

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/04/2024
NAME OF PROVIDER OR SUPPLIER  San Marcos Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 N I H 35 San Marcos, TX 78666	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42949</p> <p>Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical status for one (Resident #1) of three residents reviewed.</p> <p>The facility failed to notify the NP immediately when Resident #1 was admitted and they did not have his prescribed insulin.</p> <p>This failure could affect residents by putting them at risk of exacerbation of their health conditions and deterioration of their health.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, history of stroke, coronary artery disease, and cholecystitis (inflammation of the gall bladder).</p> <p>Review of Resident #1's EMR, on 11/04/24, reflected his 5-day MDS assessment had not been completed.</p> <p>Review of Resident #1's baseline care plan, dated 11/03/24, reflected he had an ADL self-care performance deficit with an intervention of receiving a therapy evaluations and treatment per physician's orders.</p> <p>Review of Resident #1's hospital discharge records, dated 11/02/24, reflected an order for Insulin, 42 units - HumuLIN 70/100 units/ML - twice a day.</p> <p>Review of Resident #1's physician's order, dated 11/02/24, reflected HumuLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML - Inject 42 units subcutaneously two times a day for blood sugar.</p> <p>Review of Resident #1's November 2024 MAR, on 11/04/24, reflected he had not been administered either dose of insulin on 11/03/24 or his morning dose on 11/04/24.</p> <p>Review of Resident #1's progress note, dated 11/03/24 at 4:27 PM and documented by RN A, reflected insulin was not administered due to it not being available.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress note, dated 11/03/24 at 7:27 PM and documented by RN A, reflected insulin was not administered due to it not being available.</p> <p>Review of Resident #1's progress note, dated 11/04/24 at 9:03 AM and documented by LVN B, reflected insulin was not administered due him being a new admission and waiting delivery.</p> <p>Review of Resident #1's blood sugar readings in his EMR, on 11/04/24, reflected the following:</p> <p>11/02/24 9:32 PM - 176.0 mg/dL</p> <p>11/03/24 7:33 AM - 184.0 mg/dL</p> <p>11/03/24 1:00 PM - 283.0 mg/dL</p> <p>11/03/24 4:40 PM - 245.0 mg/dL</p> <p>11/03/24 8:15 PM - 237.0 mg/dL</p> <p>11/04/24 8:05 AM - 200.0 mg/dL</p> <p>11/04/24 12:51 PM - 312.0 mg/dL</p> <p>During an interview on 11/04/24 at 12:05 PM, Resident #1 stated he was not sure if he had been getting his insulin as he was still groggy from his procedure in the hospital. He stated it was hard to know if he felt off (regarding his sugar levels) due to him having an infection and being in pain. He was asked if it was normal for his sugar levels to be in the upper 200's. His eyes opened wide and he said, Absolutely not! and that was very concerning to him.</p> <p>During an interview on 11/04/24 at 12:11 PM, LVN B stated she noticed Resident #1 did not have insulin to be administered that morning and had reached out to the pharmacy. She stated she was not sure why no one had reached out to the pharmacy sooner. She stated that particular dosage of insulin was not in their e-kit but the pharmacy assured her it would be delivered that day.</p> <p>During an interview on 11/04/24 at 12:55 PM, Resident #1's NP stated she was not notified about the insulin until that day (11/04/24). She stated she ideally would have liked to have been notified sooner. She stated if she had been notified sooner, she would have reinforced to reach to the pharmacy or could have placed an order for a different type of insulin. She stated a negative outcome of going too long without insulin could be hyperglycemia or other acute issues.</p> <p>During a telephone interview on 11/04/24 at 1:05 PM, RN A stated she was the nurse who admitted Resident #1 on 11/02/24. She stated she was pretty new to the facility and had put his orders in and was just waiting for the medications to be delivered. She stated she thought it would be a given that they needed the insulin STAT so she did not think to tell the pharmacy. She stated she kept a close eye on his sugar levels and they never reached 400 or above .</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/04/24 at 2:09 PM, the DON stated when a resident was being admitted they would come in with orders, the nurses would put the orders in, and the orders went straight to the pharmacy. She stated they did have insulin in their e-kit, but not specific insulin Resident #1 had an order for. She stated she would have expected RN A to contact the on-call NP to notify her. She stated it was not okay to go without scheduled insulin and they could have given him an alternate.</p> <p>Review of the facility's Medication Administration Policy, revised May of 2007, reflected the following:</p> <p>It is the policy of this facility to prepare, administer, and document medications.</p> <p>.</p> <p>12. Any irregularity in pouring or administering must be reported to the doctor.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42949</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of three residents reviewed for medications.</p> <p>The facility failed to administer three doses of insulin after Resident #1 was admitted on [DATE] due to pending delivery from the pharmacy.</p> <p>This failure could affect residents by putting them at risk of exacerbation of their health conditions and deterioration of their health.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, history of stroke, coronary artery disease, and cholecystitis (inflammation of the gall bladder).</p> <p>Review of Resident #1's EMR, on 11/04/24, reflected his 5-day MDS assessment had not been completed.</p> <p>Review of Resident #1's baseline care plan, dated 11/03/24, reflected he had an ADL self-care performance deficit with an intervention of receiving a therapy evaluations and treatment per physician's orders.</p> <p>Review of Resident #1's hospital discharge records, dated 11/02/24, reflected an order for Insulin, 42 units - HumuLIN 70/100 units/ML - twice a day.