

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE 170 Stonebridge Lane Southlake, TX 76092	

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** 32227</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 of 4 residents (Resident #1) reviewed for medication administration.</p> <p>The facility failed to ensure LVN A gave Resident #1 the correct IV antibiotic; she was given Resident #2's antibiotic.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 03/26/24 and ended on 03/27/24. The facility has corrected the noncompliance before the survey began.</p> <p>This failure placed residents at risk of not receiving medications as prescribed, decreased therapeutic effects of the medications, risk for drug diversion, delay in medication administration and worsening of their medical conditions.</p> <p>Findings included:</p> <p>Review of Resident #1's MDS dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility 01/25/24. The resident's diagnoses included malnutrition, bloodstream infection, recurrent enterocolitis due to clostridium difficile (a bacterium that causes an infection of the colon, the longest part of the large intestine), and delusional disorders. Resident #1 had a BIMs score of 9, indicating moderately impaired cognition.</p> <p>Review of Resident #1's current care plan reflected the resident was receiving parenteral/IV therapy, medication Miconazole for Candida Albicans Fungus (a naturally occurring fungus that lives on your body) until 03/24/24 and was previously on isolation for C-diff. Interventions included to maintain rate of infusion as ordered and give medications per order.</p> <p>Review of Resident #1's March 2024 medication's sheet revealed the resident was on miconazole 100mg intravenous solution one time daily for twenty days starting on 03/06/24 for candidiasis.</p> <p>Review of Resident #2's Patient Orders Report for March 2024 revealed he had an order for meropenem 1-gram intravenous solution every 12 hours for 7 days.</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>Review of the facility's provider investigation report dated 03/28/24 revealed the following:</p> <p>Resident's [family] contacted Executive Director with a concern that the resident had received the wrong medication. DON and ADON entered the room and the resident had the wrong IV antibiotic. Resident received Meropenem and should have received Micafungin. Physician was immediately notified and told staff to monitor resident for adverse reactions, no adverse reactions noted. In services completed with nursing staff on the 6 rights to medication.</p> <p>Observation and interview on 05/22/24 at 10:07 AM of Resident #1 revealed she was in bed and stated she was cold. The resident was asked if she was getting IV antibiotics because there was a pole in her room and Resident #1 said she was and had been on several antibiotics for different ailments on and off for the past 6 weeks. Resident #1 did not appear to recall or know she had been given the wrong IV antibiotic in March.</p> <p>Interview on 05/22/24 at 12:14 PM with Resident 1's family revealed they had gone to visit Resident #1 on 03/26/24 and she noticed one of the IV bags hanging on the IV pole had another resident's name, so it appeared the resident had gotten another resident's IV antibiotic. The family reported their concern to the Staffing Coordinator who went to get the DON and ADON. The immediately contacted the resident's doctor who ordered IV fluids to help flush all the medication out of the resident's system and she was monitored for any negative side effects. The family further stated there were no adverse reactions that she was aware of, and Resident #1 had taken that same medication in the past.</p> <p>Interview on 05/22/24 at 2:20 PM with the Staffing Coordinator revealed she was called into Resident #1's room by the family and told her the resident has been given the wrong medicine, so she went to the tell the DON and ADON.</p> <p>Interview on 05/22/24 at 2:42 PM with the ADON revealed she was called into Resident #1's room and the resident's family had showed her and the DON that the wrong IV bag was hanging. The ADON said one of the IV bags had Resident #2's name on it and when she checked Resident #1's medications, she verified it was not the same medication. The ADON said she contacted the physician and checked Resident #1's allergies on her electronic chart. The obtained vitals which were normal, and the resident was monitored to ensure there were no adverse reactions. In-services were conducted with all nurses about ensuring all medication rights were being followed prior to giving medications that included checking the resident's name. Further interview with the ADON revealed the wrong IV antibiotic had been given by LVN A, and the LVN admitted to giving Resident #1 an IV medication , but was adamant it had been the correct one. The ADON stated the LVN denied it had been the wrong one. LVN A received a one-on-one in-service and a disciplinary action for her mistake.