STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676341	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprock Nursing & Rehabilitation	900 College Ave Borger, TX 79007

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 interviews and record reviews, the facility failed to ensure residents were free of any significant medication errors for one of seven residents (Resident #1) reviewed for medication administration. LVN A administered Resident #1's short acting insulin, instead of administering her long-acting insulin, which lead to an insulin overdose and hospitalization for observation for 24 hours. The failure could place residents who receive insulin medications at an increased risk for complications such as increased blood glucose levels, change in cognition, and an exacerbation of symptoms and disease process.Findings included: Record review of Resident #1's face sheet, dated 1/20/26, revealed Resident #1 as an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had the following diagnoses: unspecified dementia without behavioral disturbance decline in memory, thinking, and reasoning that disrupts daily life), low back pain, major depressive disorder (serious mood disorder causing persistent sadness, loss of interest and impacting thoughts, feelings and daily life), Parkinson's disease (progressive nervous system disorder affecting movement), disease of pancreas (due to insulin problems or lack of digestive enzymes), moderate protein-calorie malnutrition (reduced protein and energy intake), vitamin D deficiency, hyperlipidemia (high level of fat in the blood), anxiety disorder (excessive persistent fear and worry about everyday problems), idiopathic peripheral autonomic neuropathy (nerve damage affecting involuntary bodily functions - like heart rate, digestion, sweating, blood pressure, where the cause is unknown), overactive bladder common condition causing a sudden, strong urge to urinate), Type 2 diabetes (the body does not use insulin properly or doesn't produce enough of it), gastro-esophageal reflux (symptoms of heartburn or upset stomach), hypothyroidism(thyroid gland does not make enough thyroid hormone- underactive), hypertension (high blood pressure), atherosclerotic heart disease (plaque buildup in arterial walls), Zoster without complications (shingles). Record review of Resident #1's current MDS, resident assessment, dated 11/17/25, documented the resident scored 12 of 15 on a mini-mental exam for cognitive awareness and she was interviewable. Resident #1's functional ability revealed the Resident #1 was independent with all ADL functions. Record review of Resident #1's care plan, last review dated 11/25/25, revealed Resident #1 was care planned for her Diabetes Mellitus. Interventions read that. Diabetes medication as ordered by doctor. Monitor/document side effects and effectiveness. Record review of Resident #1's physician orders, dated 1/1/26 through 1/31/26, revealed Resident #1 has an order for the following insulins: Lantus SoloStar Subcutaneous Solution Pen-Injector 100 units/ml (Insulin Glargine) - inject 42 units subcutaneously one time a day (PM) - long-acting insulin.Lantus Subcutaneous Solution 100 units/ml (Insulin Glargine) - inject 45 units subcutaneously on time a day (AM) - long-acting insulin.Flasp FlexTouch Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart (with Niacinamide)) - inject per sliding scale - short-acting insulin:-if 201 - 250 = 2 units251 - 300 = 4 units301 - 350 = 6 units351 - 400 = 8 units400 - 500 = 10 units Subcutaneously three times a day - 8:00 a.m., 12:00 p.m. and 5:00 p.m. Record review of Resident (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	#1's nurses notes documented the following:1/15/26 at 8:39 a.m. - Resident #1 was transferred to a hospital related to medication error - NP ordered for resident to be transferred out for close evaluation. This is intended to serve as notice of an emergency transfer.1/16/26 at 4:14 p.m. - Resident #1 readmitted /returned from the hospital. Reason for hospital visit: insulin overdose During an interview on 1/20/26 at 9:55 a.m., the Administrator stated LVN A gave Resident #1 her own insulin, but it was the fast-acting insulin, not the long-acting insulin that was ordered for that time of day. During an interview on 1/20/26 at 10:25 a.m., the DON stated on 1/15/26, she was in her office getting ready for a morning meeting when LVN A came to her and said she had given the wrong insulin to Resident #1. The DON stated LVN A meant to give Lantus - a long-acting insulin but gave the short-acting insulin by mistake. The DON stated LVN A realized after about 10 minutes that she had given the wrong insulin to Resident #1 and came directly to her office. The DON stated she immediately went to assess Resident #1 and called the NP to see what she needed to do to get Resident #1 situated. The DON stated the NP said to start an IV for D5, if needed, then the NP called another NP and then the MD and the MD informed her to send the resident to the hospital. The DON stated that very day, they educated LVN A and suspended her, she was still suspended. The DON stated the NP also educated LVN A about searching for medications on Google. The DON stated there were always extra mediations in the Emergency kit if needed. The DON stated LVN A was a new nurse and had been a nurse since [NAME] 2025, when she graduated LVN. The DON stated all the nurses talked very highly of LVN A, but she made a very bad mistake. The DON