STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675057	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Balch Springs Nursing Home	4200 Shepherd LN Balch Springs, TX 75180

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** 45268 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident f The facility failed to document that Resident #1 was given insulin on 08/20/24, 08/21/24, 08/23/24. This failure could place residents at risk of medical complications and a decrease in therapeutic dosages of their medications as ordered by the physician. Findings included: Review of Resident #1's electronic face sheet printed 08/28/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included but not limited to type 2 diabetes and high blood pressure. Review of Resident #1's annual MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. Review of Resident #1's care plan dated 08/26/2024 revealed Resident #1 had diabetes and was at risk for unstable blood sugar. Interventions included to administer diabetic medication as order by physician and administer diabetic medication according to a sliding scale. Review of Resident #1's physician's order dated 08/19/2024 revealed Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 180 = 0 units;181 - 240 = 3 units; 241 - 300 = 5 units; 301 - 400 = 10 units; 401 - 460 = 12 units Greater than 460mg/dL administer 12 units and call MD., subcutaneously(being, living, occurring, or administered under the skin(before meals and at bedtime for blood glucose control Review of Resident #1's MAR for the month of August 2024 reflected Resident #1's lispro was not administered on the following days -08/20/24, there was no documentation of the medication being given at 4PM or 9PM nor documentation of blood sugar being checked. (continued on next page)

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

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	-08/21/24, there was no documentation of the medication being given at 9PM documentation of blood sugar being checked -08/23/24, there was no documentation of medication given at 9PM documentation of blood sugar being checked Review of Resident #1's nursing notes from 08/19/2024-09/29/2024 revaealed no issues with blood sugar Interview on 08/28/2024 at 1:00 PM with Resident #1 revealed she had only been in the facility for 2 weeks and she was having trouble with her medication. Resident #1 stated LVN A did not give her insulin at night and she was not sure why. Resident #1 stated during LVN A's shift was the only time she was not getting her insulin. Resident #1 was not aware of any adverse effects due to not getting the medication. Interview on 08/28/2024 at 1:15 PM with the DON revealed she was not aware LVN A had not documented that the insulin was given to Resident #1. The DON stated she spoke with LVN A on 8/28/2024 before her shift began and she stated she did give Resident #1 the insulin however she forgot to document it. The DON stated LVN A would be in-serviced before beginning her shift regarding documentation. The DON stated the risk of LVN A not documenting that the medication was given would be that another nurse could see that the medication was not given and give an extra dose.