STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675677	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Rio Nursing and Rehabilitation Center	301 W Martin St Del Rio, TX 78840

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances to include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay for 1 of 8 residents (Resident #17) reviewed for grievances. RN E received a grievance from Resident #17's representative and did not initiate a grievance report. This failure could place residents at risk for not having grievances heard, addressed, and resolved. The findings included: A record review of Resident #17's admission record dated 04/10/2024, revealed an admitted [DATE] with diagnoses which included a pressure ulcer of the sacral region (a wound to her buttocks), depression and anxiety disorder. A record review of Resident #17's admission MDS assessment dated [DATE] revealed Resident #17 was a [AGE] year-old female admitted for long term care with wounds to her buttocks and assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #17's care plan dated 04/10/2024 revealed, .I have incontinence .Incontinent Care assistance every shift and as needed. A record review of Resident #17's nurse's notes revealed RN E documented on 03/27/2024 at 06:18 AM, Residents (Representative) came in at 2320 (11:20 PM 03/26/2024) to check on Resident. (Representative) approached nurses' station and stated that Resident had called her and her (Family Member) around 1830 (06:30 PM) to inform them that Resident had been on call light for a while wanting to be changed but no one had gone into change her. (Representative) stated she called facility around 1850 (06:50 PM) but no answer. This nurse informed [family member] that she will be monitor closely and changed. (continued on next page)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2024 at 7:29 PM RN E stated she worked the 10:00 PM 03/26/2024 to 06:00 AM 03/27/2024 shift and cared for Resident #17. RN E recalled an event where Resident #17's family member presented at the facility's front door ringing the doorbell around midnight. RN E stated Resident #17's representative entered the facility and went to see Resident #17 and then returned to the nurse's station to inquire about Resident #17's evening. RN E stated she gave Resident #17's representative a report that she and her CNAs had been caring for Resident #17 to include rounding on the resident every 2 hours at a minimum and had provided incontinent care. RN E stated she then received a report from Resident #17's representative which included her complaint that Resident #17 called her (Resident #17's representative) and her family member to complain she needed incontinent care, used her call light, and no one would respond. RN E stated Resident #17's representative claimed she had attempted to call the facility without success and then decided to visit the facility and Resident #17. RN E stated she reassured Resident #17's representative and would continue to answer call lights, round on the resident every 2 hours or more often and provide incontinent care. RN E stated she documented the event in Resident #17 nurses notes but had not initiated a grievance report. RN E stated she had not considered initiating a grievance report but with a review of the event RN E stated she could have generated a grievance report so that the Administrator could review the grievance and address Resident #17's complaint. RN E stated Resident #17 had received the care, but her grievance was not documented, and the Administrator was not provided the opportunity to recognize Resident #17's complaint. During an interview on 04/11/2024 at 10:20 AM Resident #17 stated when she was at her home her health had declined to the point where she was bed bound, incontinent, developed a bed sore on her backside, and was hospitalized . Resident #17 stated after her hospitalization she was admitted into the facility, and she had anxiety regarding her fear of neglect for care with her incontinence and her bed sore, and potential for injury due to a fall. Resident #17 stated she did recall an event when she did receive incontinent care and afterwards felt another incontinent episode and used her call light for assistance and stated, it was after dinner around bedtime. I was in bed. Resident #17 stated she called her Representative and (family member) to report the lack of someone answering the call light. Resident #17 stated eventually staff did answer her light and was now happy with the care she received at the facility and wished for the staff to not get into trouble, and further stated, I told (Resident #17's representative) not to make trouble. They (staff) take care of me. During an interview on 04/11/2024 at 01:20 PM the Administrator stated she had not received a grievance report on behalf of Resident #17's complaint on 03/27/2024. The Administrator stated she had reviewed RN E's documentation for the evening of 03/26/2024 to 03/27/2024, interviewed the staff and the resident for the event, and had concluded Resident #17 had received the care needed but none the less the grievance could have been documented for her review and possible interventions. The Administrator stated the potential risk for not generating a grievance report was that residents may not have their grievances heard, investigated, and documented. The Administrator stated the grievance reports were reviewed daily by the leadership team and if areas of improvement were identified the grievances would be reviewed during the Quality Assurance and Performance Improvement meetings. