| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676250 | A. Building<br>B. Wing | 04/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pecan Valley Rehabilitation and Healthcare | 3838 E Southcross Blvd<br>San Antonio, TX 78222 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 3 residents (Residents #1 and #2) reviewed for pharmacy services. 1.The facility failed to ensure Resident #1's prescribed medications of Insulin Glargine Subcutaneous Solution and NovoLOG Injection Solution 100 UNIT/ML were administered according to physician orders for the months of February 2026 - April 2026.2.The facility failed to ensure Resident #2's prescribed medications of Insulin Glargine and NovoLOG FlexPen Subcutaneous were administered according to physician orders for the month of April 2026. These failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects.The findings included:1. Record review of Resident #1's admission Record dated 04/28/2026 revealed a [AGE] year-old male admitted on [DATE]. Resident #1 was listed as his own financial responsible party, with his [family member] listed as Emergency Contact #1. Record review of Resident #1's Medical Diagnoses, undated and accessed on 04/28/2026 at 1:14 p.m., revealed diagnoses including Diabetes Mellitus (DM) (chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels), Cerebrovascular Accident (CVA) (medical term for a stroke), blindness right eye, legal blindness, and absence of left leg below knee. Record review of Resident #1's quarterly MDS, dated [DATE] and signed on 03/17/2026 as completed, reflected a BIMS score of 15, indicating cognition intact. Resident #1 was documented as having verbal behavioral symptoms directed toward others and as having not exhibited any physical behavioral symptoms. Resident #1 was documented as requiring insulin injection. Resident #1's functional abilities were documented as having functional limitation in range of motion with impairment to lower extremity requiring mobility device (wheelchair) and supervision or touching assistance to independent. Record review of Resident #1's Care Plan, undated and accessed on 04/28/2026 at 1:26 p.m., reflected Resident #1 had a history of Type 2 Diabetes Mellitus. Record review of Resident #1's Medication Administration Record, printed 04/29/2026 and revealing medication administrations from 4/1/2026 - 4/30/2026, reflected the order: Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 22 unit subcutaneously at bedtime related TYPE 2 DIABETES MELLITUS and 'Scheduled Time 2000 [8:00 p.m.]. Order noted as Active with Order Date, 03/03/2026 and start date, 03/03/2026. Record review of Resident #1's Medication Administration Record, printed 04/29/2026 and revealing medication administrations from 4/1/2026 - 4/30/2026, reflected the order: Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 22 unit subcutaneously at bedtime was administered as follows:Scheduled Time Administered Time Administered By04/22/26 20:00 [8:00 p.m.] 04/22/26 21:02 [9:02 p.m.] LVN A04/23/26 20:00 [8:00 p.m.] 04/23/26 21:01 [9:01 p.m.] LVN A Record review of Resident #1 Medication Administration Record printed 04/29/2026 and revealing medication administration from 4/1/2026 - 4/30/2026, reflected the order: NovoLOG Injection Solution 100 UNIT/ML (Insulin As part) Inject as per sliding scale:if 0 - 149 = 0 units;150 - 199 = 2 units;200 - 249 = 4 units;250 - 299 = 6 units;300 - 349 = 8<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676250 | A. Building<br>B. Wing | 04/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pecan Valley Rehabilitation and Healthcare | 3838 E Southcross Blvd<br>San Antonio, TX 78222 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | units;351 - 400 = 10 unitsBS [blood sugar] over 400 give 10 units and notify MD/NP, subcutaneously before meals related to TYPE 2 DIABETES MELLITUS. Hours Ordered 0630 (6:30 a.m.), 1130 [11:30 a.m.], and 1630 [4:30 p.m.]. Order noted as Active with order Date, 03/19/2026 and start date, 03/19/2026. Record review of Resident #1's Medication Administration Record, printed 04/29/2026 and revealing medication administration from 3/1/2026 - 3/31/2026, reflected the order: Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 22 unit subcutaneously at bedtime was administered as follows:Scheduled Time Administered Time Administered By03/16/26 20:00 [8:00 p.m.] 03/16/26 21:22 [9:22 p.m.] LVN A03/20/26 20:00 [8:00 p.m.] 03/20/26 21:42 [9:42 p.m.] LVN B Record review of Resident #1 Medication Administration Record, printed 04/29/2026 and revealing medication administrations from 2/1/2026 - 2/28/2026, reflected the order: NovoLOG Injection Solution 100 UNIT/ML (Insulin As part) Inject as per sliding scale:if 0 - 150 = 0 units;151 - 200 = 2 units;201 - 250 = 4 units;251 - 300 = 6 units;301 - 350 = 8 units;351 - 400 = 10 units BS [blood sugar] over 400 give 10 units and notify MD/NP, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS.Hours Ordered 0630 (6:30 a.m.), 1130 [11:30 a.m.], 630 [4:30 p.m.] and 2000 [8:00 p.m.]