</p> <p>Review of Resident #1's physician's order, dated 11/02/24, reflected HumuLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML - Inject 42 units subcutaneously two times a day for blood sugar.</p> <p>Review of Resident #1's November 2024 MAR, on 11/04/24, reflected he had not been administered either dose of insulin on 11/03/24 or his morning dose on 11/04/24.</p> <p>Review of Resident #1's progress note, dated 11/03/24 at 4:27 PM and documented by RN A, reflected insulin was not administered due to it not being available.</p> <p>Review of Resident #1's progress note, dated 11/03/24 at 7:27 PM and documented by RN A, reflected insulin was not administered due to it not being available.</p> <p>Review of Resident #1's progress note, dated 11/04/24 at 9:03 AM and documented by LVN B, reflected insulin was not administered due him being a new admission and waiting delivery.</p> <p>Review of Resident #1's blood sugar readings in his EMR, on 11/04/24, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/02/24 9:32 PM - 176.0 mg/dL</p> <p>11/03/24 7:33 AM - 184.0 mg/dL</p> <p>11/03/24 1:00 PM - 283.0 mg/dL</p> <p>11/03/24 4:40 PM - 245.0 mg/dL</p> <p>11/03/24 8:15 PM - 237.0 mg/dL</p> <p>11/04/24 8:05 AM - 200.0 mg/dL</p> <p>11/04/24 12:51 PM - 312.0 mg/dL</p> <p>During an interview on 11/04/24 at 12:05 PM, Resident #1 stated he was not sure if he had been getting his insulin as he was still groggy from his procedure in the hospital. He stated it was hard to know if he felt off (regarding his sugar levels) due to him having an infection and being in pain. He was asked if it was normal for his sugar levels to be in the upper 200's. His eyes opened wide and he said, Absolutely not! and that was very concerning to him.</p> <p>During an interview on 11/04/24 at 12:11 PM, LVN B stated she noticed Resident #1 did not have insulin to be administered that morning and had reached out to the pharmacy. She stated she was not sure why no one had reached out to the pharmacy sooner. She stated that particular dosage of insulin was not in their e-kit but the pharmacy assured her it would be delivered that day.</p> <p>During an interview on 11/04/24 at 12:55 PM, Resident #1's NP stated she was not notified about the insulin until that day (11/04/24). She stated she ideally would have liked to have been notified sooner. She stated if she had been notified sooner, she would have reinforced to reach to the pharmacy or could have placed an order for a different type of insulin. She stated a negative outcome of going too long without insulin could be hyperglycemia or other acute issues.</p> <p>During a telephone interview on 11/04/24 at 1:05 PM, RN A stated she was the nurse who admitted Resident #1 on 11/02/24. She stated she was pretty new to the facility and had put his orders in and was just waiting for the medications to be delivered. She stated she thought it would be a given that they needed the insulin STAT so she did not think to tell the pharmacy. She stated she kept a close eye on his sugar levels and they never reached 400 or above .</p> <p>During an interview on 11/04/24 at 2:09 PM, the DON stated when a resident was being admitted they would come in with orders, the nurses would put the orders in, and the orders went straight to the pharmacy. She stated they did have insulin in their e-kit, but not specific insulin Resident #1 had an order for. She stated she would have expected RN A to contact the on-call NP to notify her. She stated it was not okay to go without scheduled insulin and they could have given him an alternate.</p> <p>Review of the facility's Medication Administration Policy, revised May of 2007, reflected the following:</p> <p>It is the policy of this facility to prepare, administer, and document medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.</p> <p>12. Any irregularity in pouring or administering must be reported to the doctor.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medications errors for one of one (Resident #1) of three residents reviewed for significant medication errors.</p> <p>The facility failed to administer three doses of insulin after Resident #1 was admitted on [DATE] due to pending delivery from the pharmacy.</p> <p>This failure could affect residents by putting them at risk of exacerbation of their health conditions and deterioration of their health.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, history of stroke, coronary artery disease, and cholecystitis (inflammation of the gall bladder).</p> <p>Review of Resident #1's EMR, on 11/04/24, reflected his 5-day MDS assessment had not been completed.</p> <p>Review of Resident #1's baseline care plan, dated 11/03/24, reflected he had an ADL self-care performance deficit with an intervention of receiving a therapy evaluations and treatment per physician's orders.</p> <p>Review of Resident #1's hospital discharge records, dated 11/02/24, reflected an order for Insulin, 42 units - HumuLIN 70/100 units/ML - twice a day.</p> <p>Review of Resident #1's physician's order, dated 11/02/24, reflected HumuLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML - Inject 42 units subcutaneously two times a day for blood sugar.</p> <p>Review of Resident #1's November 2024 MAR, on 11/04/24, reflected he had not been administered either dose of insulin on 11/03/24 or his morning dose on 11/04/24.</p> <p>Review of Resident #1's progress note, dated 11/03/24 at 4:27 PM and documented by RN A, reflected insulin was not administered due to it not being available.</p> <p>Review of Resident #1's progress note, dated 11/03/24 at 7:27 PM and documented by RN A, reflected insulin was not administered due to it not being available.</p> <p>Review of Resident #1's progress note, dated 11/04/24 at 9:03 AM and documented by LVN B, reflected insulin was not administered due him being a new admission and waiting delivery.</p> <p>Review of Resident #1's blood sugar readings in his EMR, on 11/04/24, reflected the following:</p> <p>11/02/24 9:32 PM - 176.0 mg/dL</p> <p>(continued on next page)</p>

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