STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455732	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkwood Manor	2590 Loop 337 N New Braunfels, TX 78130

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** 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 3 residents (Resident #1) reviewed for pharmacy services. LVN A administered Resident #1's insulin from a flex pen (Aspart) for diabetes at lunchtime to Resident #1, when it was not labeled with the resident's name. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: Record review of Resident #1's face sheet, dated 06/03/2025, revealed she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: cerebral palsy (a group of neurological disorders that affect movement, balance and posture), type 2 diabetes mellitus (the most common form of diabetes characterized by the body's inability to properly use insulin, leading to high sugar levels), mild intellectual disabilities (deficits in intellectual functions pertaining to abstract/theoretical thinking), anxiety (a feeling of worry, unease, or nervousness, often accompanied by physical symptoms like a racing heart or rapid breathing and need for assistance with personal care. Record review of Resident #1's Annual MDS assessment, dated 05/04/2025, revealed the resident rarely or never understood others and could rarely or never understand. She was not a candidate for a BIMS which indicated she was severely cognitively impaired. She was dependent on staff for her ADLs, and she received insulin injections daily. Record review of Resident #1's physician's order, dated 12/27/2024, revealed the resident had the order of Fiasp (brand name) Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart (with Niacinamide, a form of Vitamin B3) Inject as per sliding scale: if 150 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10, subcutaneously with meals for DM If greater than 401notify MD Phone Active 03/25/2025. (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	Record review of Resident #1's MAR, dated from 06/01/2025 to 06/30/2025, revealed Resident #1 was receiving Fiasp Pen Fill subcutaneous Solution Pen Injector 100 unit/ml (insulin Aspart) inject as per sliding scale. Observation on 06/03/2025 at 12:15 p.m., revealed LVN A proceeded to administer Resident #1 her insulin. The insulin pen was lying on a medication tray, had an open date of 05/20/25 and an expiration date. The insulin pen which was Aspart, 100 UNITS/ML did not have Resident #1's name. In an interview on 06/03/2025 at 12:17 p.m., with LVN A she stated she usually labels the pens with the resident's names and did not know why the insulin pen was not labeled. Observation on 06/03/2025 at 12:19 p.m., revealed LVN A writing with a marker, Resident #1's name on the Aspart insulin pen. In an interview on 06/03/2025 at 12:20 p.m., LVN A, stated she knew the Aspart insulin pen belonged to Resident #1 because she was the only resident on the 400 Hall with that type of insulin. Observation on 06/03/2025 at 12:24 p.m., LVN A, proceeded to administer Resident #1 4 units of the Aspart insulin as ordered for her blood sugar sliding scale. In an Interview on 06/03/2025 at 12:46 p.m., the DON, stated insulin pens needed to be labeled. He said he was not aware Resident #1's pen was not labeled. He stated Resident #1's family brought in her insulin and the pen should not be placed on the medication cart without her name. He stated he was accountable for the nursing care at the facility and nurses were trained on the 6 rights of medication administration. He stated it was not acceptable to administer insulin to Resident #1 without a name on the insulin pen or assume an unlabeled pen belonged to a specific resident. He stated the consequences could be cross contamination of a blood borne pathogen. He stated the unlabeled insulin pen needed to be discarded when LVN A found it on the cart. Interview on 06/04/2025 at 12:50 p.m., LVN A, stated she knew not to give residents medications that was unlabeled. She stated she was trained not to do that, and did not think about it at the time, but the consequences could be cross contamination. Interview on 06/04/2025 at 1:36 p.m., the ADON, stated when insulin pens arrived at the facility they were logged in and accounted for, however, he had not encountered an unlabeled one. He stated Resident #1's family brought the insulin in and must have missed labeling one of the pens. He stated he did not know how it was found on a cart without a label. He stated he trained LVN A and provided a skills checklist which she completed. Record review of LVN A's medication administration skills checklist dated 12/12/2024 reflected Pre-Administration, gather medication for one resident at a time while adhering to the six rights of medication administration (drug, dose, route, time, resident and documentation), select correct drug and compare name on medication label with the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure titled Section: Medication Administration, Subject: Administration of Medication dated revised 07/2013 and reviewed 06/2022 reflected The seven rights of medication administration are as follows to ensure safety and accuracy of administration, 1. Right Resident, 2. Right Time, 3. Right Medication, 4. Right Dose, 5. Right Route, 6. Right Documentation and 7. Right Diagnosis.