</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 05/22/24 at 4:21 PM with the DON revealed she had been called into Resident #1's room because the family had a concern the resident had been given the wrong IV antibiotic. The DON noticed there were two IV bags hanging on the pole and one of the bags had Resident #1's name on it and both bags were not the same medication. They immediately notified the physician and checked to verify the resident's allergies and started the resident on fluids to help push the medication through. All nursing staff were educated to ensure they were following the rights to medications. LVN A was given a one-on-one in-service but the LVN denied giving the wrong medication, but her initials were on the bag and again LVN A denied giving the wrong medication. The resident was monitored and there did not appear to be any adverse effects from getting the wrong IV antibiotic as it was a medication Resident #1 had taken before. The DON further stated risks of receiving the wrong medication included serious allergic reactions to the resident.</p> <p>Attempts to contact LVN A and the Physician on 05/22/24 were unsuccessful.</p> <p>Review of the facility's In-service Training Report dated 03/26/24 provided by the ADON revealed the following:</p> <p>Topic: Medication Administration Protocol</p> <p>Contents or summary of training: 1. Right Person 2. Right Medication 3. Right Dose 4. Right time 5. Right route 6. Right Reason 6. Right Documentation</p> <p>All rights must be confirmed prior to any administration of any medications.</p> <p>Review of LVN A's Employee Coaching and Counseling Record written warning dated 03/27/24 completed by the ADON revealed the following:</p> <p>Company/Supervisor Remarks</p> <p>Violation of code 701 - violation of safety and health rules. Employee must follow the 6 rights of medication per company policy.</p> <p>Action to be Taken</p> <p>Employee must follow state/company policies and procedures. Employee educated.</p> <p>Review of a list provided by the DON on 05/22/24 revealed there was only one resident (Resident #1) currently on IV medications.</p> <p>Observation on 05/22/24 at 2:29 PM revealed LVN B properly prepared and hung the correct IV antibiotic on Resident #1, and there were no concerns with the process.</p> <p>Review of the facility's policy titled Intravenous Therapy updated May 2024 reflected the following:</p> <p>Purpose</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>To provide standards for the safe intermittent administration of drugs or solutions utilizing a saline lock; a saline lock maintains access to a vein by way of cannula with a latex injection port.</p> <p>.Procedure</p> <p>Compare label to physician's order</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 1 (Resident #1) of 4 residents reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN A gave Resident #1 the correct IV antibiotic; she was given Resident #2's antibiotic.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 03/26/24 and ended on 03/27/24. The facility corrected the noncompliance before the survey began.</p> <p>This failure placed residents at risk for harm and/or serious injury.</p> <p>Findings included:</p> <p>Review of Resident #1's MDS dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility 01/25/24. The resident's diagnoses included malnutrition, bloodstream infection, recurrent enterocolitis due to clostridium difficile (a bacterium that causes an infection of the colon, the longest part of the large intestine), and delusional disorders. Resident #1 had a BIMS score of 9, indicating moderately impaired cognition.</p> <p>Review of Resident #1's current care plan reflected the resident was receiving parenteral/IV therapy, medication Miconazole for Candida Albicans Fungus (a naturally occurring fungus that lives on your body) until 03/24/24 and was previously on isolation for C-diff. Interventions included to maintain rate of infusion as ordered and give medications per order.</p> <p>Review of Resident #1's March 2024 medication's sheet revealed the resident was on miconazole 100 mg intravenous solution one time daily for twenty days starting on 03/06/24 for candidiasis.</p> <p>Review of Resident #2's Patient Orders Report for March 2024 revealed he had an order for meropenem 1-gram intravenous solution every 12 hours for 7 days.