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Grievances policy dated December 2023, revealed, The investigation of complaints and grievances is a vital function to protect the health, safety, and welfare of residents. The Administrator is designated as the Grievance Official and is responsible for ensuring that all complaints and grievances are investigated and resolved in a timely and appropriate manner. This responsibility includes: overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the community; and maintaining the confidentiality of all information associated with grievances . each resident has the right to receive prompt resolution of grievances, including those regarding the behavior of other residents .filing grievances is not limited to a formal, written grievance process but may include a residence verbalized or written complaint to any community team member or a grievance made anonymously

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, are reported not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for 1 of 8 residents (Resident #17) reviewed for reporting allegations of neglect. RN E received an allegation of neglect from Resident #17's representative and did not report the allegation to the abuse, neglect, and exploitation prevention coordinator, the Administrator. This failure could place residents at risk for not having allegations reported. The findings included: A record review of r esident #17's admission record dated 04/10/2024, revealed an admitted [DATE] with diagnoses which included a pressure ulcer of the sacral region (a wound to her buttocks), depression and anxiety disorder. A record review of Resident #17's admission MDS assessment dated [DATE] revealed Resident #17 was a [AGE] year-old female admitted for long term care with wounds to her buttocks and assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #17's care plan dated 04/10/2024 revealed, .I have incontinence .Incontinent Care assistance every shift and as needed. A record review of resident #17's nurse's notes revealed RN E documented on 03/27/2024 at 06:18 AM, Residents (Representative) came in at 2320 (11:20 PM 03/26/2024) to check on Resident. (Representative) approached nurses' station and stated that Resident had called her and her (Family Member) around 1830 (06:30 PM) to inform them that Resident had been on call light for a while wanting to be changed but no one had gone into change her. (Representative) stated she called facility around 1850 (06:50 PM) but no answer. This nurse informed daughter that she will be monitor closely and changed. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2024 at 7:29 PM RN E stated she worked the 10:00 PM 03/26/2024 to 06:00 AM 03/27/2024 shift and cared for Resident #17. RN E recalled an event where Resident #17's family member presented at the facility's front door ring the doorbell around midnight. RN E stated Resident #17's representative entered the facility and went to see Resident #17 and then returned to the nurse's station to inquire about Resident #17's evening. RN E stated she gave Resident #17's representative a report that she and her CNA's had been caring for Resident #17 to include rounding on the resident every 2 hours at a minimum and had provided incontinent care. RN E stated she then received a report from Resident #17's representative which included her complaint Resident #17 called her (Resident #17's representative) and her family member to complain she needed incontinent care, used her call light, and no one would respond. RN E stated Resident #17's representative claimed she had attempted to call the facility without success and then decided to visit the facility and Resident #17. RN E stated she reassured Resident #17's representative and would continue to answer call lights, round on the resident every 2 hours or more often and provide incontinent care. RN E stated she documented the event in resident #17 nurses notes but had not initiated a grievance report nor reported the allegation of neglect to the Administrator. RN E stated she had not considered the complaint as an allegation of but with a review of the event RN E stated she could have generated a grievance report so that the Administrator could review the grievance and address Resident #17's complaint. RN E stated Resident #17 had received the care, but her grievance was not documented, and the a dministrator was not provided the opportunity to recognize Resident #17's allegation of neglect. During an interview on 04/11/2024 at 10:20 AM Resident #17 stated she was at her home her health had declined to the point where she was bed bound, incontinent, developed a bed sore on her backside, and was hospitalized . Resident #17 stated after her hospitalization she was admitted into the facility, and she had anxiety for her fear of neglect for care with her incontinence and her bed sore, and potential for injury due to a fall. Resident #17 stated she did recall an event when she did receive incontinent care and afterwards felt another incontinent episode and used her call light for assistance, it