. Order noted as Active with order Date, 05/22/2025, start date, 05/22/2025 and D/C [discontinued] Date 03/18/2026. Record review of Resident #1 Medication Administration Record undated and accessed 04/29/2026 and revealing medication administrations from 2/1/2026 - 2/28/2026, reflected the order: Insulin Glargine Solution 100 UNIT/MLInject 25 unit subcutaneously at bedtime for diabetes related to TYPE 2 DIABETES MELLITUS and Scheduled Time 18:00 [6:00 p.m.]. Order noted as Active with Order Date, 06/27/2025 and D/C [Discontinued] Date 03/03/2026. Record review of Resident #1 Medication Administration Record, printed 04/29/2026 and revealing medication administrations from 2/1/2026 - 2/28/2026, reflected the order: NovoLOG Injection Solution 100 UNIT/ML was administered as follows:Scheduled Time Administered Time Administered By02/16/26 20:00 [8:00 p.m.] 02/16/26 21:41 [9:41 p.m.] LVN A02/23/26 20:00 [8:00 p.m.] 02/23/26 21:19 [9:19 p.m.] LVN A Record review of Resident #1's progress notes dated 02/01/2026 - 04/30/2026 did not reveal a progress note identifying medication administration errors or notification to the provider and facility management. 2. Record review of Resident #2's admission Record dated 04/29/226 revealed a [AGE] year-old female admitted on [DATE]. Resident #2 was listed as her own financial responsible party, with her [family member] listed as Emergency Contact #1. Record review of Resident #2's Medical Diagnoses, undated and accessed on 04/29/2026 at 12:01 p.m., revealed diagnoses including Diabetes Mellitus (DM) (chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels), major depressive disorder (condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), and bipolar disorder (mental health condition characterized by significant mood swings). Record review of Resident #2's quarterly MDS, dated [DATE] and signed 02/23/2026 as completed, reflected a BIMS score of 11, indicating cognition intact. Resident #2 was documented as requiring insulin injection. Resident #2's functional abilities were documented as primarily dependent and requiring mobility device (wheelchair). Record review of Resident #2's Care Plan, undated and accessed on 04/29/2026 at 12:09 p.m., reflected Resident #2 had a history of Type 2 Diabetes Mellitus. Record review of Resident #2's Order Summary Report dated 04/29/2026, reflected the order: Insulin Glargine-yfgn Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine-yfgn) Inject 20 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED (E11.40) hold is [if] bs less than 150. Order noted as Active with Order Date, 01/29/2026 and start date, 01/29/2026. Record review of Resident #2's Medication Administration Record, printed 04/29/2026 and revealing medication administration from 4/1/2026 - 4/30/2026, reflected the order: Insulin Glargine-yfgn Subcutaneous Solution Pen-injector 100 UNIT/ML was administered as follows:Scheduled Time Administered Time Administered By04/02/26 18:00 [6:00 p.m.] 04/02/26 21:09 [9:09 p.m.] LVN A04/13/26 18:00 [6:00 p.m.] 04/13/26 21:04 [9:04 p.m.] LVN A04/20/26 18:00 [6:00 p.m.] 04/20/26 21:01 [9:01 p.m.] LVN<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676250 | A. Building<br>B. Wing | 04/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pecan Valley Rehabilitation and Healthcare | 3838 E Southcross Blvd<br>San Antonio, TX 78222 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A04/21/26 18:00 [6:00 p.m.] 04/21/26 21:22 [9:22 p.m.] LVN A04/22/26 18:00 [6:00 p.m.] 04/22/26 21:05 [9:05 p.m.] LVN A Record review of Resident #2's Order Summary Report dated 04/29/2026, reflected the order: NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 149 = 0; 150 - 200 = 2 u; 201 - 250 = 4 u; 251 - 300 = 6 u; 301 - 350 = 8 u; 351 - 399 = 10 u <400 Give 10 units and Notify MD/NP, subcutaneously before meals and at bedtime for Diabetes HOLD IF BS LESS THAN 150. Order noted as Active with Order Date 01/05/2026 and start date, 01/05/2026. Record review of Resident #2's Medication Administration Record, printed 04/29/2026 and revealing medication administration from 4/1/2026 - 4/30/2026, reflected the order: NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML was administered as follows:Scheduled Time Administered Time Administered By04/02/26 20:00 [8:00 p.m.] 04/02/26 21:09 [9:09 p.m.] LVN C04/13/26 20:00 [8:00 p.m.] 04/13/26 21:04 [9:04 p.m.] LVN A04/21/26 20:00 [8:00 p.m.] 04/21/26 21:21 [9:21 p.m.] LVN A Record review of Resident #2's progress notes dated 03/30/2026 - 04/30/2026 did not reveal a progress note identifying medication administration