STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676271	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onion Creek Nursing and Rehabilitation Center	1700 Onion Creek Pkwy 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 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, 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 one (Resident #1) of three residents reviewed for quality of care. The facility failed to implement orders from the hospital for blood glucose monitoring four times a day and administering of a sliding scale insulin four times a day upon Resident #1's admission on 09/16/24. Orders were not implemented until 10/01/24 and during that timeframe Resident #1 was worried about his diabetes, felt sick to his stomach, funny, different, and really off. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the hospital on 09/16/24 with diagnoses including respiratory failure, type II diabetes, urinary tract infection, and muscle weakness. Review of Resident #1's admission MDS assessment, dated 09/16/24, reflected a BIMS score of 7, indicating severe cognitive impairment. Section N (Medications) reflected he did not have an order for insulin. Review of Resident #1's admission care plan, dated 09/17/24, reflected he had diabetes mellitus with an intervention of administering medications as ordered by the doctor. Review of Resident #1's hospital discharge summary, dated 09/16/24, reflected the following: Diabetes with hyperglycemia (elevated blood sugar) - glucose 275 - HbA1c of 7.3 (reference 4 - 5.6) - changed to medium dose sliding scale. Home/Current Medications: Insulin lispro - 0 - 6 units subcutaneous qidACbedtime (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 0684 Level of Harm - Actual harm Residents Affected - Some	Discharge Medications (to continue with no changes): Insulin lispro - Sliding Scale Subcutaneous, 4 times a day (before meals and at bedtime) Sliding Scale Correctional Scale based on POC blood glucose level: 71 - 149 = no insulin lispro; 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. Last dose given: 09/16/24 at 5:17 PM Discharge Information: Treatments/Special Instructions: Blood Glucose Monitoring: 4 times a day Review of Resident #1's CBC results, dated 09/27/24, reflected a high glucose level of 234 (reference 74 - 100 mg/dL). Review of Resident #1's physician order, dated 09/18/24, reflected blood sugar checks two times a day for DM 2. Review of Resident #1's blood sugar readings in his EMR, from 09/18/24 - 10/02/24, reflected the following: 09/18/24 at 4:14 PM - 291.0 mg/dL 09/19/24 at 11:01 AM - 229.0 mg/dL 09/19/24 at 6:43 PM - 220.0 mg/dL 09/20/24 at 7:25 AM - 179.0 mg/dL 09/20/24 at 4:34 PM - 249.0 mg/dL 09/23/24 at 9:43 PM - 264.0 mg/dL 09/24/24 at 6:35 AM - 110.0 mg/dL 09/24/24 at 8:11 PM - 243.0 mg/dL 09/25/24 at 6:52 AM - 278.0 mg/dL 09/25/24 at 8:13 PM - 192.0 mg/dL 09/26/24 at 6:46 AM - 165.0 mg/dL 09/26/24 at 9:04 PM - 196.0 mg/dL 09/27/24 at 7:24 AM - 212.0 mg/dL (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	09/27/24 at 9:08 PM - 201.0 mg/dL 09/28/24 at 6:51 AM - 169.0 mg/dL 09/28/24 at 9:41 PM - 201.0 mg/dL 09/29/24 at 7:30 AM - 162.0 mg/dL 09/29/24 at 10:23 PM - 184.0 mg/dL 09/30/24 at 7:24 AM - 206.0 mg/dL 09/30/24 at 9:06 PM - 273.0 mg/dL 10/01/24 at 6:50 AM - 395.0 mg/dL 10/01/24 at 10:01 PM - 235.0 mg/dL 10/02/24 at 8:32 AM - 124.0 mg/dL Review of Resident #1's physician order, dated 10/01/24, reflected Novolog Solution 100 unit/ML - Inject subcutaneously three times a day for diabetes. Inject as per sliding scale: If 0 - 149 = 0 units; 150 - 299 = 2 units; 300 - 349 = 4 units; 350 - 399 = 6 units; 400 - 449 = 8 units; 450 - 999 = 10 units Review of Resident #1's TAR, October 2024, reflected insulin was not administered on 10/01/24 although his BS readings were 395 and 235. Insulin was not administered in the morning on 10/02/24 due to his BS reading falling under the parameters (124). During an interview on 10/02/24 at 10:40 AM, LVN A stated she was not sure why Resident #1 had not been on insulin prior to yesterday. She stated she did notice that his blood sugars were elevated some days. She stated she had not notified the NP because she thought she had been monitoring the levels. She stated since he was a diabetic and his blood sugars had been elevated, he should have been on insulin or Metformin (medication used to lower blood sugar) sooner. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/02/24 at 12:12 PM, Resident #1 stated he did not know why he had not been getting his insulin. He stated he was supposed to take it, that was just the way it was supposed to be. He stated he had been asking the nurses for it because he was worried about his diabetes, but he never got any answers. He stated since he was admitted to the facility and had not been getting insulin, he had felt funny, different, really off, and sick to his stomach. He stated he had a hard time eating because he had been so nauseous. During a telephone interview on 10/02/24 at 12:32 PM, Resident #1's NP stated she had not put Resident #1 on insulin when he was admitted to the facility because she believed he had some recent hypoglycemic episodes and was not clear what he was on at home before hospitalization . She stated she put an order for accu checks twice a day so his blood sugar could be monitored before she ordered something long-lasting. She stated a nurse contacted her the day prior (10/01/24) and told her FM B was asking why he was not getting insulin so she put in an order for a sliding scale. She stated she had not been notified by anyone that his blood sugars had been elevated (over 150) and would have been preferred to have been notified sooner. During an interview on 10/02/24 at 1:27 PM, the DON stated orders from the hospital should be implemented and followed after the NP reviewed the orders. She stated as far as she could remember, the NP wanted to monitor Resident #1's blood sugars before putting anything into place and was trying to get history prior to his hospitalization . She stated her expectations were for the nurses to have been notifying the NP that his blood sugar had been elevated because she was supposed to be reviewing and watching his blood sugar. She stated a negative outcome of not notifying the NP could result in hyperglycemia. A request was made for policies on physician notifications and new admissions/orders from the hospital but neither were provided prior to exiting.