was after dinner around bedtime, I was in bed. Resident #17 stated she called her Representative and (Family member) to report the lack of someone answering the call light. Resident #17 stated eventually staff did answer her light and was now happy with the care she received at the facility and wished for the staff to not get into trouble, I told (Resident #17's representative) not to make trouble, they (staff) take care of me. During an interview on 04/11/2024 at 01:20 PM the Administrator stated she had not received a grievance report or allegation of neglect on behalf of Resident #17's complaint on 03/27/2024. The Administrator stated she had reviewed RN E's documentation for the evening of 03/26/2024 to 03/27/2024, interviewed the staff and the resident for the event, and had concluded resident #17 had received the care needed but none the less the grievance could have been documented for her review and possible interventions. The Administrator stated the potential risk for not generating a grievance report was that residents may not have their grievances heard, investigated, and documented. The Administrator stated the grievance reports are reviewed daily by the leadership team and if areas of improvement are identified the grievances would be reviewed during the Quality Assurance and Performance Improvement meetings . A record review of the facility's Abuse Guidance: Preventing, Identifying and Reporting policy dated October 2022, revealed, .Reporting Allegations or suspicions of Abuse . a community owner, operator or team member who has knowledge of an allegation of, or cause to believe that, abuse, neglect, or exploitation to state authorities and may also be reported to local authorities as indicated

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #10) reviewed for drug labeling. LVN A, LVN B, LVN C, and LVN D administered Resident #10 expired insulin lispro 11 times out of a potential 17 times from 04/03/2024 to 04/11/2024. This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: A record review of r esident #10's admission record, dated 04/11/2024, revealed an admitted [DATE] with diagnoses which included type 2 diabetes (the body either doesn't produce enough insulin, a hormone that regulates blood sugar, or doesn't use it effectively. This leads to elevated blood sugar levels.). A record review of resident #10's annual MDS assessment, dated 02/07/2024, revealed resident #10 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A record review of resident #10's Care Plan dated 04/11/2024, revealed, I have diabetes and take insulin .I will not experience complications associated with my diabetes through the next review date .Administer my medications as recommended by my doctor, monitor labs as indicated A record review of Resident #10's Physician's orders dated 04/11/2024 revealed resident #10 was prescribed insulin lispro twice a day, at 07:30 AM and at 05:00 PM, per a sliding scale according to Resident #10s blood sugar measurements prior to administration of the insulin. The sliding scale was prescribed as: if the blood sugar measurement is 0 - 179 then give 0 units; 180 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 999 = 10 units. A record review of the insulin lispro injection pen manufacturers website , https://uspl.lilly.com/humalog/humalog.html#ug1, accessed 04/11/2024, revealed, .Preparing your Pen; Wash your hands with soap and water .Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen. An observation on 04/10/2024 at 03:54 PM of the facility's B-Hall nurses medication cart revealed an insulin lispro injection pen for Resident #10. The injection pen had a handwritten label date opened: 3-5-24 (LVN A initials). A record review of the calendar revealed the insulin injection pen would have become expired on the 28th day from 03/05/2024 on 04/03/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #10's April 2024 medication administration record dated 04/11/2024 revealed resident #10 could have been administered insulin lispro 17 times from 04/03/2024 to 04/11/2024 and was administered expired insulin lispro 11 times as follows : 1. On 03/03/2024 LVN A administered 6 units of expired insulin lispro to Resident #10 at 05:00 PM. 2. On 03/04/2024 LVN B administered 2 units of expired insulin lispro to Resident #10 at 07:30 AM. 3. On 03/04/2024 LVN A administered 6 units of expired insulin lispro to Resident #10 at 05:00 PM. 4. On 03/05/2024 LVN B administered 2 units of expired insulin lispro to Resident #10 at 07:30 AM. 5. On 03/05/2024 LVN C administered 6 units of expired insulin lispro to Resident #10 at 05:00 PM. 6. On 03/06/2024 LVN A administered 4 units of expired insulin lispro to Resident #10 at 05:00 PM. 7. On 03/07/2024 LVN D administered 4 units of expired insulin lispro to Resident #10 at 07:30 AM. 8. On 03/07/2024 LVN DB1 Administered 4 units of expired insulin lispro to Resident #10 at 05:00 PM 9. On 03/08/2024 LVN C administered 8 units of expired insulin lispro to Resident #10 at 05:00 PM. 10. On 03/09/2024 LVN A administered 8 units of expired insulin lispro to Resident #10 at 05:00 PM. 11. On 03/10/2024 LVN A Administered 6 units of expired insulin lispro to Resident #10 at 05:00 PM. During an interview on 04/10/2024 at 03:56 PM LVN A stated the insulin lispro injection pen belonged to Resident #10. LVN A stated the insulin