

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER The Healthcare Resort of Plano		STREET ADDRESS, CITY, STATE, ZIP CODE 3325 West Plano Parkway Plano, TX 75075	

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 - Some</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** 45053</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 1 (Resident #12) of 5 residents reviewed for pharmacy services.</p> <p>1. The facility failed to accurately transcribe the pharmacist medication change order for Resident #12's Losartan/HCTZ Tab 100-12.5 on 08/14/2024. The order was transcribed as Losartan/Tab 300 and Hydrochlorothiazide (HCTZ) 12.5 mg.</p> <p>2. LVN A, LVN B, RN C, and LVN D incorrectly documented they administered Losartan 300mg and Hydrochlorothiazide (HCTZ) 12.5 mg when they actually administered the resident's home medication of Irbesar/HCTZ Tab 300-12.5 mg from 09/08/24 to 09/15/24.</p> <p>This failure could place residents at risk of medical complications and a decrease in therapeutic dosages of their medications as ordered by the physician.</p> <p>Findings included:</p> <p>Record review of Resident #12's Face Sheet, dated 10/08/24, revealed that she was an [AGE] year-old female with an initial admitted to the facility of 08/15/24 and readmitted [DATE]. Resident #12's active diagnoses included: primary hypertension (occurs when the force of the blood pushing against the artery walls is consistently too high), hypertensive urgency (a condition where the blood pressure is very high but there are no minimal symptoms, and no signs of organ damage), and stage 3 chronic kidney disease (a moderate level of kidney damage that occurs when the kidneys are less able to filter waste and fluid from the blood).</p> <p>Record review of Resident #12's Quarterly MDS, dated [DATE] reflected she had a BIMS score of 9/15 indicating a moderate cognitive impairment.</p> <p>Record review of Resident #12's Auto Substitution Notice Medication Change Order dated 08/14/24 from [pharmacy company] reflected, Per Automatic Substitution Policy Losartan/HCTZ Tab 100-12.5 1T PO QD was substituted for Irbesar/HCTZ Tab 300-12.5 1T PO QD</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 - Some</p>	<p>1. DISCONTINUE the original order for; Irbesar/HCTZ tab 300-12.5 on the resident's medication administration record (MAR) and in the physician's order.</p> <p>2. REPLACE with the substituted medications order: Losartan HCT Tab 100-12.5 on the MAR. 3. REMOVE any currently available supply of: Irbesar/HCTZ Tab 300-12.5 from the Medication Cart.</p> <p>4. SIGN and PLACE the 'Auto Substitution Notice/Medication Order Change' form in the Physician Order section of the medical record.</p> <p>Record review of Resident #12's September 2024 MAR reflected: Losartan Potassium Oral Tablet (Losartan Potassium) Give 300 mg by mouth one time a day for Hypertension hold for sbp <110 or dbp <60. Start Date 09/08/2024 0600 [6:00 AM], D/C Date 09/15/2024 1648 [4:48 PM]. The MAR further indicated the following:</p> <ul style="list-style-type: none"> - 09/08/24 LVN A administered the medication - 09/09/24 RN C administered the medication - 09/10/24 RN C administered the medication - 09/11/24 LVN B administered the medication - 09/12/24 LVN B administered the medication - 09/13/24 RN C administered the medication - 09/14/24 RN C administered the medication - 09/15/24 LVN D administered the medication <p>Record review of Resident #12's September 2024 MAR reflected: Hydrochlorothiazide Oral Tablet (Hydrochlorothiazide). Give 12.5 mg by mouth one time a day for HTN hold for sbp <110 or dbp <60. Start Date 09/08/2024 0600 [6:00 AM], D/C Date 09/15/2024 1648 [4:48 PM]. The MAR further indicated the following:</p> <ul style="list-style-type: none"> - 09/08/24 LVN A administered the medication - 09/09/24 RN C administered the medication - 09/10/24 RN C administered the medication - 09/11/24 LVN B administered the medication - 09/12/24 LVN B administered the medication - 09/13/24 RN C administered the medication - 09/14/24 RN C administered the medication <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 - Some</p>	<p>- 09/15/24 LVN D administered the medication</p> <p>Record review of Resident #12's Order Summary Report, dated 10/08/24, reflected, Order Date of 09/07/24 with start date of 09/08/24 for Losartan Potassium Oral Tablet (Losartan Potassium) Give 300 mg by mouth one time a day for Hypertension hold for sbp <110 or dbp <60.</p> <p>Record review of Resident #12's Order Summary Report, dated 10/08/24 reflected, Order Date of 08/14/24 with start date of 08/15/24 for Losartan Potassium-HCTZ 100-12.5 MG Tablet Give 1 tablet by mouth one time a day for HTN hold for sbp<110 <60.