STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676184	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Park Rehabilitation and Skilled Nursing	5505 New Copeland Rd Tyler, TX 75703

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1of 6 residents (Resident #1) reviewed for significant medication errors. The facility did not provide Resident #1's physician ordered Trulicity Subcutaneous Solution Pen-injector (for diabetes) weekly, and this resulted in Resident #1 missing two dosages on Thursday 1/15/26 and Thursday 1/22/26. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications.Findings included: Record review of an undated Face sheet printed on 6/14/26 indicated Resident #1 was a [AGE] year-old female who admitted on [DATE]. Record review of the discharge instructions dated 1/21/26 and completed by LVN D on 1/24/26 indicated Resident #1 was discharged home on 1/24/26. Documentation reflected a medication review was completed with Resident #1 and the medications were sent with Resident #1 upon discharge. Records further identified Resident #1 was her own responsible party. Resident #1 signed the discharge instructions, acknowledging receipt and review of the discharge information. Review of the attached medication list, which reflected Resident #1's active physician orders at the time of discharge, revealed LVN D handwritten notation of 1 pen next to the Trulicity order. This notation indicated Resident #1 was discharged with one Trulicity pen. Record review of an undated diagnosis report printed on 6/15/26 indicated Resident #1 diagnosis included Type 2 diabetes (when the body cannot use insulin correctly and sugar builds up in the blood). Record review of Resident #1's care plan dated 1/31/26 to 1/24/26 revealed the following: Effective 1/22/26 Problem: Diabetes; Goal: Improve or maintain current diabetes management. Intervention: - Check blood sugar levels, -Administer diabetes medications as ordered. Record review of Resident #1's after visit summary also known as the admitting orders printed on 1/13/26 indicated Resident #1 was in the hospital from [DATE] to 1/13/26 due to syphilis of central nervous system (a bacterial infection of the brain or spinal cord. It usually occurs in people who have had untreated syphilis for many years). The AVS further indicated Resident #1 was to continue receiving Trulicity 4.5 mg/0.5 mL via subcutaneous injection every seven days. Review of the AVS revealed the document contained handwritten notations indicating it was entered by LVN B and second-checked by ADON C upon admission. These notations reflected that LVN B entered Resident #1's medication orders into the facility system and ADON C verified the information was entered correctly. Additionally, a check mark was documented next to the Trulicity order, indicating the medication had been reviewed, verified, and entered into the facility's system. Record review of an active orders report for Resident #1 printed on 1/24/26 revealed the following:-Trulicity 4.5mg/0.5ML solution, inject 4.5mg under skin every seven days for Type 2 diabetes mellitus with diabetic neuropathy. 1 Subcutaneous Information Only [Frequency: Weekly on Thursday]. Order Date 1/13/26; Start Date 1/13/26-Blood Glucose (Strip) Device (Glucose, Blood Test); Notify MD if 400 or greater for type 2 diabetes mellitus with diabetic neuropathy - Subcutaneous Information Only. Order Date 1/13/26; Start Date 1/13/26 Record review of Resident #1's January MAR from 1/13/26 to 1/24/26 revealed the following: -Trulicity 4.5mg/0.5ML solution, inject 4.5mg under skin every seven days for Type 2 diabetes mellitus with diabetic neuropathy. 1 Subcutaneous Information Only [Frequency: Weekly on Thursday]. Start Date 1/13/26 - Do Not Stop unless Directed by Physician. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Rotate Injection Site. The MAR indicated Resident #1 did not receive the medication as prescribed from 1/13/26 to 1/24/26. Review of blood glucose monitoring report from 1/13/26 to 1/24/26 revealed Resident #1's blood glucose did not elevate greater than 400 readings during the review period. During a telephone interview conducted on 6/14/26 at 11:20am, Resident #1's family member reported that Resident #1 was no longer residing at the facility and was unavailable for interview because she was out of town. The family member stated that during Resident #1's admission, Resident #1 complained that she was not receiving her Trulicity medication at the facility. The family member reported she was unaware of whom Resident #1 reported the concern to and could not identify any specific facility staff member who had been notified. During a telephone interview conducted on 6/15/26 at 11:10 am, LVN D reported that she worked the 6:00 am to 6:00 pm shift and had been employed at the facility for approximately two years. LVN D stated that she could not recall whether she was the nurse who completed the discharge process for Resident #1 on 1/24/26, as the discharge occurred several months prior. She indicated that if her name appeared on the discharge documentation, it would suggest that she was the staff member who completed the process. When asked about the administration of Trulicity during the resident's stay, LVN D stated that she did not specifically recall administering the medication. She explained that if Resident #1 had an active order for Trulicity, the medication should have been administered as