pen was labeled with the date the pen was removed from refrigeration and placed into service, 03/05/2024. LVN A stated the insulin injection pen had a shelf life of 28 days outside of refrigeration and after 28 days the pen should be discarded. LVN A stated she reviewed a calendar and assessed the insulin pen as 9 days past the expiration date. LVN A stated she would removed the insulin pen from the medication cart and discard the insulin pen. LVN A stated when the pen was in the medication cart it was available for administration and should have been discarded 28 days after being removed from refrigeration. LVN A stated she may have administered the expired insulin to Resident #10 and the potential risk for resident #10 receiving expired insulin was high blood sugar. During an interview on 04/12/2024 at 1:00 PM the DON stated the expectation for nurses removing insulin pens from refrigeration was to label the injection pen with the date when the pen was removed from refrigeration and the date for when the insulin injection pen would expire and discarded. The DON stated for insulin lispro the manufacturer recommended the insulin pen be discarded after 28 days without refrigeration. The DON stated the insulin pen should have been discarded after 28 days. The DON stated a record review of Resident #10's April 2024 medication administration record revealed LVN A, LVN B, LVN C, and LVN D had documented they administered the insulin injection for resident #10 while there being only 1 injection pen, and expired injection pen for Resident #10, available on the cart. The DON stated the risk for residents receiving expired insulin was residents may not receive the intended therapeutic effects of their prescribed medications. (continued on next page)

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	675677	A. Building B. Wing	04/12/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/11/2024 at 01:20 PM the Administrator stated she was not a clinician and referred to the DON's supervision and agreed with the DON residents should not receive expired medications and could be at risk for potentially receiving expired medications. A record review of the facility's Pharmacy Services: Provision of Medications and Biologicals policy, dated November 2023, revealed, .Labeling of medications and biologicals. Medications and biologicals are labeled in accordance with currently accepted professional standards and with local and state drug labeling regulations. Even though the pharmacy is responsible for labeling medications and biologicals, the community is responsible for ensuring that labeling requirements are being met. The critical elements of the drug label include: .expiration dates

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	675677	A. Building B. Wing	04/12/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable, for 1 of 8 residents (Resident #10) reviewed for drug labeling. The facility failed to remove Resident #10's expired insulin lispro injection pen from the medication cart. This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: A record review of r esident #10's admission record, dated 04/11/2024, revealed an admitted [DATE] with diagnoses which included type 2 diabetes (the body either doesn't produce enough insulin, a hormone that regulates blood sugar, or doesn't use it effectively. This leads to elevated blood sugar levels.) A record review of resident #10's annual MDS assessment, dated 02/07/2024, revealed resident #10 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A record review of resident #10's Care Plan dated 04/11/2024, revealed, I have diabetes and take insulin .I will not experience complications associated with my diabetes through the next review date .Administer my medications as recommended by my doctor, monitor labs as indicated A record review of Resident #10's Physician's orders dated 04/11/2024 revealed resident #10 was prescribed insulin lispro twice a day, at 07:30 AM and at 05:00 PM, per a sliding scale according to Resident #10s blood sugar measurements prior to administration of the insulin. A record review of the insulin lispro injection pen manufacturers website, https://uspl.lilly.com/humalog/humalog.html#ug1, accessed 04/11/2024, revealed, .Preparing your Pen; Wash your hands with soap and water .Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen. An observation on 04/10/2024 at 03:54 PM of the facility's B-Hall nurses medication cart revealed an insulin lispro injection pen for Resident #10. The injection pen had a handwritten label date opened: 3-5-24 (LVN A initials). (continued on next page)

