

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/06/2024
NAME OF PROVIDER OR SUPPLIER  The Belmont at Twin Creeks		STREET ADDRESS, CITY, STATE, ZIP CODE  999 Raintree Circle Allen, TX 75013	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843</b></p> <p>Based on observations, interviews, 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 of 2 Residents (Resident #1) reviewed for medication administration.</p> <p>Resident #1 received medication (Oxybutynin and Trazodone) on 06/22/2024 that was prescribed for another resident.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 06/22/2024 and ended on 06/22/2024. The facility had corrected the noncompliance before the survey on 07/06/2024.</p> <p>This deficient practice could affect resident who received medication and place them at risk of not receiving the appropriate amount of medication and could result in an adverse reaction or a decline in health.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, undated revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included hemiplegia following cerebral infarction that affected the right dominate side (paralysis of partial or total body function on one side of the body).</p> <p>Record review of Resident #1's most recent Nursing Home Comprehensive assessment, dated 06/11/2024 revealed the resident was admitted to the facility on [DATE] from general-short term hospital with a BIMS score of 14 which indicated the resident was cognitively intact.</p> <p>Record review of Resident #1's comprehensive care plan, dated 06/06/2024 revealed the resident received medication related to diabetes with interventions that included to give medication per order, monitor labs, report abnormalities to the MD .</p> <p>Record review of Resident #1's Order Summary Report, dated 05/30/2024 did not include medications Trazodone or Oxybutynin.</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>Record Review of Resident #1's MAR dated 06/22/2024 reflected Resident #1 received the following medications: Gabapentin 400 mg capsule (1) Capsule oral schedule 8:00, 14:00, and 20:00; Metoprolol tartrate 25 mg tablet (0.5) tablet oral 8:00 and 20:00; Rosuvastatin 40 mg tablet (1) tablet oral schedule 20:00.</p> <p>Record Review of Resident #2's face sheet, undated revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included urinary tract infection and insomnia.</p> <p>Record Review of Resident #2's MAR dated 06/22/2024 reflected Resident #2 received the following medications: Alendronate 70 mg (1 TAB) tablet Oral scheduled at 5:00; Aspirin 81 mg tablet, delayed release (1 tab) tablet, delayed release oral scheduled at 8:00; Wellbutrin XL 300 mg 24 hr tablet, extended release (1 tab) tablet, extended release 24 hour oral scheduled 8:00; Colace 100 mg capsule (1 Cap) Capsule Oral One time daily schedule 8:00; Fanapt 12mg tablet (1 Tab (12 MG) Oral schedule 21:00; Ferrous sulfate 325 mg (65 mg iron) tablet (1 tab) tablet Oral schedule 8:00 and 20:00; Lithium carbonate 300 mg tablet (1tab) tablet oral schedule 8:00; Metformin 500 mg tablet (1tab) tablet oral scheduled 8:00 and 20:00; Oxybutynin chloride 5 mg tablet (1 tab) tablet oral schedule 8:00 and 20:00; Pantoprazole 40 mg tablet, delayed release (1 tab) tablet delayed release schedule 7:00; Trazodone 100 mg tablet (1 tab) tablet Oral 20:00; and Trintellix 20 mg tablet (1 tab) tablet Oral schedule 8:00 .</p> <p>Record Review of progress note authored by the ADON, dated 06/24/2024 at 11:09 am revealed Resident was given Trazodone and Oxybutynin, resident had no adverse reactions or side effects, will continue to monitor resident for 48hrs post medication to ensure the continuation of non-adverse reactions are occurring. Provider, MD notified and n/o to monitor for any reactions. Conducting Q2hr checks and per shift.</p> <p>Record Review of progress note authored by LVN B, dated 06/23/2024 at 6:27 (CDT) revealed Resident comfortably resting in bed at this time w/OU closed but easily aroused/able to fully verbalize needs. Respirations are even and non-labored w/NAD or SOB noted Q 2h checks during the shift completed w/no s/s or any adverse reactions r/t Trazodone and Oxybutynin noted. Will continue to monitor. Call light/fall precautions in place.