

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Llano Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  800 W Haynie St Llano, TX 78643	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097</b></p> <p>Based interviews and record review, the facility failed to ensure each resident was free from abuse, neglect, exploitation, and misappropriation of resident property for one (1) of five (5) residents reviewed.</p> <p>The facility failed to prevent the misappropriation of Resident #1's Ozempic 4MG/3ML Pen (1MG). Ozempic is a GLP-1 agonist that assists with weight loss and blood sugar regulation.</p> <p>This failure placed the resident at risk for not receiving their prescribed medication.</p> <p>Findings Include:</p> <p>Record review of Resident #1, on August 5, 2024, through August 7, 2024, reflected a 55yo male who was admitted to the facility on [DATE], with diagnoses including in part: Cellulitis, Diarrhea, Vitamin D deficiency, Hyperlipidemia, Morbid (severe) Obesity due to excess calories, Type 2 Diabetes with unspecified complications, Pain, and Muscle Wasting and Atrophy.</p> <p>Review of Resident #1 TL's most recent MDS, dated [DATE], revealed a BIMS score of 15, and no significant cognitive impairment.</p> <p>Review of Resident #1's Care Plan, last reviewed/ revised on June 6, 2024, showed the resident was at risk for malnutrition related to prescribed weight loss regime. The approach included administering Ozempic as prescribed, Ozempic .5mg weekly, with the goal being that the resident not exhibit signs of malnutrition or dehydration. Additionally, a problem area identified in the Care Plan reviewed/ revised on June 6, 2024, was the diagnosis of diabetes, with the goal being that the resident will have no complications due to diabetes and medication use, and the approach being in part, meds as ordered.</p> <p>In an interview on August 5, 2024, at 3:40PM, Resident #1 stated that he has never missed prescribed doses of ordered medications due to misappropriation of his medications, the medication not being available, and/or oversight by facility staff.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's investigation into Resident #1's missing Ozempic medication showed that on July 3, 2024, RN K administered the ordered medication to Resident #1 as ordered. On or about July 10, 2024, RN K noted that the medication could not be located. Nursing staff searched the medication room, medication cart, and disposed of medications. The missing medication was not found. Resident #1's PCP was notified and a new order for the medication was requested. On July 11, 2024, the NP came to the facility and assessed the resident. According to the investigation record, the charge nurse checked the resident's blood sugar, which was within a normal range and no concerns were noted.</p> <p>Review of the facility's investigation records revealed a written statement by MA J, which stated in summary that on July 7, 2024, MA J went to dispose of another resident's discontinued medications when she saw what she thought to be Resident #1's new insulin syringe. MA J wrote that she questioned to herself the presence of a new medication in the discontinued medication box but writes that she failed to outwardly question this.</p> <p>Review of the facility's investigation records revealed that an Inservice Training session was conducted by the ADM to include the prohibition of resident abuse/neglect, GLP-1 class medications, storage and count sheet process, and a new facility policy which states, .All GLP-1 class of medications must be stored in narcotic box in the medication room fridge. A medication count sheet must be initiated upon receiving these medications immediately.</p> <p>In an interview with the facility ADM on August 7, 2024, the ADM stated that immediately upon learning of the missing medication, an investigation was initiated, and Resident #1 was assessed, and the resident suffered no ill effects from the missing medication. The ADM stated that the medication was immediately re-ordered and received. The administration of the medication was immediately resumed with the resident's weekly administration of the medication delayed, but not missed. The ADM stated that during this time the facility had primarily utilized agency nursing staff and she believes this contributed to the misappropriation of the medication, but she cannot conclusively say what happened to the medication.</p> <p>A review of the facility's records show a Packing Slip Proof of Delivery dated July 13, 2024, in which Ozempic 4MG/3ML PEN (1MG) was received (as a replacement) for Resident #1.</p> <p>50042</p> <p>Investigation found substantiated</p> <p>Resident #26</p> <p>FTag Initiation</p>