

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Garnet Hill Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 McCreary Rd Wylie, TX 75098	

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 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415</p> <p>Based on interview and record review the facility failed to ensure the resident representative had the right to exercise the resident's rights to the extent those rights are delegated to the representative for one of three residents (Resident #1) reviewed for resident rights.</p> <p>The facility failed to obtain consent from Resident #1's RR, prior to administering an antibiotic medication which resident was allergic to.</p> <p>This failure could place residents at risk of not having their preferred responsible party represent them in care decisions.</p> <p>Findings Include:</p> <p>Record review of Resident #1's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #1's face sheet identified her representative was a family member, RR. Resident #1's RR was listed as medical power of attorney. Resident #1 had diagnoses which included: Essential (primary) Hypertension (high blood pressure), Urinary Tract Infection (UTI), and AMS (Altered Mental Status). Resident #1's face sheet had 37 allergies listed including Sulfa.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed she had a BIMS score of 10, which meant moderate cognitive impairment.</p> <p>Record review of Resident #1's Care Plan, dated 1/25/25, revealed the resident had Cognitive loss due to dementia. Resident #1 had potential for discomfort and side effects related to medication allergies. Resident #1 becomes easily agitated and anxious at times.</p> <p>Record review of Resident Admission Agreement for Resident #1, entered into as of 08/15/2022, showed Resident #1 had RR listed as her Resident Representative.</p> <p>Record review Resident #1's Statutory Durable Power of Attorney dated 10/18/16, revealed the RR was Resident #1's power of attorney and stated, power of attorney is not affected by my subsequent disability or incapacity.</p> <p>Record review of Resident #1's Medical Power of Attorney, dated 1/11/18, revealed the RR was Resident #1's medical power of attorney.</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 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Notes, dated 3/14/25 at 1:29 a.m. by RN-E, revealed there was a new order per NP, Bactrim 1 [Tablet] .6 doses, start today. Asked NP if she was going to call and notify residents RR, she denied. Orders noted, transcribed and initial does [sic] given.</p> <p>Record review on Resident #1's notes dated 3/14/25 at 1:54 a.m. by RN-E, revealed at approximately 9:30 p. m., Resident #1's RR approached nursing with clear agitation and aggression asking what medication [Resident #1] was given and why. Explained to her that the NP ordered Bactrim 1 [Tablet] .6 doses and this nurse administered the first does, no adverse reactions noted by this nurse . [RR stated], she should have been consulted for consent.</p> <p>Record review of Notes dated 3/14/25 at 10:59 a.m. by RN-G revealed Morning antibiotic medication Bactrim not administered. Resident allergic to surfa [sic]. Call placed to NP new order received to stop medication. Medication discontinued as ordered by physician.</p> <p>Record review of Notes dated 3/14/25 at 11:18 a.m. by RN-G revealed Resident transferred to . hospital, per daughter request. NP notified.</p> <p>Record review of Notes on 3/17/25 at 4:26 p.m., as late entry from 3/14/25 at 11:00 a.m. by the DON revealed the Police officer arrived at the facility, unsure of who called for an officer. Discovered that .[RR], called the police to discuss events from previous night. Officer went in and spoke with .[RR], and stated that resident's vitals were WNL, but .[RR] still wanted resident to go to the ER. Resident transferred to .[hospital] and NP was notified. Per nurse, resident was still sleeping when .[RR] arrived but VS were assessed and stable.</p> <p>Record review of Notes on 3/18/25 at 7:47 p.m. by RN-F revealed Resident arrived Facility at 1705 from . [hospital] with DX: UTI, report received from nurse .that Resident received no treatment for UTI as her .[RR] refused meds that were prescribed for UTI.</p> <p>Record review of the facility's Incident Log Report revealed there was an incident regarding Resident #1 on 3/14/25 at 9:01 a.m. stating it was Medication Related with no apparent injury, abuse or neglect was ruled out and resident received medical treatment.