STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675800	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Serena Nursing and Rehabilitation	711 Kings Way 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 4 residents (Resident #64) reviewed for assessments, in that: The facility failed to ensure Resident #64's Quarterly MDS assessment incorrectly documented the resident as not receiving hospice care. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings were: Record review of Resident #64's face sheet, dated 09/18/2023, revealed the resident was [AGE] years old with an admitted [DATE] and a readmitted [DATE], Resident #64's with diagnoses that included: Osteomyelitis(a serious infection of the bone that can be acute or chronic) , unspecified, Type II diabetes Mellitus with unspecified complications, End Stage Renal Disease. Record review of THHS Texas Medicaid Hospice Program Individual Election/Cancellation/Update Form 3071 revealed Resident #64 elected hospice services effective 05/14/2024. Record review of Resident #64's Quarterly MDS dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment, and resident was not receiving hospice services. During an interview with the MDS nurse on 09/18/2024 at 11:58 AM, the MDS nurse stated she had completed the MDS. The MDS nurse stated Resident #64's Quarterly MDS was coded as the resident not receiving hospice services and confirmed Resident #64 readmitted to the facility on [DATE] under Hospice. MDS nurse confirmed that MDS should have been completed as a Significant Change MDS and reflected hospice election. The MDS nurse revealed that the RAI was used as reference for the MDS and she had access electronically to the RAI on her computer. During an interview with the DON on 09/19/24 at 12:18 PM, the DON stated Resident #64 was receiving hospice services and should have been coded as receiving hospice services on a Significant Change MDS. The DON confirmed the RAI is used as reference for the MDS and expected MDS Nurse follow the RAI reference. The MDS Nurse was responsible for ensuring accurate coding and the DON was responsible to review for accuracy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19. 1, September 2024, revealed, An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains resident at the nursing home.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observations, interviews, and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 9 residents (Resident #34) reviewed for treatments and care related to enteral access devices. The facility failed to ensure medications were administered according to acceptable standards and practices related to enteral access devices when Resident #34's medications were not dissolved in water for administration with a flush between each medication administered. These failures could place residents with enteral access devices at risk of not receiving the intended therapeutic effects of medications, having medical complications, or complications related to utilization of enteral access devices, potentially leading to a decline in health and well-being. Findings included: Record review of the Admission Record revealed Resident #34 was a [AGE] year-old male, originally admitted on [DATE] . Record review of the quarterly MDS assessment dated [DATE] revealed Resident #34 had a BIMS summary score of 9, indicative of moderately impaired cognition. Resident #34's primary reason for admission was cerebral infarction, unspecified [a type of stroke caused by blood clot or hemorrhage in the brain]. Other active diagnoses included seizure disorder and malnutrition. Nutritional approaches included feeding tube, with more than 51% of calories and 501 ml or more fluid intake received thru the feeding tube per day. Record review of the Order Summary Report printed on 09/18/2024 revealed: flush enteral tube with 30 ml of water between each medication; flush enteral tube with 60 ml of water before and after medication and feedings; with a start date of 02/25/2021 Medications included: metoprolol [for high blood pressure] the a start date of 07/08/2021, aspirin [for stroke] with a start date of 01/20/2023, Keppra [for seizures] with a start date of 11/04/2022, folic acid [for supplement] with a start date of 09/08/2024, Celexa [for depression] with a start date of 04/27/2022, losartan [for high blood pressure] with a start date of 02/26/2021, multivitamin [for malnutrition], and thiamine [for supplement]] with a start date of 02/26/2021. Record review of the Care Plan revealed Resident #34 had the following focus areas: seizure disorder, high blood pressure, potential for pressure injury, potential fluid deficit, on psychotropic medication related to depression, seasonal allergies, muscle spasms, and polyneuropathy [nerve damage at multiple sites can result in chronic and acute pain]; with the following associated interventions: give medications as ordered with a date initiated of 02/25/2021. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 09/18/2024 at 7:45 AM, LVN A prepared medications for Resident #34 by individually crushing each tablet or pill and pouring liquids in separate souffle cups for administration via the enteral access device. The medications were not mixed with water to dissolve. The [NAME] tions included metoprolol tartrate 25 mg, give 0.5 tablet [given for high blood pressure]; aspirin 81 mg [given for history of stroke]; Keppra 7.5 ml solution [given for seizures]; folic acid [for supplement]; Celexa 10 mg, give 0.5 tablet [given for depression]; Losartan 25 mg [given for high blood pressure]; fexofenadine 180 mg [given for seasonal allergies]; multivitamin, and thiamine [given for supplemental nutrition. In an observation on 09/18/2024 beginning at 7:55 AM, LVN A assessed the placement of the enteral access device for Resident #34 by aspiration with no fluids returned. LVN A flushed the enteral access device with 60 ml of water. When the water level got to near the bottom of the syringe, approximately 1 to 3 ml of water, LVN A then added the