

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 W. Slaughter Lane Austin, TX 78748	
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** 42600 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administering of all routine and emergency drugs and biologicals for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure that Resident #1's hospital discharge orders were followed to prevent rehospitalization due to hypoglycemia. 1. The facility failed to discontinue Resident #1's metformin and glyburide medications. 2. The facility failed to implement blood sugar monitoring for Resident #1. 3. The facility failed to start Resident #1 on the appetite stimulant (Mirtazapine) as ordered. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 02/10/2025 at 5:06 PM and an IJ template was given. While the IJ was removed on 02/11/2025 at 3:45 PM, the facility remained out of compliance at no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of exacerbation and/or deterioration of their health conditions which could result in rehospitalization and/or death. Review of Resident #1's face sheet reflected a [AGE] year-old woman readmitted on [DATE] with initial admitted [DATE] with diagnoses of end stage renal disease (a medical condition where the kidneys have permanently lost their ability to function adequately), type 2 diabetes mellitus with unspecified complications (a diagnosis of type 2 diabetes where the specific complications are not detailed or identified), dysphagia (difficulty swallowing), dependence on renal dialysis (a condition where a person's kidneys have permanently lost their ability to adequately filter waste products from the blood, requiring regular treatments to remove these toxins and maintain life), cognitive communication deficit (a difficulty with communication caused by an impairment in cognitive processes), and other speech and language deficits following cerebral infarction (a range of communication impairments that can occur after a stroke). Review of Resident #1 MDS assessment dated [DATE] reflected a BIMS score of 13 and had an active diagnosis of diabetes mellitus. (continued on next page)		

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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1 active orders as of 1/27/2025 reflected resident had order for hemodialysis three times a week with an order date of 01/17/2025. Further review reflected an order for glyburide one time a day for diabetes mellitus and metformin tablet two times a day for diabetes mellitus with a start date of 01/17/2025. Review of Resident #1 progress note dated 01/22/2025 by the DON reflected dialysis center called to notify facility Resident #1 was sent to ER after treatment due to lower blood sugar of 27. Review of Resident #1 progress note dated 01/23/2025 by LVN A reflected Resident #1 returned to facility via ambulance. Progress note reflected Resident has no medications changes, no wounds. Review of Resident #1 progress note dated 01/25/2025 by RN B reflected Resident #1 refused to eat lunch and breakfast, and blood sugar obtained at 112 with no signs or symptoms of hypo/hyperglycemia. Review of Resident #1 hospital discharge instructions with date of 01/23/2025 reflected special instructions to follow up hospitalization for hypoglycemia (condition where the blood glucose level falls below normal) after discharge to SNF. Additional instructions reflected all diabetes medications now discontinued. Monitor blood sugar. Patient started on appetite stimulant. Discharge instructions included discharge medications which reflected metformin and glyburide were not included and mirtazapine was started on 01/22/2025. Review of Resident #1 orders active as of 01/27/2025 reflected no order for blood glucose checks or orders for appetite stimulant. Review of Resident #1 active orders at of 02/10/2025 reflected blood sugar checks before meals and at bedtime with a start date of 02/04/2025 and mirtazapine (appetite stimulant) by mouth at bedtime with a start date of 02/04/2025. Review of Resident #1 MAR reflected glyburide was administered on 1/24/2025, 01/25/2025 and 01/26/2025. Further review reflected metformin was administered once on 01/23/2025, twice on 01/24/2025, and twice on 01/26/2025. Review of Resident #1 change of condition evaluation dated 01/27/2025 reflected Resident #1 displayed altered mental status, abnormal vitals signs and signs of stroke. Resident #1 had a resting heart rate of 48 and blood glucose of 24 mg/dL. Review reflected change of condition was reported to the NP recommended to administer glucagon. Review of Resident #1's hospital notes dated 01/27/2025 reflected Resident #1's metformin and glyburide were discontinued and she was discharged back to the facility. Review reflected that, Resident #1 was found minimally responsive and blood sugar was 24 and did not improve after doses of glucagon. Review of hospital notes also reflected, Resident #1 had continued to receive metformin and glyburide. Review reflected Resident presented back with hypoglycemia, severe lactic acidosis and hyperkalemia. Further review reflected Resident #1 was seen in ICU. (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 Resident #1 hospital notes dated 02/01/2025 with admitted [DATE] reflected Resident #1 was readmitted to hospital on 01/22/2025 with hypoglycemia which was corrected, and she was stopped on metformin and