</p> <p>Record review of the hospital discharge summary, dated 3/18/25 at 9:31 a.m., revealed Resident #1 was discharged with diagnoses which included Acute encephalopathy (sudden and significant decline in brain function) due to transient hypovolemia (temporary reduction in blood volume), Hypotension (low blood pressure), Asymptomatic bacteriuria (presence of bacteria in urine), COPD (Chronic obstructive pulmonary disease; a group of lung diseases that cause airflow obstruction and breathing problems), Chronic memory impairment (persistent decline in ability to remember information over time) and MTHFR gene mutation. Under Hospital course: Patient is an [AGE] years [sic] old woman with history of atrial fibrillation (irregular heartbeat) COPD, hypertension, MTHFR gene mutation (change in DNA sequence can disrupt enzyme's normal function) and hand [sic] sulfa allergy who had abnormal urinalysis and was given Bactrim at the skilled nursing facility. Per RR, patient become [sic] confused afterwards and was brought to hospital. She was hypotensive requiring IV fluid bolus. She was admitted to ICU for pressor support but did not require that. Patient become [sic] alert afterwards remained without fever, dysuria (discomfort when urinating), frequency, or urgency. No leukocytosis (increased number of white blood cells). No antibiotics were administered in the hospital .There was no skin rash noted .She is medically ready to go back to her long-term residential facility. Sulfa drugs should be avoided in the future.</p> <p>(continued on next page)</p>		

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/19/25 at 8:48 a.m. with Resident #1's RR revealed she was the medical and financial power of attorney. RR stated Resident #1 was unable to give consent because she had a learning disability. RR stated she went in the facility on 3/13/25 around 8:30 p.m. She stated the facility had given Resident #1 an antibiotic, Bactrim without getting her consent. RR stated the facility is supposed to get her consent prior to any medication changes or new medications. RR believed Resident #1 suffered neurotoxic side effects from the Bactrim as Resident #1 had a tremor in her right hand, she looked sedated, and the whites of her eyes were bloodshot. RR stated when she arrived the morning of 3/14/25, Resident #1 was unresponsive.</p> <p>Interview on 3/19/25 at 10:58 a.m. with the Admin and the DON. The Admin stated Resident #1 had a UTI, and she was started on Bactrim. She was given one dose and the RR wanted them to call to get permission before giving any medications. The Admin stated if Resident #1 could answer, they did not need to get permission from RR. The Admin stated on 3/14/25, Resident #1's RR felt Resident #1 needed medical care at the hospital. Resident #1 was sent to the hospital, and they gave Resident #1 a liter of fluids and that was about it. The Admin stated RR did not believe the resident had a UTI and refused the hospital from giving any antibiotics. The Admin stated the facility changed over their on-line documentation system and the sulfa drug allergy for Resident #1 was missed during the transition. He stated it was in the system now. The DON stated she went through all the residents' medications and there were no other errors besides Resident #1's. The DON stated Resident #1 was lucid at times.</p> <p>Interview on 3/19/25 at 11:42 a.m., Resident #1 stated she could not remember why she went to the hospital but said that was why she was in the facility. She stated staff treated her terrible, but she was not going to get into that and told the state surveyor to talk to her RR. Resident #1 did not recall if she had ever gotten the wrong medication.</p> <p>Interview on 3/19/25 at 12:41 p.m. with LVN-C, stated if she received a new medication order, the medication allergy list was in the system. LVN-C stated the doctor would have access to the allergy list in the system. LVN-C stated she would call the pharmacy to verify there was no allergy for the resident. LVN-C stated by the time the medication was ready to be administered, the medication would have been checked by the doctor and the nurse for allergies. LVN-C stated if a resident had a UTI, they may have had confusion, altered mental status, been off baseline, a change in condition or had a burning sensation. She stated if the resident was suspected of having a UTI, she would contact the doctor for further orders. LVN-C was familiar with Resident #1 since her admission. She stated there was nothing done without her RR being aware. LVN-C stated she would check with the RR to see if she consented to any medication prior to giving it.