STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676407	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pure Health Transitional Care at Thr Arlington	800 W. Randol Mill Road, 6th Floor Arlington, TX 76012

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 Based on observation, interview, and record review, the facility failed to ensure the accurate administration of medications for 1 of 1 resident observed for medication administration. (Resident # 34) RN A administered an incorrect dose of Acetaminophen to Resident #34. This failure could place the 11 residents who received medications administered by RN A at risk of not receiving the intended therapeutic benefit of their medications. Findings included: Review of Resident #34's face sheet reflected a [AGE] years old female admitted to the facility on [DATE] with the diagnoses of: displaced tri malleolar fracture of left lower leg, subsequent encounter for closed fracture with routine healing (happens when there is a break in the lower leg sections that form the ankle joint that help move the foot and ankle); depression, unspecified (a person is experiencing significant distress or impairment); and anxiety disorder, unspecified (a person's phobias that are significant enough to be distressing and disruptive. Review of Resident #34's Minimum Data Set (MDS) resident assessment, dated 03/04/2024, reflected Resident #34's Brief Interview for Mental Status score (BIMS Score) of 15/15. Resident #34's decisions are reasonable and consistent. Resident #34's Care Plan dated 03/01/2024 reflected: Resident #34 is to be administered analgesia (Acetaminophen) as per orders and Anticipate Resident #34's need for pain relief and respond immediately to any complaint of pain. Clinical Physician Orders dated 03/21/2024 for Resident #34 reflected: Acetaminophen Tablet 325 mg - Give 2 tablet by mouth every 4 hours as needed for fever - Start Date - 03/03/2024. Acetaminophen Tablet 325 mg - Give 2 tablet by mouth every 4 hours as needed for pain. The MAR (Medication Administration Record) reflected that RN A initialed that she administered Acetaminophen at 8:08 AM and 13:13 (1:13 PM),17:17 (5:17 PM) on Wednesday 03/20/2024. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/21/2024, Resident #34 reported to the state surveyor that the nurse who worked evening shift the day before gave her the wrong dose of Acetaminophen. Resident # 34 saved one of the tablets in a Kleenex to show the state surveyor. State surveyor observed round tablet labeled AZ 011. Resident #34 revealed that she looked up the number of the pill on google. The pill was Acetaminophen 500 mg (milligrams). Resident # 34 revealed that she takes Acetaminophen 325 mg (milligrams). Reviewed the Progress Notes for Resident #34 dated 03/22/2024, documentation revealed RN A was the last nurse to give Resident #34 Acetaminophen at 8:08 AM, 9:38 AM, 13:13 (1:13 PM), and 17:17 (5:17 PM). Documentation revealed that LPN B did not give Resident # 34 any Acetaminophen on the following shift. During an interview on 03/22/2024 at 3:00 PM., RN A revealed that she had worked the 6:00 AM to 2:00 PM shift on 03/20/2024 and did not administer the wrong dose of Acetaminophen to Resident #34. She gave 2 caps of 325 mg to Resident #34. RN A revealed that LPN B was on duty. During an interview with the DON on 03/22/2024 at 3:30 PM, revealed that she had spoken to Resident #34's brother concerning medication error. Revealed to DON that RN A stated that she was not working after 2:00 PM on 03/20/2024. Documentation showed that she was working and was the nurse who administered the last dose of Acetaminophen to Resident #34 at 17:17 (5:17 PM). The DON revealed that the Acetaminophen 325 mg (milligrams) and Acetaminophen 500 mg (milligrams) were in the medication cart beside each other. Numbers on 500 mg (milligrams) were AZ 011. The bottles have been separated. A roster dated 03/19/2024 indicated 11 residents resided on Hall East 2 where RN A administered medications. Reviewed facility's policy on Adverse Consequences and Medication Errors. Revised April 2014. Policy Statement: The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the Attending Physician and Pharmacist, and to federal agencies as appropriate. 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. c. Wrong dose Record review completed on Resident (#34's) file on Thursday, 03/21/2024. Findings showed that resident's Clinical Physician Orders dated 03/21/2024 for Resident #34 reflected: Acetaminophen Tablet 325 mg - Give 2 tablet by mouth every 4 hours as needed for fever - Start Date - 03/03/2024. Acetaminophen Tablet 325 mg - give 2 tablets by mouth every 4 hours as needed for pain. Further findings showed that RN A was working after 2:00 PM when the last Acetaminophen Tablet was given to resident at 17:17 (5:17PM) on 03/20/2024.