powder of the first crushed medication to the syringe, then added the 30 ml of water flush to the syringe. As the water and medication mixture then drained into the enteral access device, LVN A then added the powder from the next crushed medication to the last 1 to 3 ml mixture of water and previous medications to the syringe, adding the 30 ml flush of water after. Powder residue could be observed at the top of the 60 ml syringe, and at one point a brownish-beige frothy particulate could be seen coating the walls of the barrel of the syringe. LVN A swirled the syringe while attached to the enteral access device to have all the solid matter trapped by water and drain down the syringe into the enteral access device. After each medication was added to the dregs of the liquid in the barrel, LVN A added 30 ml water, including when she administered the liquid Keppra solution. After the last medication was administered LVN A flushed the syringe with 60 ml of water, clamped the enteral access device, capped the distal end of the enteral access device, and replaced the tube under Resident #34's shirt. In an interview on 9/18/2024 at 8:00 AM, Resident #34 stated he did not want breakfast and declined the supplement. Resident #34 stated he would see what was on the breakfast tray when it arrived, and he would decide then if he was hungry enough to eat. In an interview on 9/18/2024 at 8:03 AM, LVN A stated that either method, mixing the powder of a crushed medication in a few ml of water to dissolve or adding it directly to the syringe, would be correct. LVN A stated that adding the powder of a crushed medication directly to the syringe is how she almost always administered medication to an enteral access device, unless there were specific orders to do it differently. In an interview on 9/18/2024 at 8:40 AM, the DON stated she believed an enteral medication could be added directly to the syringe once crushed as long as there was still some liquid at the bottom of the syringe, and then immediately added the flush as per MD orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/18/2024 at 11:35 AM, R.Ph. stated that the order of operations for an enteral tube medication administration should be: 1.) check tube placement first [aspiration of fluids from the enteral access device to visually inspect color and character]; 2.) ensure patency [being unclogged, allowing flow] with a flush in the amount of water as ordered by the MD; 3.) crush each suitable tablet or pill into its own souffle cup with 10 to 15 ml of water; 4.) allow each medication to flow by gravity; 5.) after each medication flush in the amount of water as ordered by the MD; 6.) repeat as necessary and after the last medication flush in the amount of water as ordered by the MD. R.Ph. stated the initial and final flushes at the beginning and end of a medication administration were usually slightly larger, but depended on the amount the MD determined was appropriate. R.Ph. stated the frothy brownish beige particulate was most likely not a reaction between medications, but more likely the inert ingredients coming in contact with air, water and turbulence. R. Ph. stated she would have to review the resident's profile to give more specific details. R.Ph. stated she would call me back in about an hour as she was driving and en route to another facility at the time of the interview. In an interview on 9/18/2024 at 12:26 PM, the MD stated Resident #34 had originally been admitted for stroke some time back, but recently exhibited stroke like symptoms. The MD stated Resident #34's diagnostics came back as negative for a stroke; however, he had more difficulty with speech and swallowing after the stroke like symptoms were noted; which was why Resident #34 had an enteral access device placed. The MD stated he was not sure if the resident was quite at the point where he could take his medications by mouth, crushed in a puree at this point, but that was something therapy was working towards with him. The MD stated he did not believe there was much of a risk in the small amount of medications being mixed in the syringe as described in the observation above. The MD stated there would be some expectation of medication residual in the souffle cup if the medication had been dissolved in water that would approximate the amount of medication observed at the top of the syringe as described in the observation above. The MD stated his expectation was that the crushed medications be dissolved in a small amount of water and flushed as per orders. MD stated that he would consult with the pharmacist for best practice on this issue in regard to Resident #34. In an interview on 9/18/2024 at 2:37 PM, R.Ph. stated that she had reviewed the medication profile for Resident #34, and she did not see any medications that would have an adverse reaction if administered in the fashion as described in the observation above. R.Ph. stated that the best practice would be to place a medication in pill or tablet form in a syringe with 15 to 30 ml of water and allow it to become a slurry [semiliquid mixture of denser solids suspended in liquid] over approximately 20 minutes. Alternatively, medications could be dissolved in a small amount of water for administration via an enteral access device and followed with a prescribed amount of water to ensure the medication reaches the resident and does not interfere with the patency of the enteral access device. Record review of the facility's policy entitled Enteral Medication Administration, revised 1/25/2013, reflected the following procedure: flush the tube with 30 ml or according to physician order; administer one medication at a time, with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the medication is administered; verify that the medication cups are clear of any remnants of crushed pills or liquid medication; once all medications have been administered flush the tube with 30 ml of water or according to the physician order. (continued on next page)

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