</p> <p>Interview on 3/19/25 at 1:08 p.m., CMA-D stated the medication allergy list was checked by the doctor and the nurse before it was administered. He stated he did not give medication to Resident #1 because the nurses did. CMA-D stated some family members wanted the nurses to give residents their medications.</p> <p>Attempted telephone call on 3/19/25 at 3:33 p.m. to RN-E, left message and sent text.</p> <p>Attempted telephone call on 3/19/25 at 3:48 p.m. to RN-F, left message and sent text.</p> <p>(continued on next page)</p>		

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/19/25 at 3:52 p.m., NP stated regarding Resident #1, the Sulfa allergy was not on her list when she made the orders for Bactrim. The NP stated she did not know Resident #1 had the allergy to Sulfa drugs until the pharmacy let her know. The NP stated if she had known there was a Sulfa allergy, she would not have ordered Bactrim.</p> <p>Interview on 3/19/25 at 8:22 p.m., RN-F stated if a resident had a drug allergy, when a new prescription was put in the computer system, it would pop up showing there was an allergy. She stated both the NP, and she would have called the RR for consent to give a medication. RN-F stated she would call the RR herself to make sure she had knowledge of any medications because there were issues in the past.</p> <p>Interview on 3/19/25 at 8:29 p.m., RN-E stated on 3/13/25 Resident #1's UTI cultures came back positive. She stated Sulfa drugs were not listed on her allergy list in the computer system. The NP prescribed Bactrim, 6 doses with the 1st dose started that night. She stated the order started that night, so she got it out of the facility's emergency kit. RN-E stated when the NP made the order, she asked if she was going to call the RR. The NP stated she would not because the RR hinders Resident #1's care. RN-E stated she was in the room with the NP when she explained to Resident #1 what she was going to give her, the resident agreed, and she exited the room. RN-E stated when she got the medication, she explained to Resident #1 what the medication was for prior to giving it to her and Resident #1 said okay.</p> <p>RN-E stated the RR came in later and asked what had been given to Resident #1. She let her know the NP had given orders for Bactrim. RN-E stated RR started raising her voice and yelling she had not given consent for the medication. RN-E stated the RR called the police to the facility which she had done 3 or 4 times in a row because she did not feel they were doing their job correctly. The police wound up escorting the RR out of the facility for the night and allowed things to calm down. RN-E stated she did not see Resident #1's hands shake at all that night. RN-E stated she was not working the next morning when Resident #1 was sent to the hospital. RN-E stated the hospital discharge notes stated the RR refused to give any antibiotics while Resident #1 was there. RN-E stated the RR was worried about altered mental status from the Bactrim, but it could have been from the UTI. RN-E stated the NP had always called for approval from the RR in the past. She stated the NP, or the DON would call for consent from the RR.</p> <p>Record review of the facility's Resident Rights, dated 8/14/20, stated under Policy: The staff will abide by and protect resident rights in accordance with state and federal guidelines .Procedure: Staff will abide by resident rights as outlined within CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities</p> <p>Record review of the facility's Resident Admission Agreement, dated 9/24/21, revealed under Resident Representative is defined in the federal regulations governing nursing facilities as any of the following: a. an individual chosen by the resident or a person authorized by State of Federal law .to act on behalf of the resident in order to (i) support the resident in decision-making; (ii) access medical, social or other personal information of the resident .