glyburide. Resident #1 was readmitted on [DATE] with hypoglycemia as she was restarted on her metformin and glyburide at the SNF. Further review reflected lactic acidosis (condition where the body builds up too much lactic acid) was felt secondary to metformin. During an interview on 02/10/2025 at 1:24 PM, RN C stated that he was familiar with Resident #1. RN C stated Resident #1 could be forgetful and may not recall everything. RN C stated that Resident #1 does get her blood sugar taken and that the nurse is responsible for taking blood sugar. He stated that her blood sugar that morning (02/10/2025) was 100 and that was within normal range. RN C stated that when residents get readmitted, the facility received a medication list from the hospital, and they call the medications into the on-call service to [NAME] the orders with the NP or MD or if the NP is in the facility, they could review it then. RN C stated if an order was discontinued, a resident should not have received the medication unless it was approved by the NP. RN C stated that the harm of receiving a discontinued medication depended on the type of medication that was received, and that if glyburide or metformin was given, it may lower the resident's blood sugar and could cause hypoglycemia. During a telephonic interview on 02/10/2025 at 1:55 PM, RN D stated she was familiar with Resident #1. RN D stated she was aware that Resident #1 went to the hospital two times, and she was the nurse that sent Resident #1 to the hospital the second time. RN D stated that she could not recall the date that Resident #1 went to the hospital. RN D stated that Resident #1 was unresponsive, and her blood sugar was really low. RN D stated she followed protocol and gave Resident #1 a shot of glucagon IM. RN D stated that she waited with Resident #1 for 15-20 minutes and when Resident #1's blood sugar did not go up, she called 911. RN D stated that when Resident #1 was being evaluated by EMS, her face started to droop. RN D stated that when a resident returns from the hospital, the facility received discharge orders and then they are verified with the NP. RN D stated that NP would clarify whether or not to keep or discontinue the medication. RN D stated she was not sure if Resident #1 received medication that was discontinued. RN D stated that there is not anyone else that verified orders received from the hospital. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephonic interview on 02/10/2025 at 2:11 PM, LVN A stated she was familiar with Resident #1. LVN A stated she readmitted Resident #1 on 01/23/2025. LVN A stated she could not recall if there were any medication changes for Resident #1. LVN A stated that at one point Resident #1 came back to the facility from the hospital and did not have any paperwork. LVN A stated she remembered she tried calling the hospital, and was left on hold and the line got disconnected. LVN A stated she went through some of Resident #1's paperwork in her room and looked for medication changes. LVN A stated she asked Resident #1 if they made any changes at the hospital and Resident #1 answered there were no changes. LVN A clarified that Resident #1 did not come back with any paperwork and EMS did not provide LVN A with any paperwork. LVN A stated that normally EMS gave her paperwork. LVN A stated that she asked EMS if there were any changes, and she was told no. LVN A stated she looked and found an envelope in Resident #1's closet and looked through it and did not see that there were any medication changes compared to the list the facility had. LVN A stated she did not recall the title of the paperwork because there were a lot of residents and a lot of things going on. LVN A stated, normally, the facility received paperwork from the paramedics and they would get a brief report and check a medication list that was brought in. LVN A stated that she would then call on-call and let them know a resident was readmitted and would provide medication names and doses. She stated if there were a discrepancy, she would call the hospital and get clarification. LVN A stated that Resident #1 could be forgetful. LVN A stated she left the paperwork with Resident #1 and did not take it with her. LVN A stated that she looked through Resident #1's paperwork because she could be forgetful and she wanted to double check if there were any changes. During an interview on 02/10/2025 at 2:47 PM, the NP stated she was a little familiar with Resident #1 as she was usually out to dialysis. NP stated she received something that there were no changes with Resident #1's medication and that the hospital did not send paperwork back and she resumed her medications. NP stated that Resident #1 then went out to the hospital again and they caught that there was an order to discontinue medication and that they were not discontinued. NP stated she saw Resident #1 when she admitted. NP stated she did not see Resident #1 when she returned from the hospital because she was not at the facility on Fridays and Resident #1 returned on 1/23/2025. NP stated if a resident returns during business hours staff will call her and let her know and they would review the medications. NP stated if a resident return in the evening, the facility staff would have called the on-call person and reviewed medications to the on-call staff. NP stated if a resident returned without a medication list or discharge