

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Advanced Rehabilitation & Healthcare of Burleson		STREET ADDRESS, CITY, STATE, ZIP CODE 275 SE John Jones Drive Burleson, TX 76028	

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 - Immediate jeopardy to resident health or safety</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** 44700</p> <p>Based on interview and record review the facility failed to provide pharmaceutical services to include the acquiring and administering of medications to meet the needs of each resident for 1 of 6 residents (Resident #1) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #1 received his prescribed anti-convulsant medications (medications to prevent seizures) for eight days (16 doses) from 5/17/2024 until 5/25/2024. Resident #1 had a seizure on 5/25/2024 and was sent to the ED for emergent care, returned to the facility on [DATE] and had another seizure on 5/27/2024 and was sent back to the ED.</p> <p>The noncompliance was identified as PNC. The IJ began on 5/28/2024 and ended on 5/29/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could affect all residents who received medication and result in residents not receiving a therapeutic dose of prescribed medications.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 5/31/2024 reflected a [AGE] year-old male resident admitted on [DATE] with diagnoses that included: Cerebral Palsy (congenital disorder of movement, muscle tone or posture), Epilepsy (seizure disorder), Spastic Hemiplegia (type of Cerebral Palsy that affects one side of the body), Hypertensive Heart Disease (heart problems due to high blood pressure) and Intermittent Explosive Disorder (mental health condition that causes sudden, impulsive and aggressive outbursts).</p> <p>Review of Resident #1's MDS discharge assessment dated [DATE] reflected a BIMS score of 01 suggesting severe cognitive impairment. Review of Section I - Active Diagnosis reflected the following diagnosis: Cerebral Palsy, Epilepsy, Spastic Hemiplegia, Hypertensive Heart Disease, and Intermittent Explosive Disorder.</p> <p>Review of Resident #1's care plan dated 5/31/2024 reflected no focus areas, goals or interventions related to his seizure diagnosis or history.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's physician orders dated 5/31/2024 reflected a medication order: Lacosamide Oral Tablet 200 MG Give 2 tablet by mouth two times a day for seizure with a start date of 5/17/2024 and medication order: Phenobarbital Oral Tablet 64.8 MG Give 1 tablet by mouth two times a day for seizure with a start date of 5/17/2024.</p> <p>Review of Resident #1's MAR for May 2024 dated 5/31/2024 reflected a line item for anti- seizure medication Lacosamide Oral Tablet 200 MG with a code of 3 under 5/17/2024 and a code of 9 from 5/18/2024 to 5/25/2024 for the 8:00 am and 8 pm doses. Review of the May 2024 MAR chart codes for Resident #1 indicates 3 = Away from home and 9 = medication unavailable.</p> <p>Review of Resident #1's MAR for May 2024 dated 5/31/2024 reflected a line item for anti-seizure medication Phenobarbital Oral Tablet 64.8 MG with a code of 3 under 5/17/2024 and a code of 9 from 5/18/2024 to 5/25/2024 for the 8:00 am and 8 pm doses.</p> <p>Review of the May 2024 (5/1/2024-5/31/2024) MAR chart codes for Resident #1 indicates 3 = Away from home and 9 = medication unavailable.</p> <p>Review of the progress notes dated 5/25/2024 at 4:05 pm by LVN C reflected Resident #1 had a change in condition and Resident observed in bed with seizure activity of muscular convulsions and decreased level of consciousness greater than 5 minutes .the physician was notified on 5/25/2024 at 4:10 pm and the physician recommends emergency transport to the hospital.</p> <p>Review of the progress notes dated 5/27/2024 at 5:52 pm by LVN B reflected Resident #1 had a change in condition: seizure and the MD was notified at 5:10 pm on 5/27/2024 and the physician recommends the following: emergency transport to the hospital</p> <p>Review of the hospital records for Resident #1 dated 5/26/2024 at 5:25 pm reflected a date of service of 5/25/2024 at 10:12 pm with a Chief Complaint: Seizures (Multiple seizures)</p> <p>Review of the hospital lab records for Resident #1 with a collection time dated 5/25/2024 at 5:47 pm reflected a Phenobarbital level of 6.0 (L), where L means low.</p> <p>Review of the hospital lab records for Resident #1 with a collection time dated 5/27/2024 at 6:20 pm reflected a Phenobarbital level of 8.0 (L), where L means low.</p> <p>Review of the hospital lab records for Resident #1 with a collection time dated 5/30/2024 at 4:08 am reflected a Phenobarbital level of 14.8 with no letter designation, indicating result was within range and not high (H) or low (L).