STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675440	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Dallas Nursing & Rehabilitation	3808 S Central Expwy Dallas, TX 75215

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to follow physician orders for daily fasting blood sugar checks for Resident #1 on 09/03/24, 09/04/24, 09/09/24, 09/10/24, 09/15/24, and 09/16/24. This failure could place the resident at risk of not receiving the care intended by the physician. The findings included: Record review of Resident #1's face sheet, printed on 09/17/24, reflected a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of legal blindness, chronic obstructive pulmonary disease (disease causing restricted airflow and breathing problems), diabetes mellitus due to underlying condition with diabetic neuropathy (a chronic disease that occurs when the body can't regulate blood sugar levels), other sequelae of cerebral infarction (Alteration of sensation following a stroke), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis that affects only one side of the body following a stroke), and chronic kidney disease (progressive damage and loss of function in the kidneys). Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 14, which indicated Resident #1 was cognitively intact. Section GG - Functional Abilities and Goals, question GG0130. Self-Care indicated Resident #1 required moderate assistance with ADLs of toileting, showering, and personal hygiene. Record review of Resident #1's care plan, revised on 08/28/24, reflected the following: .FOCUS: The resident has Diabetes Mellitus with neuropathy . INTERVENTIONS: Fasting Serum Blood Sugar as ordered by doctor . Record review of the physician orders tab of Resident #1's electronic health record revealed an order, dated 08/28/24 to CHECK FBS EVERY AM in the morning, with a start date of 08/29/24. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's September medication administration record indicated Resident #1's blood sugar was not checked on the mornings of 09/03/24, 09/04/24, 09/09/24, 09/10/24, 09/15/24, and 09/16/24. In an Interview on 09/17/24 at 10:40 a.m., Resident #1 stated he was aware that his blood sugar should be checked every morning, but the facility nurses do not check his sugars every morning. Resident #1 stated he had not reported the missed blood pressure checks to facility management because they should already know what their nurses aren't doing. Resident #1 stated he had a way to check his own blood sugar daily, so he was not concerned the facility failed to do so. In an interview on 09/17/24 at 1:25 p.m., LVN A stated she was Resident #1's assigned 6:00 a.m. to 2:00 p. m., nurse. LVN A stated blood pressure checks were completed by facility nurses, while routine medications were provided to residents by facility medication aides. LVN A stated Resident #1's blood sugar check were the responsibility of the overnight nurse, because it was scheduled between 4:00 a.m. and 6:00 a.m. LVN A stated she had not received any reports from the overnight nurse that indicated Resident #1 had refused. LVN A stated she did not see the missed blood sugars because they filter the administration record to show medications and treatments to be administered during their shift. Record review of the facility's Station One staffing schedule, dated 09/02/24 through 09/17/24, revealed that LVN B was Resident #1's assigned overnight nurse on 09/02/24, 09/03/24, 09/08/24, 09/09/24, 09/14/24, and 09/15/24. Record review of the progress notes tab of Resident #1's electronic health record revealed no documentation that indicated Resident #1 refused his morning blood sugar checks between 09/01/24 and 09/17/24. A telephone interview with LVN B was attempted on 09/17/24 at 1:56 p.m. but was unsuccessful. In an interview on 09/17/24 at 2:40 p.m., the DON stated she was not aware of any missed blood sugar checks for Resident #1. The DON stated facility nurses were solely responsible for blood sugar checks and they were expected to provide all medications and treatments according to physician orders. The DON stated not completing blood sugar checks according to physician orders could cause a delay in care. The DON stated she would begin to in-service nursing staff on following physician orders and the documentation of medication and treatment orders. The DON stated she would conduct daily MAR audits to ensure medications and treatments were administered according to physician orders in the future. In an interview on 09/17/24 at 3:32 p.m., the ADMIN stated he was not aware that Resident #1 had not received his ordered blood sugar checks. The ADMIN stated facility nurses were expected to always follow physician orders. The ADMIN stated Resident #1 could have experienced elevated blood sugar that would have not been relayed to his physician. The ADMIN stated to ensure all physician orders were followed he planned to update facility reporting procedures and in-service nursing staff on following physician orders and documentation. The ADMIN stated the DON would conduct daily MAR audits for three months and then weekly thereafter, to ensure all physician orders are followed in the future. A related policy was requested from the DON and ADMIN on 09/17/23 at 2:40 p.m. and 3:32 p.m. but was not provided prior to exit.