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were labeled for 1 of 3 residents (Resident #1) reviewed for medication labeling. 2. An insulin flex pen (Aspart) for diabetes had no resident's name labeled and was found on the 400-hall medication cart on 06/03/2024 and assumed by LVN A to belong to Resident #1. This failure could place residents at risk of use of the medication for more than one resident which could result in contamination of a blood borne pathogen. The findings included: Record review of Resident #1's face sheet, dated 06/03/2025, revealed she was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: cerebral palsy (a group of neurological disorders that affect movement, balance and posture), type 2 diabetes mellitus (the most common form of diabetes characterized by the body's inability to properly use insulin, leading to high sugar levels), mild intellectual disabilities (deficits in intellectual functions pertaining to abstract/theoretical thinking), anxiety (a feeling of worry, unease, or nervousness, often accompanied by physical symptoms like a racing heart or rapid breathing and need for assistance with personal care. Record review of Resident #1's Annual MDS assessment, dated 05/04/2025, revealed the resident rarely or never understood others and could rarely or never understand. She was not a candidate for a BIMS which indicated she was severely cognitively impaired. She was dependent on staff for her ADLs, and she received insulin injections daily. Record review of Resident #1's physician's order, dated 12/27/2024, revealed the resident had the order of Fiasp (brand name) Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart (with Niacinamide, a form of Vitamin B3) Inject as per sliding scale: if 150 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10, subcutaneously with meals for DM If greater than 401notify MD Phone Active 03/25/2025. Record review of Resident #1's MAR, dated from 06/01/2025 to 06/30/2025, revealed Resident #1 was receiving Fiasp Pen Fill subcutaneous Solution Pen Injector 100 unit/ml (insulin Aspart) inject as per sliding scale. Observation on 06/03/2025 at 12:15 p.m. revealed LVN A proceeded to administer Resident #1 her PRN insulin. The insulin pen was lying on a medication tray, had an open date of 05/20/25 and an expiration date. The insulin pen which was Aspart, 100 UNITS/ML did not have Resident #1's name. In an interview on 06/03/2025 at 12:17 p.m., LVN A, stated she usually labels the pens with the resident's names and did not know why the insulin pen was not labeled. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/03/2025 at 12:19 p.m. revealed LVN A writing with a marker, Resident #1's name on the Aspart insulin pen. In an interview on 06/03/2025 at 12:20 p.m., LVN A, stated she knew the Aspart insulin pen belonged to Resident #1 because she was the only resident on the 400 Hall with that type of insulin. Observation on 06/03/2025 at 12:24 p.m. of LVN A, she proceeded to administer Resident #1 4 units of the Aspart insulin as ordered for her blood sugar sliding scale. In an Interview on 06/03/2025 at 12:46 p.m., the DON, stated insulin pens needed to be labeled. He said he was not aware Resident #1's pens were not labeled. He stated Resident #1's family brought in her insulin and the pen should not be placed on the medication cart without her name. He stated the consequences could be cross contamination of a blood borne pathogen. He stated the unlabeled insulin pen needed to be discarded when LVN A found it on the cart. Interview on 06/04/2025 at 12:50 p.m., LVN A, stated Resident #1's insulin pens was provided by the family and the family member would label them. She did not know how the pen was on the medication cart without a resident label. Interview on 06/04/2025 at 1:36 p.m. with the ADON, he stated when insulin pens arrived at the facility they were logged in and accounted for, however, he had not encountered an unlabeled one. He stated Resident #1's family brought the insulin in and must have missed labeling one of the pens. He stated he did not know how it was found on a cart without a label. He stated it would be difficult to identify whose medication it was without a label and would not be safe. Interview on 06/04/2025 at 2:08 p.m. with RN B, she stated an unlabeled insulin pen in the medication cart needed to be discarded. Record review of the facility policy and procedure titled Section: Medication Administration, Subject: Administration of Medication dated revised 07/2013 and reviewed 06/2022 reflected The seven rights of medication administration are as follows to ensure safety and accuracy of administration, 1. Right Resident, 2. Right Time, 3. Right Medication, 4. Right Dose, 5. Right Route, 6. Right Documentation and 7. Right Diagnosis. Record review of the facility policy and procedure titled Section: Care and Treatment, Subject: Medication Access and Storage revised 05/2025 reflected: Medications labeled for individual residents are stored separately from floor stock medications.