</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/30/2024 at 1:40 pm with the DON , she stated Resident #1 had been admitted on [DATE] from the hospital and had orders for four different anti-convulsant (anti-seizure) medications. She stated she did not realize Resident #1 did not have two of his anti-seizure medications until 5/28/2024, after Resident #1 went to the hospital for the second time. She stated the medication orders had been put in and sent to the pharmacy, but they were controlled substances, so the pharmacy sent an electronic message back through the EMR stating they needed a triplicate prescription order (a special type of prescription order for controlled substances/medications). The facility never saw this electronic message because the pharmacy previously would either call or fax the facility to let them know there was a problem filling a medication order. She stated the facility learned on 5/29/2024 how to run this report in the EMR every day so they can keep track of any pharmacy messages related to problems filling medication orders. She stated nursing staff had been coding the medications in the EMR as unavailable since 5/17/2024. She stated if a medication was not available nursing staff were supposed to check the e-kit, call the pharmacy, and notify the Doctor. She stated the admitting nurse did check the e-kit, but the two missing medications were not in the e-kit. The nurse did not call the pharmacy or the doctor. She stated the ADON was working on 5/17/2024 when Resident #1 was admitted . She stated the ADON was working the medication aide cart that evening for coverage. She stated the ADON was part of the nursing leadership team and was an agent of the facility Doctor. As an agent, the ADON had the authority to call the pharmacy and order controlled substances on behalf of the Doctor. The DON stated even though the ADON was working the medication aide cart passing medication, she should have called the pharmacy and ordered Resident #1's missing medications. The DON stated when she discussed the missing medications with the ADON, the ADON admitted to being an agent of the doctor, but stated she was working as a medication aide that shift and no one had asked her to call it in. The DON stated the ADON was familiar with the two missing medications, she knew they were controlled substances and required a triplicate, and she was an agent of the doctor so her expectation was that the ADON should have called the pharmacy and taken care of the missing medications when the ADON found out they were not available. She stated no nursing staff called the pharmacy until 5/20/2024; at that time LVN A called the pharmacy and was informed the medications for Resident #1 would be sent that afternoon, 5/20/2024. The medications did not show up on 5/20/24 and staff continued to mark it as unavailable with nursing staff failing to call the pharmacy, notify the doctor or the DON.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/31/2024 at 12:04 pm, the ADON stated she worked on 5/17/2024 as a MA. The ADON stated when she went to give Resident #1 his medication the Lacosamide and Phenobarbital were not in the cart. She stated she notified the charge nurse they were not in the cart and documented in the MAR that the medications were not available. She stated after that she finished the medication pass and then went home. She stated she had received training on following physician orders and if a med was unavailable the nurse is supposed to check the e-kit, call the pharmacy, and notify the doctor; but the MA was supposed to notify the charge nurse and that's what she did. She stated she was aware that the medications that were unavailable were used to prevent seizures and require a triplicate prescription. She stated she was an agent of the Doctor and was authorized to call in triplicate prescriptions and I could have sent it [prescription] over if she [LVN B] had asked me. She stated even though she was an LVN, she was working as a MA and all she was supposed to do was pass meds. The ADON stated it was not her responsibility to follow up on the missing medications because she was working as a MA - not the charge nurse - the charge nurse would have been the one to follow up on the medications. The ADON stated she had also worked on 5/18/2024 and 5/19/2024 as a charge nurse but was not aware the medications had still not come in, because the MA had not said anything to her about the medications being unavailable. The ADON stated she knew the medications were being used to prevent seizures and if Resident #1 had not gotten his medications it could have caused his levels [of medication in the blood] to drop but did not believe that missing one dose would cause an adverse reaction or caused a seizure. The ADON stated she was in serviced on 5/29/2024 on what to do if a medication was not available: check the e-kit, call the pharmacy, notify the doctor and DON, and complete all documentation in the EMR. She stated she was also in serviced one on one as to the role of the ADON and expectations of her role.