</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>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** 49415</p> <p>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 of three residents (Resident #1) reviewed for pharmacy services.</p> <p>1) The facility failed to update Resident #1's allergy list completely when they manually transcribed the information into their new operating system.</p> <p>2) The facility failed to ensure Resident #1 was not administered Bactrim (Sulfa drug) on 3/13/25 when Resident #1 had an allergy to Sulfa.</p> <p>These failures could place residents at risk of receiving medications they have allergies to which could contribute to adverse reactions resulting in a decline in health and/or hospitalization .</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #1's face sheet identified her representative was a family member. Resident #1 had 37 allergies listed which included: Albuterol, Methocarbamol, Levodopa, Acetaminophen, Oxycodone, Hydrocodone, Lidocaine, Docusate, Senna, Calcium Carbonate, Carbidopa, Ferrous Sulfate, Potassium Chloride, Iodine, Penicillin G, Polyethylene Glycol, Pantoprazole, Melatonin, Fluticasone, Cefazolin, Megestrol, Ketorolac, Ondansetron, Diphenhydramine, Tramadol, Zolpidem, Loratadine, Cefpodoxime, Fentanyl, Naproxen, Maltodextrin, Xanthan Gum, Furosemide, Prednisone, Morphine, Sulfa (Sulfonamide) and Propoxyphene.</p> <p>Resident #1 had diagnoses which included: Essential (primary) Hypertension (High Blood Pressure), UTI (an illness in any part of the urinary tract), and AMS (Altered Mental Status).</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed she had a BIMS score of 10, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1's Care Plan, dated 1/25/25, revealed the resident had Cognitive loss due to Dementia. Resident #1 had potential for discomfort and side effects related to medication allergies. Resident #1 becomes easily agitated and anxious at times.</p> <p>Record review of Resident #1's Notes, dated 3/14/25 at 1:29 a.m. by RN-F, revealed there was a new order per NP, Bactrim DS 1 Tab .6 doses, start today. Asked NP if she was going to call and notify residents /RR, she denied. Orders noted, transcribed and initial does [sic] given.</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>Record review on Resident #1's notes dated 3/14/25 at 1:54 a.m. by RN-F, revealed at approximately 9:30 p. m., Resident #1's RR approached nursing with clear agitation and aggression asking what medication her [Resident #1] was given and why. Explained to her the NP ordered Bactrim 1 Tab .6 doses and this nurse administered the first dose, no adverse reactions noted by this nurse RR stated, she should have been consulted for consent and because of the antibiotic [Resident #1's] hands are shaking.</p> <p>Record review of Resident #1's eMar for Bactrim revealed the medication was ordered on 3/13/25 and was administered at 8 p.m. The eMar showed the medication was discontinued on 3/14/25.</p> <p>Record review of Notes dated 3/14/25 at 10:59 a.m. by RN-G revealed Morning antibiotic medication Bactrim DS not administered. Resident allergic to surfa [sic]. Call placed to NP new order received to stop medication. Medication discontinued as ordered by physician.</p> <p>Record review of Notes, dated 3/14/25 at 11:18 a.m. by RN-G, revealed Resident transferred to .hospital, per . [RR] request. NP notified.</p> <p>Record review of Notes dated 3/17/25 at 4:26 p.m., as late entry, from 3/14/25 11 a.m. by the DON, revealed Police officer arrived at facility, unsure of who called for an officer. Discovered that .[RR], called the police to discuss events from previous night. Officer went in and spoke with . [RR,] and stated that residents vitals were WNL, but . [RR] still wanted resident to go to the ER. Resident transferred to[hospital]and NP was notified. Per nurse, resident was still sleeping when [RR] arrived, but VS were assessed and stable.</p> <p>Record review of Notes, dated 3/18/25 at 7:47 p.m. by RN-E, revealed Resident arrived Facility at 1705 [5:05 p.m.] from [hospital] with DX: UTI, report received from nurse .that Resident received no treatment for UTI as her [RR] refused meds that were prescribed for UTI.