STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675942	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towers Nursing Home	372 Hill Road Smithville, TX 78957

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interviews and record review, the facility failed to ensure residents were free of any significant medication errors for one (Resident #1) of four residents reviewed for medication errors. The facility failed to ensure Resident #1's glucose was monitored, and insulin was administered regularly from 07/21/24 - 08/02/24. She was sent to theER on [DATE] with a glucose level of 649 and a diagnosis of DKA. The noncompliance was identified as PNC. The IJ began on 08/02/24 and ended on 08/09/24. The facility had corrected the noncompliance before the survey began. This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, worsening or exacerbation of chronic medical conditions, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end-stage renal disease , dependence on renal dialysis, type I diabetes, long-term (current) use of insulin, and history of DKA (a serious complication of diabetes that happens when the body does not have enough insulin, causing the body to break down fat for energy). Review of Resident #1's admission MDS assessment, dated 07/22/24, reflected a BIMS score of 12, indicating a moderate cognitive impairment. Section N (Medications) reflected she received insulin injections. Section O (Special Treatments, Procedures, and Programs) reflected she required dialysis. Review of Resident #1's admission care plan, dated 07/17/24, reflected she had chronic renal failure related to end-stage renal disease with an intervention of monitoring vital signs as ordered or as needed and monitoring for changes in mental status. Review of Resident #1's physician order, dated 07/17/24, reflected Insulin Glargine Subcutaneous Solution Pen-Injector - 100 unit/ML - Inject 8 unit subcutaneously one time a day (9:00 AM) for diabetes. (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's MAR, July 2024, reflected she was not administered the Insulin Glargine Solution on 07/25/24, 07/29/24, and 07/30/24. Review of Resident #1's MAR, August 2024, reflected she was not administered the Insulin Glargine Solution on 08/02/24. Review of Resident #1's physician order, dated 07/21/24, reflected Insulin Lispro Injection Solution - Inject as per sliding scale: If 71 - 149 = 0 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; Greater than 399 = 12 units and notify Provider Three times a day for Diabetes before meals Review of Resident #1's MAR, July 2024, reflected her BS was not checked and she was not administered the Insulin Lispro Injection on 07/25/24 (11:00 AM and 4:00 PM), 07/26/254 (4:00 PM), 07/29/24 (7:00 AM and 4:00 PM), and 07/30/24 (11:00 AM and 4:00 PM). Review of Resident #1's MAR, August 2024, reflected her BS was not checked and she was not administered the Insulin Lispro Injection 08/02/24 (7:00 AM). Review of Resident #1's Change of Condition Communication form, dated 08/02/24, reflected the following: Signs/Symptoms: high blood sugar greater than 300, low blood pressure, change in mental status .increased confusion . slurred speech . decreased appetite. Review of Resident #1's progress notes, dated 08/02/24 at 1:15 PM and documented by LVN B, reflected the following: At 11:45 (AM) [Resident #1]'s [FM D] called inquiring about [Resident #1]. Stated her blood sugars were elevated, didn't feel good and was not going to dialysis. Shortly after the phone call, [LVN A] came and informed me that [Resident #1]'s BS was high . I notified the NP which was present in the facility. 12:10 PM - NP gave an order to administer 12 units of insulin, hydrate with water, and to recheck in 30 minutes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/20/24 at 11:24 AM, LVN B stated Resident #1's FM D had called the nurses station on 08/02/24 around 12:00 PM. She stated FM D was upset because Resident #1 did not feel well and did not want to go to dialysis. She stated she located LVN A who told her the glucometer was reading high when she tested Resident #1's blood sugar. She stated the glucometer stops reading blood sugar levels when they are above 500. She stated she asked LVN A what her levels were that morning and LVN A stated, I did not do them. She stated she asked her why she had not checked her blood sugar, but LVN A had no answer for her. She stated missing doses of insulin repeatedly could lead to DKA. She stated it was hard to say if the missing dose of insulin on 08/02/24 was what caused Resident #1 to go into DKA, but she did have a history of it, so it was likely. She stated the importance of checking blood sugar levels and not missing insulin doses was to avoid situations like that one. She stated it was important when someone's body was not producing insulin that insulin gets administered. She stated the nurses were recently in-serviced on glucometer checks and administering insulin. During an interview on 08/20/24 at 11:55 AM, LVN C stated she worked with Resident #1 and had heard about her requiring hospitalization for DKA. She stated Resident #1 was a type I diabetic