

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455917	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2025
NAME OF PROVIDER OR SUPPLIER Deer Creek of Wimberley		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Ranch Rd 3237 Wimberley, TX 78676	

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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician when there was a significant change for one (Resident #1) of four residents reviewed for notification of changes. The facility failed to notify the NP when Resident #1's diabetic pump malfunctioned in July of 2025. Resident #1's blood sugar readings were sporadically out of range which led her to experience increased dizziness, nausea, and sweatiness. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/30/25 PM and a template was provided. While the IJ was removed on 08/01/25 at 2:13 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of DKA, dizziness, nausea, and a decreased quality of life. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type I diabetes, gastroparesis (a condition in which the muscles in the stomach do not move well), chronic kidney disease, and muscle weakness. Review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 15, indicating she was cognitively intact. Section N (Medications) reflected she received insulin injections since admission. Review of Resident #1's admission care plan, dated 06/30/25, reflected there was not a focus regarding her being a diabetic or having an insulin pump. Review of Resident #1's physician order, dated 07/03/25, reflected the following: Dexcom G7 Receiver Device (Continuous Glucose System Receiver) - Apply to bar of upper arm topically one time a day every 10 day(s) for DM management. Review of Resident #1's TAR, July of 2025, reflected the receiver was changed on 07/03/25 and 07/13/25. Review of Resident #1's physician order, dated 07/01/25, reflected the following: Omnipod 5 Libre2 Plus G6 Kit (Insulin Infusion Disposable Pump) - Inject 200 ml subcutaneously one time a day every 3 day(s) for DM management. Review of Resident #1's MAR, July of 2025, reflected insulin was placed in the pump on 07/01/25, 07/04/25, 07/10/25, and 07/14/25. It reflected she refused on 07/07/25. Review of Resident #1's physician order, dated 07/01/25, reflected Glucagon Emergency Kit 1 MG - Inject 1 mg intramuscularly as need for hypoglycemia per protocol if patient is unconscious or unable to swallow. Review of Resident #1's MAR, July of 2025, reflected she was administered the Glucagon three times: 07/08/25 at 4:36 AM - BS: 7407/09/25 at 4:48 PM - BS: 5307/11/25 at 3:49 AM - BS: 65 Review of Resident #1's blood sugar readings in her EMR, from 07/01/25 - 07/15/25, reflected the following days/times her blood sugar was abnormally out of normal the range (normal range is 70 mg/dL -100 mg/dL): 07/01/25 10:43 PM - 42.0 mg/dL 07/05/25 6:21 PM - 300.0 mg/dL 07/06/25 6:33 AM - 326.0 mg/dL 07/09/25 4:49 PM - 52.9 mg/dL 07/13/25 8:55 PM - 350.0 mg/dL 07/14/25 7:09 AM - 400.0 mg/dL 07/14/25 12:09 PM - 399.0 mg/dL Review of Resident #1's physician order, dated 07/15/25, reflected to d/c insulin pump. Review of Resident #1's physician order, dated 07/15/25, reflected HumaLOG KwikPen Subcutaneous Solution Pen-inject 100 UNIT/ML - Inject subcutaneously before meals for DM. Review of Resident #1's physician order, dated 07/15/25, reflected Lantus Subcutaneous Solution 100 UNIT/ML - Inject 10 unit subcutaneously in the morning for DM - hold if BG is less than 110. During a telephone interview on 07/15/25 at 12:23 PM, Resident #1's NP stated she had been working with the facility for about a week but was familiar with Resident #1. She stated she had a conversation with her that morning (on 07/15/25) and there were concerns that the pump was not functioning the way it should be, so she put in orders to discontinue the pump. She stated she should not have it on her if it was not working. She stated she ordered a sliding scale to better manage her blood sugars. She stated the staff had been informing her of general concerns regarding Resident #1 such as refusing showers and not eating much of her meals, but they had not mentioned irregular blood sugar readings. She stated if she had been, she would have discontinued the pump sooner. She stated if the pump was not working, a negative outcome could be potentially all the negative things with diabetes. She stated there was not a way to check those pumps in these environments. During a telephone interview on 07/15/25 at 12:38 PM, RN A stated she was very familiar with Resident #1. She stated since she had a pump, she would tell the nurses what her blood sugar was, and they would document it. She stated her biggest concern was that the nurses did not know what the pump was set at, so they did not know how much insulin she was getting. She stated Resident #1 had also not been eating much and that was a problem as well. She stated she did relay to the NP that she was not eating but not about the irregular blood sugar readings. She stated a few days prior in the morning (could not remember date) her blood sugar was 400 and she realized the pump was off. She</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of four residents reviewed for quality of care. The facility failed to: - Notify Resident #1's NP when her diabetic insulin pump malfunctioned in July of 2025. - Ensure nursing staff were trained on Resident #1's insulin pump.- Ensure nursing staff were aware of how much insulin Resident #1 was receiving and not relying on her for blood sugar readings.- Ensure there were parameters in place on when to notify Resident #1's NP when her readings were abnormal. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 07/30/25 at 2:14 PM and a template was provided. While the IJ was removed on 08/01/25 at 2:13 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of DKA, dizziness, nausea, and a decreased quality of life, and death. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type I diabetes, gastroparesis (a condition in which the muscles in the stomach do not move well), chronic kidney disease, and muscle weakness. Review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 15, indicating she was cognitively intact. Section N (Medications) reflected she received insulin injections since admission. 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