</p> <p>During an interview on 5/31/2024 at 12:28 pm, the Regional Compliance Nurse (RCN) stated when the facility discovered the issue with the medications being unavailable, they made sure the medications were ordered and received on 5/29/2024 for Resident #1. She stated they also had those medications added to the facility e-kit on 5/29/2024. She said the facility started educating staff immediately on 5/28/2024 on medication ordered and receiving, what to do if a medication has not arrived, who to call - Pharmacy, DON, Doctor, RP and the documentation needed for the MAR and progress notes. She stated the DON was now monitoring the electronic transmission report from the pharmacy daily and the facility added additional agents of the doctor on each hall to ensure triplicate prescriptions can be handled by multiple nursing staff.</p> <p>During an interview on 5/31/2024 at 1:30 pm, with the AD and DON, the DON stated when Resident #1 went to the hospital for the second time on 5/27/2024, she had been reviewing his hospital notes and she saw something in the notes about his medications not being available. She then reviewed Resident #1's Orders and MAR and that was when she found out that two of his medications to prevent seizures had never been received. She stated she immediately brought it to the attention of the AD. The AD stated as soon as the DON made him aware there was an issue, he completed a self-report on 5/28/2024 to the state agency and they held an ad hoc QAPI meeting with the medical director to discuss the root cause of the incident and developed a timeline and performance improvement plan to include a complete audit of all medication availability and ongoing monitoring. The DON also stated that LVN C was not available for interview as she was out of the country, and they were unable to contact her.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/31/2024 at 1:48 pm, LVN A stated he was working on 5/20/2024 through 5/24/2024, 6 am to 2 pm. He stated on 5/20/2024 the MA had come to him and notified him that Resident #1 had two missing medications. He stated he called the pharmacy to check on the medications and the pharmacy told him they would be there that afternoon. He stated at the end of his shift he completed shift hand off report to LVN B and verbally passed on that the medications would be coming in that afternoon. He stated he did not complete any document regarding his call with the pharmacy and the status of the missing medications for Resident #1. He stated the remaining days that he worked, none of the MA came and told him the medications were not available and nothing was shared in shift report from the other nurses, so he assumed the medications had come in for Resident #1. LVN A stated he had received training on following doctors orders and if you cannot follow an order to give medications they were supposed to document that you don't have it, call the pharmacy to find out where it was and then call the doctor to see if there were any new orders and if so they were supposed to put the orders in. He stated he did call pharmacy, but he did not complete any documentation and did not call the doctor on 5/20/2024 to tell her the medications were not there. LVN A stated, I should have done that [call the doctor] and I guess I forgot to do it - there is no justification for that. He stated he had received training on the medication administration procedure and the nurse was responsible; if the medication was unavailable the MA should notify the nurse and the nurse was responsible for taking action. He stated he was aware the missing medications for Resident #1 were controlled substances and used to prevent seizures. He stated Resident #1 by missing his medications the resident could surely have a seizure and that is not desirable - we don't want them to have a seizure. LVN A stated he did not find out Resident #1's medications never being received until after her had a seizure and went to the ED. LVN A stated he was in serviced on 5/29/2024 on what to do if a medication was not available: check the e-kit, call the pharmacy, notify the doctor and DON, and complete all documentation in the EMR.