</p> <p>Record review of Resident #12's Order Summary Report, dated 10/08/24, reflected Order Date of 08/14/24 with start date of 08/15/24 for Irbesartan-hydroCHLOROthiazide Oral Tablet 300-12.5 MG (Irbesartan-Hydrochlorothiazide) Give 1 tablet by mouth one time a day for ANTIHYPERTENSIVES.</p> <p>In an interview on 10/08/2024 at 2:00 pm with RN C revealed that he administered Resident #12's blood pressure medication from the bottle, that her family member provided from home irbesartan/HCTZ 300-12.5mg by mouth daily. RN C stated he understood how to do all medication rights of administration. RNC stated that if a patient has medication from home, we notify the physician or the NP to get approval then transcribe to the MAR. RN C stated that error in transcription could cause medication errors that can harm the patient like a drop in blood pressure.</p> <p>In an interview with the DON on 10/08/2024 at 2:15 pm, revealed that new orders were transcribed as received. If the pharmacy does not have it, the pharmacy will do pharmaceutical interchanger, then the nurse will notify the physician for approval. She stated that patients were allowed to bring their own medication. She was admitted on [DATE] with orders for Irbesartan/HCTZ 300mg-12.5mg, it was discontinued on 8/15, and there was a therapeutic interchange to losartan/HCTZ 300-12.5mg potassium. The DON stated that all nurses should be following what is on the MAR when administering medication and doing all medication rights of administration. The DON stated, from what I know the nurse gave from our supply not home medication because we should not have that medication in the building.</p> <p>In a telephone interview on 10/08/2024 at 2:30pm with LVN B, revealed that Resident #12's family member was opposing all the medication for Resident #12's blood pressure. LVN B stated, I educated him on the risks of stopping BP medication, {the family did not want her to take metoprolol. I notified the NP about the medication she was taking at home (Irbesartan 300-12.5). LVN B stated that the NP approved the medication for Resident #12. She stated that Resident #12's medication was ordered from the pharmacy, and the staff started giving the medication from the pharmacy. She stated that the pharmacy did not have the combination, so the pharmacy brought losartan and HCTZ. LVN B stated that she came back from her scheduled off day and noticed that there were two separate medications from the pharmacy. LVN B stated that she spoke with the NP who explained to her that sometimes the medication can be dispensed separately if the pharmacy does not have the combination. The NP did not want to d/c metoprolol because Resident #12's blood pressure remained high.</p> <p>In a telephone interview with the Pharmacist on 10/09/24 at 11:20 AM, she confirmed, on 08/14 there was a therapeutic interchanged from Irbesartan 300-12.5mg to Losartan 100-12.5mg. She stated that the first time Losartan 100-12.5mg was filled was 8/15/24. She stated that the last refill for Losartan 100-12.5mg was 09/09/24.</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 - Some</p>	<p>In a telephone interview with the Pharmacy Consultant on 10/09/24 at 11:53 AM, she stated that all admission orders were sent to the pharmacy that dispensed the medication and were reviewed by their pharmacist, then she would review new admission orders and then monthly. She stated that the original order was entered on 08/14/24 for Irbesartan 300-12.5mg, d/c 8/15/24. She stated that Losartan 100mg and HCTZ was ordered for Resident #12. She stated that she would usually review the MAR and the hospital record doing medication reconciliation on admission. She reported that she was not sure if there was a policy to check new orders daily. She stated that, In this case, the dispensing pharmacy would be the one to review it first.