some stiffness toward the end of the last dose missed but it would have been doubtful.</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 - Few</p>	<p>During an interview on 8/23/24 at 1:08 PM, the ADON stated when orders were entered in the computer, the medication may move to an interchange status and pending confirmation if medications were not readily available and could be dispensed another way once confirmed with the physician. She reviewed the MAR and orders in the electronic medical record. The ADON stated the doses of Carbidopa-Levodopa were missed because when the pharmacy placed the order in pending confirmation status, the dose times on the MAR would not show up for the nurses and medication aides. She stated that should not have occurred because she had placed the status of his medications as on hand which let the pharmacy know the medications were already available. She stated, when she arrived back to the facility on [DATE], she noticed the interchange and pending confirmation status and called the pharmacy. She stated she questioned the pharmacy why the medications had been showing an interchange when she clearly marked them as 'on hand. The ADON stated the pharmacy contact looked at the orders and stated they had a new technician who had missed it. She stated she informed the pharmacy she was going to discontinue the interchanges made and reorder the medications the way they were supposed to be ordered. The ADON stated she believed by the time the changes were made in the orders and system, Resident #1 had missed the 4 doses of his Carbidopa-Levodopa. The ADON stated, as she was making the corrections, she corrected the strength of Resident #1's Memantine but failed to change the doses back to once a day and they remained twice a day. The ADON stated she had been unaware of the error until it came time to discharge Resident #1 from the facility and they were handing over his medications to the family. She stated his family noted the missing medications and questioned it and that was when she realized her mistake. She stated she explained what had happened to Resident #1's family. She assessed Resident #1 and there were no changes noted to his condition. The ADON stated she apologized to Resident #1's family and assured them they would replace his medication stock. She stated the family member did not express any concerns other than getting his medications returned and stated he would take care of Resident #1 and ensure other family were aware. She stated Resident #1's family returned the next day to pick up his medications and told her Resident #1 was doing fine. She stated she had explained everything to the Administrator who had investigated the issue.</p> <p>In an interview on 8/23/24 at 1:51 PM, the Administrator stated he was out of the country when the events involving Resident #1's medication errors were discovered. He stated he had been in contact with the outside Social Worker who had initially set up his respite stay, had investigated the matter and discussed it with them. He stated he learned there had been errors involving the pharmacy technician communication and transcription of the orders. He stated he had interviewed the ADON about it and the ADON, DON and Medical Director had reviewed the medication errors. The Administrator stated the incident had been added to their QAPI ongoing issues and they had the pharmacy involved to ensure the situation did not occur again. The Administrator stated the risk of medication errors including overdosing and missed medications depended on the resident in terms of the medication, severity, and disease processes involved.</p> <p>During an interview on 8/23/24 at 2:35 PM, the DON stated she had been made aware of the medication errors from her ADON who had explained her transcription errors. She stated she had discussed it with the Medical Director. She learned more about the pharmacy details, where they had missed the on-hand portion of the order when the Administrator initiated the investigation. She stated the risk of medication errors depending on the medications and resident's condition. Missed medications and extra doses could lead to resident harm.</p> <p>Record review of the facility's undated policy titled, Pharmacy Services reflected the following:</p> <p>The facility provides routine and emergency drugs and biologicals to residents under</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 - Few</p>	<p>arrangement and/or by contracted services . The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of the resident. The pharmaceutical services of this facility was the responsibility and under the direction of the director of nurses and the consultant pharmacist.</p> <p>When pharmacy services are provided by a person or agency outside the facility, the facility assumes responsibility for obtaining services that meet professional standards, principles and timeliness of the service. Arrangements for such services specify this responsibility in writing .Consultation: A licensed pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. The pharmaceutical services consultant establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The pharmaceutical services consultant determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The number of hours spent in the facility by the consulting pharmacist is based on the number of hours determined to be sufficient to meet the needs of the residents. A record of all consultant pharmacist services, consultations, and recommendations for pharmacy</p> <p>procedure is maintained at the facility.</p>		