STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455834	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Place Rehabilitation and Skilled Nursing	150 Gibson Rd Athens, TX 75751

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interviews and record reviews, the facility failed to notify the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications) for 1 of 4 residents (Resident #54) reviewed for change in condition. LVN B failed to notify the physician when she did not administer Resident #54's scheduled insulin dose due to low blood sugar level. This failure could place residents at risk for non-therapeutic effects of the medication and decline in health status. Findings included: A record review of Resident #54's face sheet indicated she was a [AGE] year-old female who admitted to the facility on [DATE]. She had multiple diagnoses which included diabetes mellitus, dysphagia (difficulty swallowing) following a stroke, gastrostomy status (refers to the presence of a surgical opening into the stomach that allows for nutritional support), and cerebral infarction (stroke) with hemiplegia and hemiparesis (conditions that cause weakness or paralysis) of both sides of the body. A record review of the quarterly MDS dated [DATE] noted Resident #54 had a BIMS of 2 indicating her cognition was severely impaired and was dependent on staff for all activities of daily living. The same MDS indicated Resident #54 had a diagnosis of diabetes and received insulin injections. A record review of Resident #54's physician orders dated 12/03/2024 indicated Resident #54 had orders for routine (medications taken at the same time each day at the same time and by the same route) and sliding scale injections of insulin (amount of insulin given based on the patient's blood sugar level). The physician's order dated 06/26/2024 indicated Resident #54 was to routinely receive 5 units of Humalog insulin by subcutaneous injection 3 (three) times a day at 08:00 AM, 01:00PM, and 05:00 PM. The order did not require Resident #54's blood sugar to be checked prior to administering the insulin nor parameters for withholding the insulin. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 12/03/2024 at 01:00 PM, LVN B was observed to use a glucometer to check Resident #54's blood sugar. LVN B said Resident #54's sugar level was 71. LVN B said the insulin was not to be given if the if Resident #54's blood sugar was less than 100. During an interview on 12/03/2024 at 01:45 PM, LVN B said the order to administer 5 units of Humalog insulin did not require Resident #54's blood sugar to be checked prior to administering the insulin. She said the order did not include instructions for holding (not giving) insulin. She said the nurses just knew to check blood sugar levels before administering insulin and to not administer insulin if any resident's blood sugar was below 100. During an interview on 12/04/2024 at 10:05 AM, LVN B said she did not notify the physician of holding Resident #54's insulin. LVN B said she did not call the doctor to request an order for glucometer checks prior to insulin administration and to request parameters for holding insulin. LVN B said she did not know why the routine insulin was withheld on the 2 days Resident #54's blood sugar was 150 and 103. A record review of Resident #54's insulin administration record dated 12/01/2024-12/03/2024 indicated Resident #54's blood sugar levels were checked 9 times prior to administering the routinely scheduled insulin using a glucometer. The blood sugar levels were noted to be less than 100 (one hundred) for 4 (four) of the 9 (nine) glucometer checks. The insulin administration record indicated the 5 units Humalog insulin were withheld (not given) at those times. The insulin administration record indicated the routine doses of insulin were held 2 (two) of the 9 (nine) times when the blood sugar levels were greater than 100. There was no indication of the physician being notified of the 6 (six) withheld insulin doses nor the glucometer levels on 12/01/24 08:00 AM BS 150, 12/01/24 01:00 PM - BS 93, 12/01/24 05:00 PM - BS 103, 12/02/24 05:00 PM BS - 79, 12/03/24 13:00 PM - BS 71, and 12/03/24 05:00 PM BS - 91). During an interview on 12/04/2024 at 02:00 PM, the DON said if a nurse decides to hold an insulin dose per nursing judgement based on the blood sugar level without having pre-established parameters, the physician or nurse practitioner should be notified as soon as possible. She said Resident #54 had an order for sliding scale insulin (a prescription that adjusts the amount of insulin a person receives based on their blood sugar level) 4 times a day plus the order for 5 units of regularly scheduled insulin 3 times a day. The DON said the physician should have been notified of the withheld insulin doses. The DON said the physician should also have been consulted about the 2 (two) separate orders for insulin administration resulting in 7 finger sticks a day to check blood sugar levels. The DON said she spoke with the Nurse Practitioner and Resident #54's order for the routinely scheduled insulin (5 units Humalog 3 times a day) was placed on hold until the physician was consulted. The DON said the routine order for insulin would probably be discontinued since Resident #54 had an order for sliding scale insulin administration 4 times a day. The DON said Resident #54 was at risk for a lower-than-normal blood sugar level and a decline in status. The DON said the facility did not have a policy specific to insulin. A review of the facility's policy dated 12/2018 and titled Change of Condition - Observing, Reporting, and Recording indicated the following: Policy: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this home to inform the resident, the resident's physician, and if indicated the resident's responsible party of the following: 2. A significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental, or psychosocial status, in life-threatening conditions or clinical complications. 4. A need to alter treatment significantly.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140 Based on interview and record review the facility failed to ensure accurate MDS assessments were completed for 6 of 9 residents (Residents #1, #2, #17, #50, #60, and #65) reviewed for accuracy of MDS assessments. The facility failed to ensure Residents #1, #2, #17, #50, #60, and #65's MDS assessment was accurately coded for Preadmission Screening and Resident Review (PASRR). These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: 1.A review of Resident #1's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, anxiety, psychosis, schizophrenia and depressive disorder. A review of Resident #1's PASRR Level 1 screening done 11/07/2022 indicated she was positive for MI/ID/DD. A review of Resident #1's PASRR Evaluation done 11/08/2022 indicated she was negative for ID and negative for DD. The resident was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. A review of Resident #1's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression, and schizophrenia. 