prescribed. LVN D also stated that she did not recall Resident #1 reporting that she was not receiving her Trulicity medication, noting that Resident #1 was typically very vocal. LVN D stated that if she documented 1 pen next to the Trulicity order on the discharge medication list dated 1/24/26, the notation would indicate one Trulicity pen was available and was sent home with Resident #1 at the time of discharge. During a telephone interview conducted on 6/15/26 at 11:41 am, the Physician stated that if Resident #1 had an active physician order for Trulicity, he would expect the medication to be administered as prescribed. The Physician further stated that if the medication appeared on the MAR, he would expect nursing staff to administer the medication and document the administration accordingly. The Physician stated that a possible outcome of missing scheduled doses of Trulicity could be hyperglycemia (elevated blood glucose levels). However, the Physician stated he was not notified and was not aware Resident #1 had not received the Trulicity medication and had missed two scheduled doses. The Physician stated that because Resident #1 resided in a nursing facility, blood glucose levels were being monitored, and sliding-scale insulin was available as an intervention to address elevated blood glucose levels. During an interview conducted on 6/15/26 at 2:35pm, ADON C reported that the facility's admission process required the admitting nurse to enter physician orders from the resident's AVS into the electronic medical record and that a second licensed nurse completed a re-check to verify the orders were entered correctly. ADON C stated that her signature on Resident #1's AVS indicated she completed the re-check of the orders entered by LVN B. ADON C stated it was possible LVN B, who no longer worked at the facility, entered the Trulicity order incorrectly. ADON C explained that medications were not intended to be set up as Info Only. She stated the Trulicity order should have generated administration options on the MAR, such as scheduled administration times, rather than appearing in the Info Only section. ADON C reported that if a medication did not generate a scheduled administration time under the Hour category, it was possible the medication would not appear on the MAR for nursing staff to administer. ADON C stated Trulicity was typically administered by a day-shift nurse. She reported that because Resident #1 had been discharged and the order was no longer active, she was unable to review how the order was originally entered into the system. ADON C stated that during her re-check she was verifying that the physician orders were entered into the system correctly and did not verify whether medications were displayed in the Info Only section of the MAR. ADON C stated she missed the issue and was unaware Resident #1 had not received the Trulicity medication. ADON C stated that based on the admitting orders and the active physician order, Resident #1 should have been receiving Trulicity as prescribed. ADON C further stated that review of the MAR indicated Resident #1 never received the Trulicity medication during the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission. During an interview conducted on 6/15/26 at 3:00 pm, the DON stated she was not aware Resident #1 had not received the ordered Trulicity medication during the admission. The DON reported that the ADON was responsible for completing the re-check of admission orders and verifying the accuracy of orders entered into the facility's system. The DON further stated that LVN B, the admitting nurse responsible for entering Resident #1's admission orders, no longer worked at the facility. Record review revealed LVN B's last day of employment was 1/16/26. The DON stated Resident #1 never complained to her about not receiving the Trulicity medication on the scheduled Thursday administration dates. The DON further stated Resident #1's vital signs and blood glucose levels remained stable throughout the admission and she was not aware of any adverse effects related to the missed Trulicity doses. The DON reported Resident #1's blood glucose levels were monitored during the admission and did not exceed 400. The DON stated she was not aware of any negative outcome resulting from Resident #1 not receiving the Trulicity medication. However, the DON acknowledged that, according to the physician's order, Resident #1 should have received the medication as prescribed. Record review of Medication Administration Subcutaneous Insulin policy dated 01/2023 Section 7.23 indicated the following To administer subcutaneous insulin as ordered and in a safe, accurate and effective manner. Record review of revised Medication error policy dated 1/12/2020 last reviewed on 1/10/2023 indicated the following Purpose: To describe the procedure for reporting a medication error and the mechanism for review to allow appropriate follow-up and possible implementation of change to decrease the causes and incidences of medication errors. Standard of Practice: Community staff and prescribing practitioner will mitigate the occurrence of medication errors and attempt to identify and manage them appropriately when they occur in accordance with standard practice guidelines. Definitions: Medication error - is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in control of the health care professional, or patient. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.