</p> <p>In an interview on 10/09/2024 at 12:20 pm with LVN B, revealed that when Resident #12 was admitted she was on Metoprolol and another blood pressure medication [unknown]. She stated Resident #12's family member did not want the facility to administer the medication because Resident #12 had home medication that controlled her blood pressure. LVN B stated that she notified the NP at the time the family could not remember the name of the medication, so the facility staff requested for him to bring the medication. The family member brought the medication to the facility for Resident #12. The medication was Irbesartan 300-12.5mg. The NP was notified and approved for the facility to give Resident #12 the medication from home that was brought to the facility by the family member until the facility pharmacy delivered Resident #12's medication. LVN B stated that she transcribed the order for Resident #12 and sent it to the pharmacy to be refilled. LVN B stated that when she returned to work after her off day, she noticed there was an order for Losartan and a separate order for HCTZ. LVN B stated she spoke with the NP who clarified that the losartan and irbesartan were in the same group of medications and stated that sometimes losartan/HCTZ can be dispensed as two separate pills. The family member did not want the facility to administer the Losartan, so we continued administering the Irbesartan300-12.5mg from the patient's home supply. LVN B stated she never touched the medication from the pharmacy. She only administered the home medication because the family member would come to the medication cart, watch her pop the resident medication, then go in the room with her, and watch her administer the medication. LVN B stated she has never seen the auto substitution notice for therapeutic interchange from the pharmacy. Today was the first time she saw it. LVN B stated that she understood the right of medication administration to include checking right patient, right medication, right dose, and route before administering medication. LVN B stated that the risk to patient when there was an error in transcription included patient receiving the wrong medication, which could lead to dizziness, hypotension, and death.</p> <p>In an interview on 10/09/24 at 1:46pm with the DON revealed that Resident#12 was admitted [DATE], then she came with orders for Irbesartan/HCTZ 300-12.5mg which was interchanged for losartan by the pharmacy. On 8/16 the resident was transferred back to the hospital due to vomiting dark brown emesis. She returned to the facility on [DATE] with orders from the hospital for metoprolol succ 50mg. The FM did not want her to take the metoprolol, he wanted Irebsartan300-12.5mg. The FM brought the bottle to the NP, the NP reviewed it and said it was okay to give home medication (Irbersartan 300-12.5mg). She stated that from their investigation the medication for Resident #12 was transcribed wrong and LVN B read and transcribed the medication as Losartan. She stated that the Losartan that was sent from pharmacy was not given to Resident #12 and was removed from the medication cart and returned to pharmacy on 09/11/2024. She reported that the initial medication was ordered and was sent from was not given and stated that she had the entire dosage in her office.</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 - Some</p>	<p>In an interview on 10/09/2024 at 2:15pm with the ADON revealed that Resident#12 admitted from home with Irbesartan 300-12.5 mg. The ADON stated the pharmacy did not have the dosage for the Irbesartan, so the pharmacy completed a therapeutic interchange for losartan/HCTZ. The ADON stated Resident #12's family member brought her Irbesartan to the facility for administration, which was what the facility was administering to Resident #12. The ADON stated he was responsible for verifying new admission orders. The ADON stated that if the pharmacy changed a resident's order, then he was notified through the EMR system. The ADON stated that if the nurses enter or change an order, the EMR system did not notify him so he could not verify if the order was accurately transcribed. The ADON stated it was important that orders were accurately transcribed because it put the resident at risk of either not receiving enough medication or receiving too much of the medication, resulting in the therapeutic level being affected.</p> <p>In an Interview on 10/09/24 at 2:36 PM, the DON stated that if residents want to use medication that the facility does not have, they can bring their home supply of medications. She stated that the nurses will then notify the MD or the NP and get approval for the medication and order the medication from the pharmacy. The DON stated that the dispensing pharmacy reviews admission orders, consultant pharmacist reviews admission orders, and reviews orders monthly. She reported that the ADON reviewed the MAR daily for any new orders entered in between the pharmacy reviews. The DON stated that the nurses were expected to do all the rights of medication administration before administering medication to residents. She stated, when there is a therapeutic interchange, she would receive a notification on PCC (a cloud-based healthcare software platform that helps healthcare providers improve patient care, streamline operations, and enhance financial performance) and see is the interchange notification on the MAR then she will approve it. She reported that the ADON usually reviewed the written orders. She stated, the risk to the patient when there is wrong transcription of the medication can cause an adverse event would be the worst event, I cannot explain but bad.