</p> <p>Record review of the facility's Incident Log Report revealed there was an incident regarding Resident #1 on 3/14/25 at 9:01 a.m. which stated it was Medication Related with no apparent injury, abuse or neglect ruled out and resident received medical treatment</p> <p>Record review of hospital Clinical Notes, dated 3/17/25, revealed Resident #1 had Delirium/encephalopathy, metabolic and toxic (change in mental status): In the context of someone who is very frail, severe malnutrition and probably pretty advanced dementia, very debilitated. Potential causes and contributors: It is possible this is a side effect of medication. Also possible for UTI but no fevers and no leukocytosis .Avoid sulfa drugs, doubt if patient's current symptoms are related to Bactrim .The patient had to get fluid bolus in the ER .The patient also started on ceftriaxone for UTI, but [RR] refused antibiotics.</p> <p>Record review of hospital discharge summary, dated 3/18/25 at 9:31 a.m., revealed Resident #1 had sulfa allergy who had abnormal urinalysis and was given Bactrim at the skilled nursing facility. Per RR patient become [sic] confused afterwards and was brought to hospital. She was hypotensive requiring IV fluid bolus . she was admitted to ICU for pressor support but did not require that .there was no skin rash noted.</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>Interview on 3/19/25 at 10:58 a.m. with the Admin and the DON. The Admin stated Resident #1 had a UTI, and she was started on Bactrim. She was given one dose and the RR wanted them to call to get permission before giving any medications. The Admin stated if Resident #1 could answer, they did not need to get permission from RR. The Admin stated on 3/14/25, Resident #1's RR felt Resident #1 needed medical care at the hospital. Resident #1 was sent to the hospital, and they gave Resident #1 a liter of fluids and that was about it. The Admin stated RR did not believe the resident had a UTI and refused the hospital from giving any antibiotics. The Admin stated the facility changed over their on-line documentation system manually and the sulfa drug allergy for Resident #1 was missed during the transition. He stated it was in the system now. The Admin stated they did not know the medication was missed until Resident #1's RR stated there was an adverse reaction to the Bactrim. The DON stated she went through all the residents' medications and there were no other errors besides Resident #1's. The DON stated Resident #1 was lucid at times.</p> <p>Interview on 3/19/25 at 11:42 a.m., Resident #1 stated she could not remember why she went to the hospital but said that was why she was in the facility. She stated staff treated her terrible, but she was not going to get into that and told the state surveyor to talk to her RR. Resident #1 did not recall if she had ever gotten the wrong medication.</p> <p>Interview on 3/19/25 at 12:41 p.m., LVN-C stated if a resident was prescribed a new medication order by the doctor, the resident's allergy list was in the system. LVN-C stated she would call the pharmacy to verify there were no drug allergies if she was in question.</p> <p>Interview on 3/19/25 at 1:08 p.m., CMA-D stated a resident's allergy list was checked by the doctor and the nurse before a medication was ordered. He stated the nurses gave medication to Resident #1 as the RR requested.</p> <p>Attempted interview on 3/19/25 at 3:33 p.m. with RN-E, left message and sent text.</p> <p>Attempted interview on 3/19/25 at 3:48 p.m. with RN-F, left message and sent text.</p> <p>Interview on 3/19/25 at 3:52 p.m. with NP, stated regarding Resident #1, the Sulfa allergy was not on her list when she made the orders for Bactrim. NP stated she did not know Resident #1 had the allergy to Sulfa drugs until the pharmacy let her know. NP stated if she had known there was a Sulfa allergy, she would not have ordered Bactrim.</p> <p>Interview on 3/19/25 at 4:37 p.m., the Admin stated it was a simple human error that the Sulfa drug allergy was not switched over to the new medical documentation system.</p> <p>Interview on 3/19/25 at 8:22 p.m., RN-F stated a medication technician or nurse would give a resident their medications unless a family member wanted a nurse to administer medications. She stated if a resident had an allergy, when a new prescription was put in the system, the system would have a pop-up showing there was an allergy listed. RN-F stated there was concern Resident #1's RR was not allowing staff to provide care. She stated the RR had so many drug allergies listed, it was difficult to find an antibiotic that could be given to Resident #1. RN-F stated the RR told her the medications made Resident #1's eyes red.