instructions, she could usually call the doctor because he works at the hospital as well and get the doctor to send the medications. NP stated when she received a call about a resident that was readmitted to the facility, she would ask the facility staff if there were changes to previous medications and the nurse would clarify to resume or not. NP stated she would normally check the resident's admission the following day. NP stated she missed seeing Resident #1 because Resident #1 was either at dialysis or in the hospital. NP stated that Resident #1 was not a good historian and she did have some cognitive deficits. NP stated that glyburide and metformin were long-acting diabetic pills and were meant to lower blood sugar. She stated that if a resident was on an oral medication to control blood sugar, then blood sugar was not checked. NP stated it may be checked the first few days to get a trend and from there it would be checked every three months or if the Resident was symptomatic. NP stated that if Resident #1 was not eating, and with dialysis filtering her blood, it could contribute to her blood sugar lowering. NP stated that she was notified that the facility did not receive paperwork from the hospital and NP was not going to stop all medications just because the paperwork was not received. NP stated that normally, the following day, she would see the resident and reconcile medications, but she was not at the facility on 1/24/2025, and the MD saw her and they are unable to see a resident on the same day. (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 2/10/2025 at 3:12 PM, RN E stated that Resident #1 was sent out from dialysis on 1/22/2025 due to low blood sugar. She stated Resident #1 was sent around 11:13 AM. RN E stated her blood sugar was 42 and did not increase after she was provided glucose gel. During an interview on 2/10/2025 at 3:35 PM, the ED stated that the admission assessment packet was the policy used for readmissions and medication reconciliation during readmissions. During an interview on 2/10/2025 at 3:36 PM, the DON stated the facility was not aware when Resident #1 returned without paperwork from the hospital. She stated LVN A said whoever brought Resident #1 back to the facility stated there were no changes to her medication, and Resident #1 stated she had no paperwork. DON stated LVN A tried to call the hospital because the hospital did not call for report. DON stated after Resident #1 was readmitted, the doctor called and said the medications should have been discontinued. DON stated she spoke with LVN A, and LVN A stated there was no paperwork. DON stated if a resident returned from the hospital with no paperwork, the nurse was supposed to call the ER and try to get a medication list. DON stated LVN A tried to get ahold of the hospital, but she was not able to get through. DON stated that Resident #1 was alert and oriented, and she said there were no changes. DON stated that it was the facility's responsibility to ensure there were no changes. DON stated she would have expected LVN A to document her attempts to try and get the medication list from the hospital, and any information she received that there were no changes. DON stated LVN A took EMS' word because nothing was sent with Resident #1 and assumed nothing had changed. DON stated Resident #1 went out to the hospital again on 1/27/2025 because her blood sugar had dropped again, and the nurse thought she was having a stroke because her heart rate was high and other symptoms. DON stated, initially, Resident #1 went to the hospital from dialysis. DON stated the admission packet was used for new admissions and readmissions after a 72-hour hospital stay. During an interview on 2/10/2025 at 3:51 PM, Resident #1 stated she had returned from dialysis and stated she was tired. Resident #1 stated she had been to the hospital a few times because her blood glucose dropped. Resident #1 stated when that happened, she felt dizzy. Resident #1 was unable to remember if she had paperwork when she returned from the hospital or the nurse that was working. Review of undated admission assessment packet reflected no guidance on medication reconciliation. Review of the facility's policy titled Medication Administration dated June 2022 reflected it is the policy of this facility that medications shall be administered as prescribed by the attending physician. The ED and DON were notified on 2/10/2025 at 5:00 PM that an IJ had been identified. An IJ template was provided and a POR was required. The following POR was approved on 02/11/2025 at 1:09 PM and indicated: Immediate Plan of Removal The facility submits this Plan of Removal to address the Immediate Jeopardy identified, on 2/10/2025. Identification of Others Affected by Alleged Deficient Practice: (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All admissions and re-admissions have the potential to be affected by this alleged deficient practice. Summary: On 2/10/2025 an abbreviated survey was initiated at [facility]. On 2/10/2025 the surveyor provided an Immediate Jeopardy (IJ) that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy (IJ) states as follows: F755- The facility failed to ensure pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals. The facility failed to ensure that Resident #1's hospital discharge orders were followed to prevent rehospitalization due to hypoglycemia. Action: Medical