</p> <p>During an interview on 5/31/2024 at 2:50 pm, the Regional Compliance Nurse stated the facility found out about the electronic transmission report from the pharmacy on 5/29/2024. She stated the facility ran the report and discovered the two medications for Resident #1 were on the report as of 5/17/2024 with the error code stating the orders could not be filled without a script.</p> <p>During an interview on 5/31/2024 at 4:14 pm, LVN B stated she was the charge nurse on 5/17/2024 and completed Resident #1's admission. She stated she worked the 2pm - 10pm shift on 5/17/2024 and put in all of Resident #1's medication orders. She stated she checked the e-kit for all of the medications due that evening but two of the anti-seizure medications were not available. She stated she figured they would come in later that evening on the midnight run for the pharmacy. She stated she did not document that the medications were unavailable, did not call the pharmacy and did not notify the doctor. She stated she did not know the medications for Resident #1 were not available until he had a seizure on 5/27/2024 and went out to the ED. LVN B stated if she was not able to follow a physicians' order for medication she was supposed to check the e-kit, call the pharmacy, and notify the doctor. LVN B stated she was in serviced on 5/29/2024 on what to do if a medication was not available: check the e-kit, call the pharmacy, notify the doctor and DON, and complete all documentation in the EMR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/31/2024 at 4:48 pm, the Medical Director stated no one from the facility had contacted her and informed her that Resident #1's medication were not available . On 5/28/2024 the DON notified her that Resident #1 had a seizure due to no medications. She stated she was informed there was a communication issue back from the pharmacy that there was no script available, but the facility had not received that communication. The MD stated she had participated in the ad hoc QAPI meeting by phone on 5/29/2024 and they determined the root case was the admitting nurse was not aware these medications had to be called in and cannot wait to see if they show up - they had to be in the building and staff not communicating to pharmacy, DON and doctor when medications were not available. The MD stated her expectation for missing medications were that staff would inform the DON or ADON and then contact the MD to see if they have new orders or if there was something she could do - but not wait a day or two for the medications. She stated Resident #1 not getting his medication could lead to seizures and possibly having further complications from the seizures. She further stated, this is a major mistake and delay on everybody's part that took care of this patient - I wouldn't have known it was not available unless someone called me. She further stated another concern was the pharmacy just sat on it [the medication orders] when there had been minor mistakes in the past on scripts and they did not call her [MD] or the DON.</p> <p>Record Review of the Pharmacy Electronic Transmission Report dated 5/29/2024 at 2:07 pm, revealed the two unavailable medications for Resident #1 (Lacosamide and Phenobarbital) were listed as of 5/17/2024 at 5:16 pm with the Error Details: unsigned new order for Narcotics.</p> <p>Record Review of an in-service indicated staff were in-serviced on 5/29/2024 about Admission, Ordering/Receiving Meds, if a med did not arrive notify your charge nurse and the DON, ADON. Document attached for your review and was signed by 27 nurses and 4 medication aides.</p> <p>Review of Ad-Hoc PIP/Off cycle review QAPI meeting revealed the meeting was attended by AD, DON, RNC and MD and included root cause analysis, Performance Improvement Project (PIP), and detailed Plan of Correction (POC).</p> <p>Record review of the facility's Policy for Medication Administration dated 10/1/19 indicated:</p> <p>1.K. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the night box/emergency kit.</p> <p>2.F. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response.</p> <p>Record review of the facility's policy Medication - Treatment Administration and Documentation Guidelines dated 4/6/2023 indicated:</p> <p>7. Medications or treatments that were not administered should be documented as not administered on the EMAR/ ETAR with the reason for the not administration.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>9. Check the E Box list for medication not available. If medication is not available verify availability with pharmacy.</p> <p>10 Notify the physician when medication or treatment will be available, provide information regarding medications in E-Box and document physician response and/or physician .</p>