</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>Interview on 3/19/25 at 8:29 p.m., RN-E stated last Thursday, 3/13/25, Resident #1's UTI cultures came back positive. She stated Sulfa drugs were not listed on Resident #1's allergy list. RN-E stated the NP prescribed Bactrim with the 1st dose started that night. RN-E asked the NP if she was going to call the RR, but she said no because the RR hinders the resident's care. RN-E stated she obtained the Bactrim medication out of their emergency kit. RN-E stated the RR called the police after she arrived and found out the medication was given without her consent. She stated the police officer wound up escorting RR out of the building to deescalate the situation that night. RN-E stated she was not working when Resident #1 was sent out to the hospital the next morning. She stated she did not see Resident #1's hands shake at all night before.</p> <p>Attempted interview on 3/20/25 at 11:52 a.m. with the police department/PD, stated Officer-H and Officer-I worked the scene when Resident #1 was sent out to the hospital, but Officer-H was on vacation this week and Officer-I did not work until 7 p.m. tonight.</p> <p>Interview on 3/20/25 at 8:37 p.m. with Officer-I, stated he was present the evening of 3/13/25, but was not there on 3/14/25 when Resident #1 was sent to the hospital. Officer-I stated RR was complaining about several different things regarding the treatment of Resident #1, including staff not consulting her prior to giving medications.</p>		

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NAME OF PROVIDER OR SUPPLIER Garnet Hill Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 McCreary Rd Wylie, TX 75098	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415</p> <p>Based on record review and interviews, the facility failed to maintain medical records on each resident that were accurately documented for one (Resident #1) of three residents reviewed for accuracy of records.</p> <p>The facility failed to add one of Resident #1's medication allergies, Sulfa, into the new operating system when they transferred the information.</p> <p>This failure could place residents at risk of not receiving medications as ordered which could cause a decline in the resident's overall health.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #1's face sheet identified her representative was a family member. Resident #1 had 37 allergies listed which included: Albuterol, Methocarbamol, Levodopa, Acetaminophen, Oxycodone, Hydrocodone, Lidocaine, Docusate, Senna, Calcium Carbonate, Carbidopa, Ferrous Sulfate, Potassium Chloride, Iodine, Penicillin G, Polyethylene Glycol, Pantoprazole, Melatonin, Fluticasone, Cefazolin, Megestrol, Ketorolac, Ondansetron, Diphenhydramine, Tramadol, Zolpidem, Loratadine, Cefpodoxime, Fentanyl, Naproxen, Maltodextrin, Xanthan Gum, Furosemide, Prednisone, Morphine, Sulfa (Sulfonamide) and Propoxyphene.</p> <p>Resident #1 had diagnoses which included: Essential (primary) Hypertension (High Blood Pressure), UTI (an illness in any part of the urinary tract), and AMS (Altered Mental Status).</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed she had a BIMS score of 10, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1's Care Plan, dated 1/25/25, revealed the resident had Cognitive loss due to Dementia. Resident #1 had potential for discomfort and side effects related to medication allergies. Resident #1 becomes easily agitated and anxious at times.</p> <p>Record review of Resident #1's eMar for Bactrim revealed the medication was ordered on 3/13/25 and was administered at 8 p.m. The eMar showed the medication was discontinued on 3/14/25.</p> <p>Record review of Notes dated 3/14/25 at 10:59 a.m. by RN-G revealed Morning antibiotic medication Bactrim DS not administered. Resident allergic to surfa [sic]. Call placed to NP new order received to stop medication. Medication discontinued as ordered by physician.</p> <p>Record review of Notes, dated 3/14/25 at 11:18 a.m. by RN-G, revealed Resident transferred to .hospital, per . [RR] request. NP notified.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Notes dated 3/17/25 at 4:26 p.m., as late entry, from 3/14/25 11 a.m. by the DON, revealed Police officer arrived at facility, unsure of who called for an officer. Discovered that [RR], called the police to discuss events from previous night. Officer went in and spoke with [RR] and stated that residents vitals were WNL, but [RR] still wanted resident to go to the ER. Resident transferred to [hospital] and NP was notified. Per nurse, resident was still sleeping when [RR] arrived, but VS were assessed and stable.