Director notification Start Date: 2/10/25 Completion Date: 2/10/25 Responsible: Executive Director Action: Audit all admissions/readmissions from 1/23/25 to present to ensure all medications were correctly verified. Start Date: 2/10/25 Completion Date: 2/10/25 Responsible: DON/Designee/Clinical Resource Action: Inservice DON on admission requirements to verify orders. If the sending facility (hospital, SNF, etc.) does not provide discharge summaries or orders: a. The admitting nurse will call the hospital and/or facility resident is returning from to obtain discharge orders. b. In the event orders are unable to be obtained, the NP/DON/ADON/MD will be notified by the admitting nurse to assist in retrieving discharge summaries/orders. c. These steps will remain in the permanent admission/readmission protocol. Start Date: 2/10/25 Completion Date: 2/10/25 Responsible: Clinical Resource (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Action: Inservice Nursing and Nursing Leadership staff on admission requirements to verify orders. If the sending facility (hospital, SNF, etc.) does not provide discharge summaries or orders: a. The admitting nurse will call the hospital and/or facility resident is returning from to obtain discharge orders. b. In the event orders are unable to be obtained, the NP/DON/ADON/MD will be notified by the admitting nurse to assist in retrieving discharge summaries/orders. c. These steps will remain in the permanent admission/readmission protocol. Start Date: 2/10/25 Completion Date: 2/11/25 Responsible: DON/Designee Action: Ad hoc QA1 meeting. Attendees will include ED, DON, Clinical Resource, Cluster Partners, Medical Director. Meeting will include the Plan of Removal and inventions. Start Date: 2/10/25 Completion Date: 2/10/25 Responsible: Executive Director Action: Admissions Coordinator inservice on notification of pharmacy consultant of all admissions/readmissions for medication review. Start Date: 2/11/25 Completion Date: 2/11/25 Responsible: DON Systemic Change to Prevent Re-Occurrence: DON/Designee will ensure admitting nursing staff verify admission/readmission orders. If the sending facility (hospital, SNF, etc.) does not provide discharge summaries or orders: d. The admitting nurse will call the hospital and/or facility resident is returning from to obtain discharge orders. e. In the event orders are unable to be obtained, the NP/DON/ADON/MD will be notified by the admitting nurse to assist in retrieving discharge summaries/orders. f. These steps will remain in the permanent admission/readmission protocol. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring to Ensure Ongoing Compliance: DON/ Designee will audit order listing report daily to include admissions and readmissions. Will include trends of verification of orders upon admissions during QAPI meeting x 90 days. Surveyor monitored the POR on 2/11/2025 as followed: Review of the facility's in-service training report dated 02/10/2025 and titled admission process verification of medication on admission and readmission reflected it was provided to the DON by Clinical resource. Review of facility in-service titled notification of pharmacy consultant of all admission and readmission for medication review dated 02/11/2025 reflected in-service was provided to admission coordinator. Review of facility in-service dated 02/10/2025 titled Admission/Verification of Meds reflected it was completed with 25 nurses. Review reflected any admission will have medication verification against discharge orders. If a resident did not bring orders, hospital needed to be called and attempts needed to be made to get orders. If unable to do so, documentation needed to be noted in the resident's charge. Notification to DON/ADON/NP was to be made to attempt to get discharge orders and staff should pass along on the 24-hour report. Review of admission medication orders audit for admissions on 1/23/2025 included 23 residents. No discrepancies were listed. Review of QAPI sign-in sheet dated 02/10/2025 reflected a meeting was conducted and included the ADM, DON, NP, and Medical Director. During interviews on 02/11/2025 between 2:27 PM and 3:30 PM, with 2 RNs and 4 LVNs, it was revealed that staff received an in-service either 2/10/2025 or prior to their shift on 2/11/2025 by the DON or Clinical resource. Staff stated that the in-service included to ensure orders were received for any new admission and if the resident did not come with paperwork then the staff should try to contact the hospital and if they are unable to get through then they should notify the DON/ADON. Staff stated this information should be written on the 24-hour report and document all that was done and who was notified in management and attempts made to get the orders. Staff stated the NP should also be called and notified that a patient was sent with no orders. Staff stated if a resident was still at the hospital at midnight then they would be considered a new admission and all orders should have been discontinued and all new orders would be put in as if they were a new patient. Staff stated that if a resident was sent out with low blood sugar, they would want to check the resident's blood sugar when they returned and may ask the NP if they wanted to initial blood sugar checks and felt that was standard nursing care. (continued on next page)		

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