</p> <p>Review of the facility's provider investigation report dated 03/28/24 revealed the following:</p> <p>Resident's [family] contacted Executive Director with a concern that the resident had received the wrong medication. DON and ADON entered the room and the resident had the wrong IV antibiotic. Resident received Meropenem and should have received Miconazole. Physician was immediately notified and told staff to monitor resident for adverse reactions, no adverse reactions noted. In services completed with nursing staff on the 6 rights to medication.</p> <p>Observation and interview on 05/22/24 at 10:07 AM of Resident #1 revealed she was in bed and stated she was cold. The resident was asked if she was getting IV antibiotics because there was a pole in her room and Resident #1 said she was and had been on several antibiotics for different ailments on and off for the past 6 weeks. Resident #1 did not appear to recall or know she had been given the wrong IV antibiotic in March.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/22/24 at 12:14 PM with Resident #1's family revealed they had gone to visit Resident #1 on 03/26/24 and she noticed one of the IV bags hanging on the IV pole had another resident's name, so it appeared the resident had gotten another resident's IV antibiotic. The family reported their concern to the Staffing Coordinator who went to get the DON and ADON. The immediately contacted the resident's doctor who ordered IV fluids to help flush all the medication out of the resident's system and she was monitored for any negative side effects. The family further stated there were no adverse reactions that she was aware of, and Resident #1 had taken that same medication in the past.</p> <p>Interview on 05/22/24 at 2:20 PM with the Staffing Coordinator revealed she was called into Resident #1's room by the family and told her the resident has been given the wrong medicine, so she went to the tell the DON and ADON.</p> <p>Interview on 05/22/24 at 2:42 PM with the ADON revealed she was called into Resident #1's room and the resident's family had showed her and the DON that the wrong IV bag was hanging. The ADON said one of the IV bags had Resident #2's name on it. When she checked Resident #1's medications, she stated she verified it was not the same medication. The ADON said she contacted the physician and checked Resident #1's allergies on her electronic chart. The resident's vital signs were checked, and they were normal. She stated the resident was monitored to ensure there were no adverse reactions. She stated in-service training was conducted with all nurses about ensuring all medication rights were being followed prior to giving medications that included checking the resident's name. Further interview with the ADON revealed the wrong IV antibiotic had administered to Resident #1 by LVN A. She stated LVN A admitted to giving Resident #1 an IV medication, but LVN A was adamant it had been the correct antibiotic. The ADON stated LVN A denied it had been the wrong antibiotic. She stated LVN A received a one-on-one in-service training and a disciplinary action for her mistake.</p> <p>Interview on 05/22/24 at 4:21 PM with the DON revealed she had been called into Resident #1's room because the family had a concern the resident had been given the wrong IV antibiotic. The DON noticed there were two IV bags hanging on the pole and one of the bags had Resident #1's name on it and both bags were not the same medication. The DON stated they immediately notified the physician, checked to verify the resident's allergies, and started the resident on fluids to help push the medication through. The DON stated all nursing staff were educated to ensure they were following the rights of medication administration. LVN A was given a one-on-one in-service, but the LVN denied giving the wrong medication. The DON stated LVN A's initials were on the bag, but LVN A denied giving the wrong medication. The resident was monitored and there did not appear to be any adverse effects from getting the wrong IV antibiotic as it was a medication Resident #1 had taken before. The DON further stated the risk of receiving the wrong medication included serious allergic reactions.</p> <p>Attempts to contact LVN A and the Physician on 05/22/24 were unsuccessful.</p> <p>Review of the facility's In-service Training Report dated 03/26/24 provided by the ADON revealed the following:</p> <p>Topic: Medication Administration Protocol</p> <p>Contents or summary of training: 1. Right Person 2. Right Medication 3. Right Dose 4. Right time 5. Right route 6. Right Reason 6. Right Documentation</p> <p>All rights must be confirmed prior to any administration of any medications.</p> <p>(continued on next page)</p>		

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