errors or notification to the provider and facility management. During an interview on 04/29/2026 at 1:20 p.m., MA D revealed the medication administration protocol is to give scheduled dose one hour before or one hour after the prescribed time before going into violation. She stated the DON took medication administration seriously and the protocol was to notify the DON if dose was missed or late. MA D stated medication aides were to document the missed or late dose in the resident's progress notes and notify the charge nurse. MA D stated the medication aides are required to follow medication orders as missed or late dose could be harmful to the resident. During an interview on 04/29/2026 at 1:36 p.m., MA E revealed that medication aides were required to follow physician orders and their specific times and to stay within the one hour before or one hour after the prescribed time. MA E stated a medication error would be reported to the DON immediately, she would be required to document error in progress notes. She stated the DON checks medication administration daily and would let her know if an error was made. She stated the impact of medication errors could be harmful to residents. During an interview on 04/29/2026 at 1:58 p.m., RN F revealed that medication administration protocol times were one hour before and one hour after the medication wasdue and making sure the right medication, right person, right time were followed. RN F stated if administered outside of the one-hour window the staff were to administer it to the resident as soon as possible, and were to inform the resident why it happened, and if late would be considered a medication error. RN F stated if a medication error was identified staff were required to notify the ADON and make a progress note stating what occurred. She stated the impact of administering medication outside of the one-hour window could make residents worry if the staff were providing the proper care, they could lose trust in the staff. During an interview on 04/29/2026 at 2:42 p.m., ADON G revealed that most medications were set up with a 6-10 window, if scheduled then it was one hour before or one hour after. ADON G stated if outside of the one-hour time staff were required to contact the physician and provide reason as to why medication was administered late. ADON G stated staff should be documenting progress notes as to why it was administered late and depending on the medication there could be negative effects if given late. She stated the management staff could pull a report and see the times medications were administered and could identify if out of range and would prompt staff to investigate what was going on and there would be follow-up with staff. ADON stated she had not counseled LVN A on late medication administration and she was not aware of the medication errors. During an interview on 04/29/2026 at 3:10 p.m., ADON H revealed the medication administration protocol/times follows RIGHTS-right person, right time, right dose, right medication. She stated if staff deviated from the scheduled dose, they needed to notify the doctor to see if okay with this and if anything needed to be done differently on their end. ADON H stated doses that were out of range meaning hour after it was order, anything out of range will trigger was late and identified as a medication error. She stated medication aides were required to notify the charge nurse, the charge nurse would then notify the provider, make a progress note and document the 24-hour report, (continued on next page) |

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|---|---|---|---|
| | 676250 | A. Building<br>B. Wing | 04/29/2026 |

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| Pecan Valley Rehabilitation and Healthcare | 3838 E Southcross Blvd<br>San Antonio, TX 78222 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | which the management team reviewed daily in morning meetings. She stated all (3) ADONs could pull a report to determine if medication administration were outside of range. ADON H said depending on the medication there could be negative side effects on the resident if administering medication late. ADON H stated she had not seen late medication administration entries, and staff did not notify her of late entries. During an interview on 04/29/2026 at 4:29 p.m., the DON revealed medication administration times are based on physician orders. She noted medication administration outside of an hour before and an hour after need to be documented in the progress note, the reason it was administered late, would require notification to the doctor. The DON stated she was aware of late medication entries by LVN A. The DON stated if residents want to talk, LVN A would not interrupt them, and this could potentially cause her to document medication