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	675677	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2024 at 03:56 PM LVN A stated the insulin lispro injection pen belonged to Resident #10. LVN A stated the insulin pen was labeled with the date the pen was removed from refrigeration and placed into service, 03/05/2024. LVN A stated the insulin injection pen had a shelf life of 28 days outside of refrigeration and after 28 days the pen should be discarded. LVN A stated reviewed a calendar and assessed the insulin pen as being 36 days out of refrigeration and 8 days past the expiration date. LVN A stated she would remove the insulin pen from the medication cart and discard the insulin pen. LVN A stated when the pen was in the medication cart it was available for administration and should have been discarded 28 days after being removed from refrigeration. LVN A stated the potential risk for resident #10 receiving expired insulin was high blood sugar . During an interview on 04/12/2024 at 1:00 PM the DON stated the expectation for nurses removing insulin pens from refrigeration was to label the injection pen with the date when the pen was removed from refrigeration and the date for when the insulin injection pen would expire and discarded. The DON stated for insulin lispro the manufacturer recommended the insulin pen should be discarded after 28 days without refrigeration. The DON stated the insulin pen should have been discarded after 28 days. The DON stated the risk for residents receiving expired insulin was residents may not receive the intended therapeutic effects of their prescribed medications . During an interview on 04/11/2024 at 01:20 PM the Administrator stated she was not a clinician and referred to the DON's supervision and agreed with the DON residents should not receive expired medications and could be at risk for potentially receiving expired medications. A record review of the facility's Pharmacy Services: Provision of Medications and Biologicals policy, dated November 2023, revealed, .Labeling of medications and biologicals. Medications and biologicals are labeled in accordance with currently accepted professional standards and with local and state drug labeling regulations. Even though the pharmacy is responsible for labeling medications and biologicals, the community is responsible for ensuring that labeling requirements are being met. The critical elements of the drug label include: .expiration dates 47564

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675677	A. Building B. Wing	04/12/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41937 47564 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: The facility failed to maintain the cleanliness of the facility ice maker. The failure could place residents at risk for cross-contamination and foodborne illnesses. The findings included: Observation on 04/10/2024 at 5:06 PM revealed a black substance build-up within the walls of the ice maker in the kitchen storage room. Interview on 04/10/2024 at 5:06 PM, the DM stated the kitchen and maintenance staff were both responsible for cleaning the ice maker monthly . The DM stated that the substance in the ice machine appeared to be mold and could be dangerous to residents as it could make them sick. Interview on 04/12/2024 at 11:55 AM, the Administrator stated her expectation was for the ice maker to be cleaned weekly and emptied out and cleaned thoroughly monthly. The Administrator stated that the ice machine appeared dirty. The Administrator further stated that no residents had had any GI issues. Interview on 04/12/2024 at 11:57 AM, the DON stated that her expectation was for the ice machine to be clean. The DON also stated that the ice machine appeared dirty and could potentially affect residents' GI systems but that no residents had had GI issues. Record review of facility policy titled, Ice Machines, undated, revealed, The facility will maintain the ice machine, scoop and storage container in a sanitary manner to minimize the risk of food hazards. The ice machine will be cleaned once per month or more often as needed. The scoop and storage container will be cleaned once each day. Record review of US FDA Food Code, dated 2022, revealed Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as . ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. Some equipment manufacturers and industry associations, e.g., within the tea industry, develop guidelines for regular cleaning and sanitizing of equipment . and 3-304.11 Food Contact with Equipment and Utensils. FOOD shall only contact surfaces of: (A) EQUIPMENT and UTENSILS that are cleaned as specified under Part 4-6 of this Code and SANITIZED as specified under Part 4-7 of this Code; P (B) Single-service and single-use articles.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675677	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Rio Nursing and Rehabilitation Center	301 W Martin St Del Rio, TX 78840

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on interview and record review, the facility failed to provide a minimum of 80 square feet per resident in 2 of 28 multiple resident rooms as required for (Rooms #14, #21) reviewed for the 80 square feet per Resident requirement . The facility failed to ensure all resident rooms met the minimum size requirements. This deficient practice could affect residents who may reside in these rooms and not allow sufficient room to carry out activities of daily living care, or have the room furnished as they would like and place them at risk for decreased quality of life. The findings included: Record review of HHSC Form-3740, dated 4/9/2024, reflected rooms #14 and #21 were indicated as Title 18/19 beds with a total facility occupancy of 60 beds. Interview on 04/12/2024 at 11:00 AM with the Administrator revealed 2 resident Rooms (#14, #21) required a room waiver and she wanted to continue the room waiver as the size of the rooms had not changed. Review of the facility daily census dated 04/09/2024 revealed resident room [ROOM NUMBER] had no occupants, and #21 had 1 occupant.