</p> <p>Record Review of progress note authored by LVN C, dated 06/23/ 2024 at 12:41 (CDT) revealed this nurse was notified that the resident was more slurred speech than usual. Vital signs were 123/62/82 . Muscle weakness was noted to be worse. Patient was responsive to commands. O2 stat was down to 60. Patient was put on Oxygen 3L.</p> <p>Record Review of progress note authored by LVN C, dated 06/23/2024 at 14:06 (CDT) revealed this nurse was notified that the resident was more slurred speech than usual. Vital signs were 123/62/82. Muscle Weakness was not noted to be worse. Patient was responsive to commands. O2 sat was down to 87. Patient put on Oxygen 3L and post oximeter reading went up to 90% on continuous oxygen with MD notified. N/O to do x-ray and lab work on Stat before this writer place the order in. Patient situation start deteriorating 9-1-1 called and patient was sent to ER.</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 of hospital records, 06/23/2024, revealed, .Per reports, patient was accidentally given Trazadone for the first time so this may be a medication side effect MRIs are negative for acute stroke .Case discussed with patient's family. The are concerned because reportedly the nursing home accidentally gave her trazadone for the first time yesterday evening. This was given in error. I explained that some of the symptoms may be due to medication side effect .will plan to observe in the hospital for Neuro eval .noted her left facial weakness and right UE weakness appeared to be neurologically stable .Pt was placed in observation and neurology was consulted .Pt recent CVA about 3 months ago .</p> <p>Record Review of in-service training report, 06/23/2024, revealed, nursing department training was conducted on 06/23/2024; employee groups present education with nurses and medication aides; topic medication administration conducted by ADON attached signature page.</p> <p>In an interview on 07/06/2024 at 3:39 PM the CMA A stated she took the blood pressure for Resident #2, then pulled her medications. Resident #2's stated that the resident just started eating and to hold off on medication. CMA A stated she placed the medication back in the cup and labeled the cup with Resident #2's room number. CMA A stated she placed the cup back on the medication cart and pulled medication for Resident #1. She stated that the nurse on duty pulled her away from the medication cart for assistance. When she returned to the medication cart, she picked up the cup labeled for Resident #2. She gave resident #1 the cup labeled Resident #2 with the medication for Resident #2. At that time, the family member who was in the room stated that the cup of medication was labeled with Resident #2's room number. CMA A stated she instructed Resident #1 to spit out the medication and noticed she had swallowed two of the pills. CMA A then exited the room and alerted the ADON on duty. She stated that the risk for a resident taking medication that was not prescribed by a doctor could make the resident sick or kill them .</p> <p>In an interview on 07/06/2024 at 4:03 pm the ADON stated the medication aide came to her and stated that she made a mistake. He stated he then checked medical records to verify if Resident #1 had medication allergies. Then Resident #1's vitals were checked, and the DON was notified. The doctor advised to monitor the resident for fatigue and lethargy (A condition marked by drowsiness and an unusual lack of energy and mental alertness). He stated that the CMA A was given a corrective action with skills check off. The risk to the resident was adverse side effects .</p> <p>In an interview on 07/06/2024 at 5:15 PM the LVN A revealed the 6 Rights of Medication Administration: Right Patient, Right Drug, Right Dose, Right Dosage Form, Right Time, Right Route, Right Indication.</p> <p>In an interview on 07/06/2024 at 5:28 PM the DON revealed the expectation for the Medication Aide was to prepare medications for one resident at a time, complete everything before you go to the next resident. She stated Resident #1 was sent to the hospital because of altered mental status .</p> <p>Record review of the policy and procedure titled, Medication Administration not dated revealed 2. The 6 rights of medication administration. A. Right Patient identify correct patient before preparing medications and check patient location to ensure your patient is ready to receive medications.</p>		