

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Town East Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3617 O'Hare Dr Mesquite, TX 75150	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859</p> <p>Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments for 1(Resident #1) of 1 resident reviewed for storage of medication.</p> <p>The facility failed to ensure Resident #1's Fluticasone Propionate (Nasal spray) and Trelegy Ellipta Inhalation Aerosol Powder (Inhaler) were not stored at the resident's bedside table and not secured in the medication cart or medication room.</p> <p>This failure could place residents at risk of overdosing.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 04/20/24, revealed the resident was an [AGE] year-old female with an admitted [DATE]. Resident #1's diagnoses which included Type 2 diabetes mellitus (an impairment in the way the body regulates and uses sugar) and chronic respiratory failure (happens when the airways that carry air to lungs become narrow and damaged).</p> <p>Review of Resident #1's MDS quarterly Assessment, dated 04/12/24, revealed a BIMS score of 10, indicating moderate cognitive impairment.</p> <p>Review of Resident #1's care plan dated 01/10/24, reflected: Problem: Category: shortness of breath rule out chronic obstructed pulmonary disease. Resident takes ellipta and fluticasone propionate spray for allergies . Goal: Resident will remain free from complications of asthma through the review date. Intervention: Administer medications as ordered, monitor/document for side effect, effectiveness. Resident #1's care plan did not reflect anything regarding being able to self-administer any medications.</p> <p>Review of Resident #1's physician order, dated 12/13/23, revealed she had an order for Fluticasone Propionate Nasal Suspension 50 mcg/act (Fluticasone Propionate (Nasal) 2 sprays in each nostril one time a day for allergy) at 8:00AM.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's physician order dated 07/25/23 revealed Resident #1 had an order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 mcg/act (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally one time a day for COPD (a group of diseases that cause airflow blockage and breathing-related problems) at 8:00 AM.</p> <p>Observation and interview on 04/20/24 at 9:12 AM revealed Resident #1 in her room, laying on her bed. There were 2 boxes, 1 with nasal spray of Fluticasone Propionate 50 mcg spray and another with Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 mcg/act on resident's bedside table. Resident #1 stated a nurse left the 2 inhalers on her table yesterday in the morning. She stated the nurses provide them to her every morning. She said she was unable to recall the nurses' names. She stated she had not used the inhalers since yesterday.</p> <p>Interview on 04/20/24 at 10:25 AM with LVN A revealed he was the nurse assigned to Resident #1. LVN A stated he was in Resident #1's room earlier and did not see any medications in the room. He stated all medications needed to be secured to ensure the resident's safety. He said anyone could take the unsecured medications resulting in overdose or negative side effect. LVN A stated if Resident #1 is not care planned or did not have an order to self-administer nasal spray, the risk for leaving medications in the room could lead to resident over medicating or another resident taking them.</p> <p>Interview on 04/21/24 at 3:36 PM with the DON revealed she did not have any residents who were able to self-administer medications. She stated she has addressed the concerns with her staff and made sure they remove any medications left in resident rooms. She stated Resident #1 should not have had nasal spray in her room. The DON stated the risk of leaving medication in rooms was that it could lead to another resident taking the medication or the resident not taking the medication as ordered. She stated she had done in-services with the staffs on medication administration at the beginning of the month.</p> <p>Review of the facility in-services revealed the facility offered training titled do not for any reason leave medications in a resident room on 04/04/24.</p> <p>Review of the facility's Self-Administration of Medications policy, revised January 2021, reflected: .any medication found at the bedside that are not authorized for self-administration are turned over to the nurse in charge</p>		