</p> <p>Record review of the facility's Incident Log Report revealed there was an incident regarding Resident #1 on 3/14/25 at 9:01 a.m. which stated it was Medication Related with no apparent injury, abuse or neglect ruled out and resident received medical treatment</p> <p>Record review of hospital Clinical Notes, dated 3/17/25, revealed Resident #1 had Delirium/encephalopathy, metabolic and toxic (change in mental status): In the context of someone who is very frail, severe malnutrition and probably pretty advanced dementia, very debilitated. Potential causes and contributors: It is possible this is a side effect of medication. Also possible for UTI but no fevers and no leukocytosis. Avoid sulfa drugs, doubt if patient's current symptoms are related to Bactrim. The patient had to get fluid bolus (a single, large dose) in the ER. The patient also started on ceftriaxone for UTI, but [RR] refused antibiotics.</p> <p>Record review of hospital discharge summary, dated 3/18/25 at 9:31 a.m., revealed Resident #1 had sulfa allergy who had abnormal urinalysis and was given Bactrim at the skilled nursing facility. Per RR patient become [sic] confused afterwards and was brought to hospital. She was hypotensive requiring IV fluid bolus. she was admitted to ICU for pressor support (use of medications called vasopressors to increase blood pressure and improve blood flow) but did not require that. there was no skin rash noted.</p> <p>Interview on 3/19/25 at 10:58 a.m. with the Admin and the DON. The Admin stated the facility changed over their on-line documentation system manually and the sulfa drug allergy for Resident #1 was missed during the transition. He stated it was in the system now. The Admin stated they did not know the medication was missed until Resident #1's RR stated she had an allergy to Sulfa drugs. The DON stated she went through all the residents' medications and there were no other errors besides Resident #1's.</p> <p>Interview on 3/19/25 at 11:42 a.m., Resident #1 stated she could not remember why she went to the hospital but said that was why she was in the facility. She stated staff treated her terrible, but she was not going to get into that and told the state surveyor to talk to her RR. Resident #1 did not recall if she had ever gotten the wrong medication.</p> <p>Interview on 3/19/25 at 12:41 p.m., LVN-C stated if a resident was prescribed a new medication order by the doctor, the resident's allergy list was in the system. LVN-C stated she would call the pharmacy to verify there were no drug allergies if she was in question.</p> <p>Interview on 3/19/25 at 1:08 p.m., CMA-D stated a resident's allergy list was checked by the doctor and the nurse before a medication was ordered. He stated the nurses gave medication to Resident #1 as the RR requested.</p> <p>Attempted interview on 3/19/25 at 3:33 p.m. with RN-E, left message and sent text.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Attempted interview on 3/19/25 at 3:48 p.m. with RN-F, left message and sent text.</p> <p>Interview on 3/19/25 at 3:52 p.m. with NP, stated regarding Resident #1, the Sulfa allergy was not on her list when she made the orders for Bactrim. NP stated she did not know Resident #1 had the allergy to Sulfa drugs until the pharmacy let her know. NP stated if she had known there was a Sulfa allergy, she would not have ordered Bactrim.</p> <p>Interview on 3/19/25 at 4:37 p.m., the Admin stated it was a simple human error that the Sulfa drug allergy was not switched over to the new medical documentation system.</p> <p>Interview on 3/19/25 at 8:22 p.m., RN-F stated a medication technician or nurse would give a resident their medications unless a family member wanted a nurse to administer medications. She stated if a resident had an allergy, when a new prescription was put in the system, the system would have a pop-up showing there was an allergy listed.</p> <p>Interview on 3/19/25 at 8:29 p.m., RN-E stated last Thursday, 3/13/25, Resident #1's UTI cultures came back positive. She stated Sulfa drugs were not listed on Resident #1's allergy list. RN-E stated the NP prescribed Bactrim with the 1st dose started that night.</p>