

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  LA Paloma Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  138 S Fm 1329 San Diego, TX 78384	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50039</p> <p>Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #17) of 6 residents reviewed for accuracy and completeness of clinical records.</p> <p>The facility failed to accurately document the correct duration of time for Resident #17's order for enteral nutrition. The order stated the hours were 6:00 AM to 10:00 PM, when the correct duration was 10:00 PM to 6:00 AM.</p> <p>This failure could result in residents' records not accurately reflecting the administration of enteral nutrition and could result in further error including weight gain/loss.</p> <p>The findings included:</p> <p>Record review of Resident #17's face sheet dated 02/10/25 revealed a [AGE] year-old female with an original admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included Alzheimer's Disease and gastrostomy status (surgical procedure that creates an opening in the abdomen and inserts a tube directly into the stomach).</p> <p>Record review of Resident #17's Quarterly MDS Assessment section C, cognitive patterns, dated 12/23/24 revealed a BIMS score of 10 (moderate impairment).</p> <p>Record review of Resident #17's order summary revealed an active order dated 01/17/25 for every night shift [enteral nutrition] at (65ccs per hour) via G-tube stationary pump. RUN Time: (6am to 10pm) Provides: 624 kcal, 29 g pro and 419 mL water, (1020CC total with flush).</p> <p>Record review of Resident #17's comprehensive care plan dated 02/10/25 revealed the problem [Resident #17] requires tube feeding r/t Swallowing problem, Weight loss initiated on 09/24/24. Interventions listed for the problem included:</p> <ul style="list-style-type: none"> <li>- As per MD orders for feeding tube initiated on 03/31/23.</li> <li>- Enteral Feed AS per MD orders initiated on 03/31/23.</li> </ul> <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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #17 on 02/10/25 at 11:12 AM, Resident #17 stated she received nutrition from the feeding tube at night while she slept. Resident #17 stated she was not sure about the specific hours that it was on.</p> <p>In an interview with LVN A on 02/11/25 at 2:23 PM, LVN A stated Resident #17 had a G-tube. LVN A stated Resident #17 received nutrition during the night but was not sure about the specific hours. LVN A stated if she was not sure what time the resident received nutrition, she would check the MAR and orders. LVN A stated Resident #17 ate food during the day. LVN A stated if there was a discrepancy in the order she would talk to the DON and call the dietician to confirm what the correct timing was for the order. LVN A stated the order for enteral nutrition showed the duration 6:00 AM to 10:00 PM but she thought it was supposed to be 10:00 PM to 6:00 AM. LVN A stated the audit review on the order showed the dietician, the DON and the MD all saw the order and approved it. LVN A stated an incorrect order like this could result in the resident gaining a lot of weight and the facility would not know why it was happening.</p> <p>In an interview with the ADON on 02/11/25 at 2:42 PM, the ADON stated she ran a report every day showing all new orders from the previous day and reviewed them. The ADON stated she reviewed them for indication, parameters of whether to give the medication or not, and duration. The ADON stated Resident #17 had a G-tube. The ADON stated Resident #17 received nutrition at night through the tube. The ADON stated Resident #17 received breakfast, lunch, and dinner every day as well. The ADON stated if she did not know what hours the G-tube was supposed to run, she would look it up in the MAR or plan of care to see what the correct hours were. The ADON stated the order currently stated the run time was from 6:00 AM to 10:00 PM. The ADON stated the correct time was 10:00 PM to 6:00 AM. The ADON stated this was an order she would have reviewed. The ADON stated if she saw an incorrect order, she would call the person who put in the order to confirm what the order should be. The ADON stated with the order written the way it was the resident could inadvertently receive extra nutrition.</p> <p>In an interview with the DON on 02/11/25 at 2:55 PM, the DON stated the charge nurses reviewed new medication orders. The DON stated she reviewed all new dietician orders. The DON stated when she reviewed orders she looked to see if there were any changes or new recommendations in the orders. The DON stated Resident #17 ate breakfast, lunch, dinner and snacks and received enteral nutrition only at night. The DON stated if she was not sure of the hours of the enteral nutrition, she looked it up in the orders. The DON stated the order in the computer stated the enteral nutrition was from 6:00 AM to 10:00 PM. The DON stated the correct time was 10:00 PM to 6:00 AM. The DON stated when an order for enteral nutrition was not put in correctly the resident was at risk of being overfed or underfed.</p> <p>Record review revealed the facility policy titled Medication Reconciliation implemented 04/10/23 stated the following:</p> <p>5. Daily Processes:</p> <p>b. Verify medication labels match physician orders and consider rights of medication administration each time a medication is given.</p> <p>c. Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Verify medications received match the medication orders.</p> <p>6. Monthly Processes:</p> <p>c. Verify orders printed on new monthly physician order forms and medication administration records match current medication orders.</p>