STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675932	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Terrace Healthcare Center	609 Rio Concho Dr San Angelo, TX 76903

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133 Based on interview and record review the facility failed to ensure residents were free from of any significant medication errors for 1 of 11 residents (Resident #1) reviewed for medication regimen. The facility did not administer physician ordered medications to Resident #1 that included handheld nebulizer breathing treatments, inhalers, nasal sprays, and tablets for diagnosed respiratory diseases. This resulted in the need for Resident #1 to be transferred to ED on 08/04/2024 at 8:55 PM and admitted to hospital with diagnosis of acute exacerbation of chronic obstructive pulmonary disease (lung disease causing breathing problems) and symptoms of shortness of breath. An Immediate Jeopardy was identified on 08/09/2024. The Immediate Jeopardy Template was provided to the Administrator on 08/09/2024 at 3:40 PM. While the Immediate Jeopardy was removed on 08/10/2024 at 5:41 PM, the facility remained out of compliance at a scope of pattern and severity level of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective actions. This failure placed residents at risk of significant medication errors and a decline in health status, serious injury, and/or death. The findings included: Record review of Resident #1's Admission Record, dated 08/08/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE] at 03:38 PM. The resident's diagnoses included chronic obstructive pulmonary disease (lung disease causing breathing problems), anxiety disorder (feelings of worry), essential hypertension (high blood pressure), hypothyroidism (thyroid disorder), type 2 diabetes mellitus (elevated blood sugar), long term (current) use of anticoagulants (use of blood thinner), unspecified asthma (breathing disorder caused by airway restriction), gastro-esophageal reflux disease (stomach digestive disease), pain (discomfort), localized edema (swelling in a specific area), allergic rhinitis (allergic response causing sneezing) and hereditary and idiopathic neuropathy (weakness, numbness, pain from nerve damage). Record review of Resident #1's Medication Administration Record, dated 08/08/2024, revealed in part: Brezti HFA 160-9-4.8ncg 2 puffs inhalation twice a day Dx: COPD, inhaled medication to open airways and decrease breathing difficulties (2 of 2 missed doses) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/08/24 at 1:51 PM, ADON H stated the Charge Nurse was responsible for ordering medications and if they could not get the medication after calling the pharmacy, they should have notified administrative staff to give direction on what to do. ADON H stated the failure of Resident #1 not getting her medication could have occurred because of a lack of knowledge maybe. ADON H said the risk of the failure for Resident #1 not receiving her medications was an Exacerbation of her Chronic Diseases. In an interview on 08/08/24 at 2:02 PM, ADON I stated the medication aide should have notified the nurse that Resident #1's medication had not been delivered in the medication cart and the Nurse did not follow through to make sure Resident #1 got her medication. ADON I said she did not realize Resident #1 had not received any of her medications for 08/03/24 or 08/04/24 until the morning of 08/08/24. ADON I said the Charge Nurse and the medication aide lacked initiative to get the medication which caused the failure. She said if it were her, I would have pulled everything possibly from the (EMDS) and then contacted the pharmacy to have the rest delivered from backup. ADON I said that did not occur because, PRN nurses, either didn't know the process or just didn't follow it. ADON I stated it was the responsibility of the med aide, nurse, nurse on call, DON ADM to order medications for a new admission. ADON I stated the failure could include death for a resident. In an interview on 08/08/24 at 3:50 PM the DON, stated training began on 08/05/24 with the anticipated DON, start date of 08/12/24. The DON further stated Resident #1 did not receive any of her medications for 08/03/24 or 08/04/24, but the facility did not realize Resident #1 did not receive any of her medications until after the State Surveyors began the investigation and the facility began a Chart Audit after 6ish Wednesday (6:00PM 08/07/24). The DON said (Resident #1) should have received her medications and the on-call nurse, DON, MD should have been immediately notified if the medications were not available. The DON stated the failure occurred because, lack of communication, agency LVN, and admission process. The DON stated the ADON and the LVN had access to the EMDS, and (facility) were working on getting all facility employed nurses' access to the system. The DON stated nurses were responsible for providing residents with nebulizers, inhalers and nasal sprays. In an interview on 8/08/24 at 4:10 PM, MA D stated the licensed nurses give the initial dose of medications. If a resident is new to the facility, then all their medications are considered initial doses, and the Med Aide doesn't do it. MA D stated I did not give Resident #1 any medications. Medication Aide D said The nurses put the orders in the computer for the pharmacy and the licensed nurses give the initial doses and all the PRN medications. The nurses can get meds from (EMDS) (EMDS), but the med aides cannot. I did not see LVN A give Resident#1 any medications and I don't know if she (LVN A) gave the resident any medications. MA D stated the resident did not have any medications in the med cart because she didn't come with any. MA D also stated Medication Aides do not do any kind of respiratory care or breathing treatments - no inhalers or nebulizer treatments. The med aides can get the oxygen cylinder, but the nurse sets the liters and applies the oxygen. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/08/24 at 4:27 PM the Clinical Resource Nurse stated the medications were ordered, but the pharmacy should have been called to ensure the orders were filled, the medication should have been obtained from (EMDS) and what isn't obtained from (EMDS) the pharmacy should have been called, the physician should have been called, or you could call the family to see if they have home medications, we could have gotten medication from hospital, we could have notified DON. The Clinical Resource Nurse said the nurse didn't administer Resident #1's medications from the EMDS because, I am not sure why she didn't give them, but there were many opportunities for her to seek the assistance to obtain the medication. The Clinical Resource Nurse stated the failure could have occurred because of a lack of education, further stating the nurses were responsible for initial doses of medications, nebulizers or breathing treatments and inhalers. The Clinical Resource Nurse said the failure could have caused the rehospitalization of Resident #1. In an interview on 8/8/24 at 4:44 PM, the Administrator stated, the facility failure was that they did not check the (EMDS) and did not notify nursing management that they were missing all of those medications, as well as the charge nurse. The Administrator stated I know I got a call Sunday about an uber and picking up medication how to pay an uber, I said no the pharmacy orders thru a local pharmacy they take care of it, at that time I called ADON I, at that time I was aware of the clonazepam only. Otherwise, I didn't know of anything else until yesterday . I was not aware of other medications not given until yesterday evening. Record review of the facility's policies/procedures for Medication Orders revealed [in part]: Non-controlled Medication Orders, 12/12 Procedures - Elements of the Medication Orders 4. The prescriber shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not available. Documentation of the Medication Order: a. New orders b. Written transfer orders (sent with a resident from a hospital or other health care facility): Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete or the date signed is different from the date of admission. 