which made it more imperative that her blood sugar levels were checked regularly, and no doses of her insulin were missed. She stated with type I diabetics, they were unable to produce insulin, so no matter what they ate, the sugar levels would always spike high. She stated it was a life-or-death situation and missed doses could lead to coma, DKA, or death, especially for someone like Resident #1 who had a history of DKA. She stated the nurses had recently been in-serviced on accuchecks and insulin administration. During an interview on 08/20/24 at 1:14 PM, the NP stated when the nursing staff alerted her on 08/02/24 that Resident #1's blood sugar was reading high, she ordered 12 units of insulin, asked them to push fluids, and to re-check her levels in an hour. She stated when it was still high, she gave orders for more insulin. She stated that along with Resident #1's comorbidities and her being altered for her baseline, she made the decision to send her to the hospital at that time. She stated that there were multiple risk factors for DKA and did not believe missing the insulin doses was what caused her to go into DKA. During an interview on 08/20/24 at 1:37 PM, the MD stated if a resident was missing multiple doses of insulin, it would concern him as it could cause blood sugar to be unstable. He stated Resident #1's blood sugar was controlled until that day (08/02/24), so he would not say the missed dose that morning was what had caused DKA. He stated individuals with type I diabetes go into DKA a lot. During an interview on 08/20/24 at 4:15 PM, LVN E stated the nursing staff had recently been provided in-serviced on accuchecks, insulin, following physician orders, and administering medications timely. She stated they also did check-offs with the DON. She stated it was important for insulin to get administered as ordered because it could lead to coma or death. During an inteview on 08/20/24 at 4:33 PM, the Interim DON stated she reviewed a report of missed medications the prior day that was generated by their EMR system every morning to investigate the reasoning for the missed doses. On 08/20/24, several attempts were made to contact LVN A. A returned call was not received prior to exiting . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's QAPI Meeting Agenda, dated 08/02/24, reflected the ADM, the DON, the MD, the ADON, and the RNRCS were in attendance to discuss diabetics, accuchecks, physician orders, changes in condition, and medication administration. Review of the DON an LVN A's termination documents, dated 08/04/24, reflected both were terminated. Review of a statement, dated 08/02/24 and documented by the ADM, reflected the following: [Pharmacist] consultant was notified via phone by the Administrator regarding the medication error that occurred on 08/02/24. Administrator request a pharmacist visit to review all resident in facility with orders for accuchecks and or insulin orders/antidiabetic medications. Visit was scheduled for 08/09/24. Review of an audit conducted by the Pharmacist, dated 08/09/24, reflected no recommendations were made. Review of an audit conducted by the DON/clinical team, dated 08/02/24, reflected no residents with orders for accuchecks and insulin had been affected and had been receiving treatments according to physician orders. Review of in-services entitled AccuChecks/Medication Administration, from 08/02/24 - 08/06/24 and conducted by the DON and ADON, reflected all nurses were in-serviced on timely accuchecks and medication administration: Importance of Timely Accuchecks and Medication Administration - Resident Safety: Consistent and timely blood glucose checks and medication administration are vital to managing chronic conditions like diabetes, preventing adverse events such as hypo- or hyperglycemia. - Compliance with Physician Orders: Adherence to prescribed schedules ensures that residents receive their treatments as intended by their healthcare providers. - Legal and Regulatory Compliance: Accurate and timely documentation is necessary to meeting regulatory requires and avoid potential legal liabilities. Review of in-services entitled Accu Checks/Medication Administration, from 08/02/24 - 08/03/24 and conducted by the DON and the ADON, reflected all nurses were in-serviced on timely accuchecks and medication administration. Review of in-services entitled Medication Administration, from 08/02/24 - 08/06/24 and conducted by the DON and the ADON, reflected all nurses were in-serviced on their Medication Administration Policy. Review of the facility's Medication Administration Policy, dated 10/01/19, reflected the following: Medications are administered as prescribed in accordance with good nursing principles and practices only by persons legally authorized to do so. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Medication Pass and Obtaining Blood Sugar Readings checkoffs, dated 08/02/24 - 08/07/24, reflected all nurses and medication aides completed competency checkoffs with no concerns. The noncompliance was identified as PNC. The IJ began on 08/02/24 and ended on 08/09/24. The facility had corrected the noncompliance before the survey began.