2. A review of Resident #2's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral palsy, depressive episodes, bipolar disorder, schizophrenia and anxiety disorder. A review of Resident #2's PASRR Level 1 screening done 08/17/2024 indicated she was positive for MI/ID/DD. A review of Resident #2's PASRR Evaluation done 09/17/2024 indicated she was positive for ID and positive for DD. The resident was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Neurological indicated the resident had cerebral palsy and under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression, bipolar disorder and schizophrenia. 3. A review of Resident #17's face sheet for December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included bipolar disorder. A review of Resident #17's PASRR Level 1 screening done 11/03/2022 indicated she was positive for mental illness. A review of Resident #17's PASRR Evaluation done 12/06/2022 indicated she was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. A review of Resident #17's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had bipolar disorder. 4. A review of Resident #50's face sheet for December 2024 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included anxiety disorder, mild intellectual disabilities, and bipolar disorder with psychotic features. A review of Resident #50's PASRR Level 1 screening done 09/08/2023 indicated he was positive for ID. A review of Resident #50's PASRR Evaluation done 09/22/2023 indicated he was positive for ID and positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. A review of Resident #50's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder and bipolar disorder and other active diagnoses he had mild intellectual disabilities. 5. A review of Resident #60's face sheet for December 2024 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included psychotic disorder with delusions, major depressive disorder, and other symbolic dysfunctions. A review of Resident #60's PASRR Level 1 screening done 03/27/2023 indicated he was negative for MI/ID/ID. A second PASRR Level 1 screening dated 04/03/2023 indicated he had a primary diagnosis of dementia and was considered negative for mental illness for specialized services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #60's PASRR Evaluation done 09/26/2023 indicated he had a primary diagnosis of dementia and was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. A review of Resident #60's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression and psychotic disorder. 6. A review of Resident #65's face sheet December 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, major depressive disorder, psychotic disorder with delusions, and anxiety disorder. A review of Resident #65's PASRR Level 1 screening done 11/03/2022 indicated she had a primary diagnosis of dementia and was considered negative for mental illness for specialized services. A PASRR Evaluation was not done because she had a primary diagnosis of dementia and would not qualify for specialized services. A review of Resident #65's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had anxiety disorder, depression and psychotic disorder. During an interview on 12/04/2024 at 10:05 AM, the Regional Reimbursement Consultant said she was in the process of training the recently hired MDS Coordinator. She said the facility used the RAI Version 3.0 Manual as the policy for completing MDS assessments. She said she had been auditing some of the residents MDS files and noted some residents' coding was incorrect and she was submitting changes to the MDS to CMS. She said Section A 1500 indicated if the resident was positive for mental illness, intellectual disability or developmental disability. She said she did not realize the Section I Active Diagnoses was related to Section A PASRR screening documentation. She said the local authority had found residents that did not qualify for PASRR services because they did not meet the PASRR definition for mental illness for specialized services. She said she did not know Section A had to be coded as positive for mental illness, intellectual disability or developmental disability even though they did not qualify for PASRR services. During an interview on 12/04/2024 at 1:35 PM the administrator said the facility did not have a specific policy regarding maintaining accuracy of MDS assessments. He said the RAI manual was used to ascertain accuracy. 37495 47204 47723

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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** 47204 Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3(Resident #22) reviewed for pharmacy services. MA C failed to administer a correct dose of a scheduled medication, lactulose solution (to treat constipation and liver disease) to Resident #22 as ordered by the physician. This failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications which could result in diminished health and well-being. Findings included: A record review of Resident #22's face sheet indicated he was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included stroke, slow transit constipation (condition where the large intestine moves waste too slowly, leading to constipation and other issues), and chronic hepatic failure (liver is permanently damaged and can no longer function properly). A record review of the quarterly MDS dated [DATE] indicated Resident #22 had a BIMS of 3 indicating his cognition was severely impaired. A record review of the physician orders dated 12/03/2024 indicated an order for Resident #22 to be given lactulose solution; 10 gram/15 ml; Amount to Administer: 30 ml oral - 4 Times A Day for the treatment of chronic liver failure. During observation of medication administration on 12/03/2024 at 09:25 AM, MA C was noted to pour 20 ml of lactulose from a bottle labeled lactulose 20 gm/30 ml. MA C said she poured 20 ml of the solution. MA C gave Resident #22 his meds including the 20 ml of the lactulose 10 gm/15 ml solution. After Resident #22 had taken his medications MA C returned to the cart, documented the medications administered, and said she was finished. During an interview on 12/03/2024 at 10:30, MA C said she gave the correct dose of lactulose solution. MA C pointed to the 20gm portion of the order and said the order said to give 20 ml. After discussing the variance in the order as written on the MAR (lactulose 10mg/15ml give 30 ccl) and the label on the bottle that read lactulose 20mg/30cc give 30 cc, MA C said she did not understand the error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/2024 at 10:45 AM, the DON said MA C misunderstood the order. DON said the concentration of lactulose on the physician's order should match the pharmacy label on the lactulose container (bottle). She said MA C misinterpreted the 20gm to mean 20cc. The DON said understanding liquid concentrations (ratios of medication amount to liquid amount) was important to ensuring the correct doses of medication are given. She said she would re-train MA C on liquid medications and add additional administration instructions for the lactulose order to the MAR's Special Instructions section. A record review of the facility's policy dated 12/20/2018 and titled Medication Administration: indicated the following: Policy: It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations. 13. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.