4. Scheduling new medications orders on the Medication Administration Record (MAR)/Treatment Administration Record (TAR): a. Non-emergency medication orders: The first dose of medication is scheduled to be given after the next regularly scheduled pharmacy deliver to the nursing home. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/10/2024 at 5:00 PM with the DON, she said they had a QAPI meeting and attendance with the medical director via phone. The Medical director was called by the ADM. Interview also revealed that Medical Director was notified by the DON regarding medications not administered to Resident #1 on 08/08/24 at 10:53AM. In an interview with ADM 08/10/2024 at 5:02PM regarding physician notification of Medical Director regarding IJ and SQC, ADM stated that medical was notified by ADM via phone on 08/09/24 at 5:11PM. Record review of Resident #1 hospital record dated 08/04/24 at 9:42 PM, revealed Resident #1 arrival to the emergency department with symptoms of shortness of breath at 9:15 PM on 08/04/2024. In an interview on 08/10/24 at 10:21am, with Resident #1's family, she said Resident #1 discharged from the hospital on 08/09/24 to a different nursing facility and was feeling much better. Record review of Chart Audit, dated 08/09/24, revealed All Medication Carts were audited and completed as signed by CRN and dated 08/09/24. Record Review of In-services dated, 08/08/24 & 08/09/24, included the following: Initial Dosing-8/9/24Certified Medication Aide (CMA) are not to administer the initial dose of any medication. This includes newly admitted residents and residents who have orders for any new medication. Initial dosing medication is not within the scope of practice of a CMA. This inservice had facility staff signatures and facility staff names and phone numbers indicating nurses and medication aides were inserviced on the information. New Admit Readmit Med Process Med Dispense Machine-Nurse Administrative Staff-8/9/24. 1. New Admission Medication 2. Med Dispense 3. Nebulizer Med Administration dated 8/9/24-Admission/Readmission Medication Process- Always including nights and afterhours-1. Enter orders for residents hospital discharge medication list. 2.Contact the pharmacy to confirm medication time of arrival 3. Enter pharmacy communication information in a nurse's note. Include name of person that was spoken to at pharmacy. 4.Check the medication dispensing machine for available medications. 5. At this time notify doctor, director of nursing, assistant director of nursing, or administrator of any medication that is unavailable, to obtain a substitute medication or in order to DC the medication until it is available from the pharmacy. And alternate pharmacy may be considered (local pharmacy) 6. Communication with director of marketing, to request discharge medication for medication that is unavailable prior to discharge. 7. In the morning meeting review referral documentation. communicate with the director of marketing to request discharge medication for medication that is unavailable prior to discharge. Consider holding admission if it is foreseen that we will be unable to attain medication including after hours or on weekends. 8. The morning following admission the DON or designee will verify the medications were obtained. - Nursing staff signatures reflected they reviewed and acknowledged the information. Accessing medication from med dispense located in the med room at the nurses station medication that cannot be found in the medication cart can be found in the Med dispense. Charge nurses employed by (facility) may access the Med dispense machine agency staff should ask for assistance obtaining medication needed from the medication dispense machine including tablet, capsules, liquids, HHN, injectables. Nursing staff signatures reflected they reviewed and acknowledged the information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675932	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Terrace Healthcare Center	609 Rio Concho Dr San Angelo, TX 76903

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1 The Director of Nursing/designee will review referrals preadmission specifically those that may be admitting after hours/weekends and request potential discharge date and time and discharge orders if these are available.2 The Director of Nursing/designee will determine what medications are needed and specifically note if any medications will not be available in the facility's emergency medication dispenser (review the referral prior to admission, communicate with the discharging entity on potential discharge date (s), proactively request discharge orders from the discharging entity).3. If the Director of Nurses/designee identifies medications that are not in the Emergency medication dispenser and if this medication will be needed prior to the next Pharmacy delivery the Director of Nurse/designee will request the discharging entity to provide medications until the facility can obtain the medications. If the discharging entity is unable to supply the medication{s) the facility will notify the physician and determine further actions or delay the admission until the medication can be obtained.- Nursing staff signatures reflected, they reviewed and acknowledged the information. Medication unavailable report to be ran and reviewed during clinical meetings, Monday-Friday, staff will know to communicate unavailable medications with the Director of Nursing, Assistant Director of Nursing, and/or Administrator and notification of the MD through the above education if there is a noted issue with medications being unavailable. Nursing staff signatures reflected, they reviewed and acknowledged the information. Record review of QAPI Meeting on 8/8/24: Problem-Failure to ensure new resident admission received medications. Attendees included Resident #1's Physician and Medical Director, ADM, CRN, CCM, ADONs, and Social Worker. The Administrator was informed the Immediate Jeopardy was removed on 08/10/24 at 5:41PM. The facility remained out of compliance at a scope o [TRUNCATED]