administration later than time it was administered, and this would cause a medication error. The DON stated she had not counseled LVN A on medication administration late entries. Attempted interview with LVN A, on 04/29/2026 at 5:06 p.m., no return call received. During an interview on 04/29/2026 at 5:22 p.m., the Administrator revealed staff were to follow physician orders. She stated there could be an adverse reaction depending on type of medication if medication was administered outside of physician's orders. During an interview on 04/29/2026 at 5:58 p.m., Human Resources revealed LVN A had not been counseled on the numerous medication administration late entries identified during the investigation. Record review of In-Service Acknowledgement titled Rights of Medication Administration, dated 04/3/2026 revealed ADON was the instructor and staff education included: Right Time: Administer at the prescribed frequency and time. Right Documentation: Record medication given, time, dose, and route immediately. Record review of In-Service Acknowledgement titled Insulin Administration, dated 03/24/2026, revealed ADON was the instructor and staff education included: Always read the order completely The Six Rights of Safe Medication Administration. 4. Right Time. Does the administration time match the order? . 6. Right Documentation. Document immediately after the medication is administered. Record review of policy titled, Your Rights in a Nursing Facility dated January 2025, revealed .You have the right to: Receive all care necessary to have the highest possible level of health. Record review of policy titled, Charting and Documentation, dated 05/2007, revealed .The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under current law and regulations at the time of admission.[Importance And Use of the Record] 1.To the resident is saves time if needed at a future date. 2. To the institution it reflects the quality of care given to the resident. 3. To the physician, it guides him in his treatment, use and effects of drugs and plan for care.6. To the nurse, it provides a multidisciplinary record of the physical and mental status of the resident. [Rules for Charting] 1. Notes are to be written on all long-term residents by day, evening and night shifts; frequency is determined by the individual nursing service. 2. Daily notes are required as the necessary arises. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Pecan Valley Rehabilitation and Healthcare | 3838 E Southcross Blvd<br>San Antonio, TX 78222 |

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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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 of 3 residents (Residents #1 and #2) reviewed for medical records. 1.The facility failed to maintain progress notes and documentation of notification to physician when medication errors were identified for Resident #1's prescribed medications, Insulin Glargine Subcutaneous Solution and NovoLOG Injection Solution 100 UNIT/ML for the months April 2026.2.The facility failed to maintain progress notes and documentation of notification to physician and management team when medication errors were identified for Resident #2's prescribed medications, Insulin Glargine and NovoLOG FlexPen Subcutaneous for the month of April 2026. These failures placed residents at risk for missed treatment and medications which could result in decline in health and well-being.The findings included: 1. Resident Record review of Resident #1's admission Record dated 04/28/2026 revealed a [AGE] year-old male admitted on [DATE]. Resident #1 was listed as his own financial responsible party, with his [family member] listed as Emergency Contact #1. Record review of Resident #1's Medical Diagnoses, undated and accessed on 04/28/2026 at 1:14 p.m., revealed diagnoses including Diabetes Mellitus. Record review of Resident #1's quarterly MDS, dated [DATE] and signed on 03/17/2026 as completed, reflected a BIMS score of 15, indicating cognition intact. Resident #1 was documented as requiring insulin injection. Record review of Resident #1's Care Plan, undated and accessed on 04/28/2026 at 1:26 p.m., reflected Resident #1 had a history of Type 2 Diabetes Mellitus. Record review of Resident #1's Medication Administration Record, printed 04/29/2026 and revealing medication administrations from 4/1/2026 - 4/30/2026, reflected the order: Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 22 unit subcutaneously at bedtime related TYPE 2 DIABETES MELLITUS and 'Scheduled Time 2000 [8:00 p.m.]