</p> <p>In an interview on 10/09/24 at 3:10pm with Administrator revealed that Resident#12 was admitted to the facility with Irbesartan, then she was sent to the ER at the hospital and readmitted to the facility without the Irbesartan. She stated that Resident #12's family member said he wanted Resident #12 to get back on the home medications with was irbesartan. The nurse called the NP, who reviewed the medication and approved it, so we put the order in. The pharmacy thought it wasn't the correct dose. So, they sent us a three-day dose. The Pharmacy called the NP and clarified the order, corrected it on their end, but the pharmacy did not inform the facility. The Administrator stated they had communication problems with the pharmacy that was why they discontinued services with that pharmacy and contracted a new pharmacy. The order that was delivered was losartan 100m-12.5mg and it was returned. The facility staff administered irbersartan300-12.5 mg from the family supply. The nurse transcribed new orders to the MAR, all daily orders were reviewed by the ADON, the DON, and treatment team daily.</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 - Some</p>	<p>In an interview on 10/09/2024 at 3:36pm with the NP revealed that Resident #12 was admitted to the facility with Clonidine and Metoprolol. She stated that Resident #12's family member mentioned to her that he did not want Resident #12 on both medications, stating that her blood pressure was controlled when she was on her home medication. The NP stated that one day LVN B told her that Resident #12's blood pressure was high, and she ordered the Irbesartan/HCTZ 300-12.5mg. The resident was taking at home medication and the pharmacy did a Therapeutic Interchange to Losartan 100-12.5mg, but the family member did not agree to the interchange. She stated that Resident #12 was over [AGE] years old, therefore she did not want to change her medication if it has been controlling her BP. The NP stated that she spoke with the family member and told him to bring the medication that Resident #12 was taking at home. The NP talked to LVB B and asked her to give Resident #12 the medication from home that the family member brought to the facility, which was Irbesartan/HCTZ300-12.5mg. The NP stated that she did review the MAR when she was at the facility, usually once a week or twice a week, and if an error was found, she would talk to the nursing staff to correct the error. She stated that when she gave orders, she wrote the orders on the physician's order sheet. She stated, the nurses do vital signs every day, it is explanatory that she was not getting losartan 300mg per the MAR because her blood pressure remained high. She stated that she thought that LVN B did not look at the bottle and just gave the medication to Resident #12. She reported that usually if there was a discrepancy between prescription on the medication card and the MAR, the nurse would usually call the NP to clarify the order. However, she did not recall anyone calling her to inform her that the MAR did not match the prescription on the medication bottle. The NP stated that harm can be caused to a resident if there is an error in medication transcription. She stated that if the medication is transcribed incorrectly, the resident can receive the wrong medication. She also stated that harm can be caused to the resident if the dosage of incorrect medication is administered to the resident, which can cause the residents blood pressure drop.</p> <p>On 10/09/2024 attempts were made to contact LVN A and LVN D, but attempts were unsuccessful.</p> <p>Record review of the facility's revised policy dated 05/2007 titled; Pharmacy Services - Physician Orders, reflected the following:</p> <p>Policy Statement: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments.</p> <p>Record review of the facility's policy dated, 07/2017 titled; Wellness Services - Administration of Medications, reflected the following:</p> <p>Policy: It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant.</p> <p>Procedure:</p> <p>12. Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule don the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.</p>		