. Order noted as Active with Order Date, 03/03/2026 and start date, 03/03/2026. Record review of Resident #1's Medication Administration Record, printed 04/29/2026 and revealing medication administrations from 4/1/2026 - 4/30/2026, reflected the order: Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 22 unit subcutaneously at bedtime was administered as follows:Scheduled Time Administered Time Administered By04/22/26 20:00 [8:00 p.m.] 04/22/26 21:02 [9:02 p.m.] LVN A04/23/26 20:00 [8:00 p.m.] 04/23/26 21:01 [9:01 p.m.] LVN A Record review of Resident #1's progress notes dated 02/01/2026 - 04/30/2026 did not reveal a progress note identifying medication administration errors or notification to the provider and facility management. 2. Record review of Resident #2's admission Record dated 04/29/226 revealed a [AGE] year-old female admitted on [DATE]. Resident #2 was listed as her own financial responsible party, with her [family member] listed as Emergency Contact #1. Record review of Resident #2's Medical Diagnoses, undated and accessed on 04/29/2026 at 12:01 p.m., revealed diagnoses including Diabetes Mellitus (DM) {chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels}, major depressive disorder {condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), and bipolar disorder (mental health condition characterized by significant mood swings). Record review of Resident #2's quarterly MDS, dated [DATE] and signed 02/23/2026 as completed, reflected a BIMS score of 11, indicating cognition intact. Resident #2 was documented as requiring insulin injection. Record review of Resident #2's Care Plan, undated and accessed on 04/29/2026 at 12:09 p.m., reflected Resident #2 had a history of Type 2 Diabetes Mellitus. Record review of Resident #2's Order Summary Report dated 04/29/2026, reflected the order: Insulin Glargine-yfgn Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine-yfgn) Inject 20 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED (E11.40) hold is [if] bs less than 150. Order noted as Active with Order<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676250 | A. Building<br>B. Wing | 04/29/2026 |

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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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Date, 01/29/2026 and start date, 01/29/2026. Record review of Resident #2's Medication Administration Record, printed 04/29/2026 and revealing medication administration from 4/1/2026 - 4/30/2026, reflected the order: Insulin Glargine-yfgn Subcutaneous Solution Pen-injector 100 UNIT/ML was administered as follows:Scheduled Time Administered Time Administered By04/02/26 18:00 [6:00 p.m.] 04/02/26 21:09 [9:09 p.m.] LVN A04/13/26 18:00 [6:00 p.m.] 04/13/26 21:04 [9:04 p.m.] LVN A04/20/26 18:00 [6:00 p.m.] 04/20/26 21:01 [9:01 p.m.] LVN A04/21/26 18:00 [6:00 p.m.] 04/21/26 21:22 [9:22 p.m.] LVN A04/22/26 18:00 [6:00 p.m.] 04/22/26 21:05 [9:05 p.m.] LVN A Record review of Resident #2's progress notes dated 03/30/2026 - 04/30/2026 did not reveal a progress note identifying medication administration errors or notification to the provider and facility management. During an interview on 04/29/2026 at 2:42 p.m., ADON G revealed all medication errors and notification to the physician and management team were to be documented in the resident's electronic medical record immediately. ADON G further stated failure to do so could negatively impact a residents' care. During an interview on 04/29/2026 at 3:10 p.m., ADON H revealed medication errors are required to be documented in the resident's electronic medical record. She stated this process will help staff recall reasons for late medication administration entries. During an interview on 04/29/2026 at 4:29 p.m., the DON revealed all staff who identify a medication administration error need to document the electronic medical record immediately. She stated the documentation in progress notes would help management understand why there was a late entry for medication administration. The DON stated failure to document medication errors could have an impact on the residents by not having accurate medical records. Record review of In-Service Acknowledgement titled Rights of Medication Administration, dated 04/3/2026 revealed ADON was the instructor and staff education included: Right Documentation: Record medication given, time, dose, and route immediately. Record review of In-Service Acknowledgement titled Insulin Administration, dated 03/24/2026, revealed ADON was the instructor and staff education included: The Six Rights of Safe Medication Administration. 6. Right Documentation. Document immediately after the medication is administered. Record review of policy titled, Charting and Documentation, dated 05/2007, revealed .The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. [Rules for Charting] 1. Notes are to be written on all long-term residents by day, evening and night shifts; frequency is determined by the individual nursing service. 2. Daily notes are required as the necessary arises. |