stated LVN A was still suspended for the time being. During an interview on 1/20/26 at 12:46 p.m., LVN A stated she had gone to her medication cart and had already taken Resident #1's vitals but she always wanted her insulin at a certain time. LVN A stated she was looking for Resident #1's insulin pens as she had two the last time she took care of her, but there was only one pen in the medication cart. LVN A stated afterwards, she had found a vial of Resident #1's insulin but not the pen and it was the long-acting insulin she needed. LVN A stated she contacted ChatGPT, which is like an AI thing the younger generation uses instead of Google, and it said the insulin was the right kind, but she admitted to not reading all of the answer. LVN A asked the State surveyor if she knew what AI was because all the younger generation used it, to which the State surveyor informed LVN A that she was aware of AI. LVN A stated she had gone on to give insulin to another resident, and that resident's insulin was the same as Resident #1's and that was when she knew she had given the wrong medication (short-acting insulin) to Resident #1. LVN A stated she immediately locked her medication cart and went to the Administrator's office and then the DON and told them what happened. LVN A stated Resident #1 was doing good and they gave her two glasses of apple juice and some crackers, and Resident #1 drank both glasses of apple juice and some of the crackers. LVN A stated she checked Resident #1's blood sugar and it was 200 and she checked Resident #1's blood sugar 10 minutes later and her blood sugar was 145. LVN A stated right after that, Resident #1 was sent to the hospital for observation and the resident was not in any distress. LVN A stated the NP wanted her sent to the hospital for further evaluation and treatment. LVN A stated she was terrified by the mistake she made. LVN A stated she would never do that again and instead of contacting ChatGPT, she would go ask the charge nurse or the DON for assistance when she was not sure of the medication she was giving. During an interview on 1/20/26 at 1:54 p.m., Resident #1 stated she remembered getting an IV when she got to the hospital. Resident #1 stated the first thing they did after she got the wrong insulin was give her a glass or two of apple juice and some crackers. Resident #1 wasn't upset about getting the wrong insulin until she found out how serious it could be. Resident #1 stated she usually got insulin from a pen, but she had gotten insulin from a regular insulin syringe. Resident #1 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she remembered the nurse (LVN A) was scared to death. Resident #1 stated the doctor insisted on sending her to the hospital so she could be monitored closely, and she was just monitored at the hospital and then she was sent back to the facility. Resident #1 stated she did not have any low blood sugars at the hospital. Resident #1 stated those young nurses that were coming to the facility or PRN nurses, she did not understand why the facility used so many of them. Resident #1 stated she was uncomfortable with new nurses, and she trusted the older nurses that had been in the facility for a while. Resident #1 stated she was glad that someone was doing a follow-up on giving her the wrong insulin because that should never have happened. (Resident #1's blood sugars were checked with the medical record on 1/15/26 before being transported to the hospital and all of her blood sugar were in a normal range for her.) During an interview on 1/10/26 at 2:11 p.m., Resident #1's NP stated she was told that the nurse was out of long-acting insulin and googled to see if the other insulin was the same thing and google said it was, so she gave 45 units of short acting insulin in error. The NP stated she was very upset when she was told that because it was a very serious situation. The NP stated she called the doctor and informed him of what happened, and he said to send her to the hospital because they could monitor her better. The NP stated the facility had everything in house to take care of her, but she needed closer monitoring and the resident would be better off in the hospital. The NP stated she was aware that the nurse who made the error was a new nurse and new to the facility but nursing 101 would tell you to look for the DON for any answers that would be needed. The NP state a nurse should never google to make a nursing judgement, a nurse should always ask the DON or ADON, that was what they were there for. The NP stated Luckily, Resident #1 was fine and thought her blood sugar never got below 120. Record review of the facility's, Medication Administration and General Guidelines, undated, documented the following:Policy: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication, monograph of all medications is available in LinkRX otherwise authorized personnel should refer to Drug Reference material provided by facility. -Subcutaneous Injection Administration:-Insulin Injection:1. Assure type of insulin, unit dosage and syringe are correct.-Procedure:2. Read label three times before administering, check with MAR.4. Check label with order. Record review of the facility in-service training, dated 1/15/26, titled Medication Rights, documented the following:-There are 5 rights to medication administration *Right Patient *Right Medication *Right Dose *Right Route *Right Time*Always check you five rights before giving any medication to a resident. It is our responsibility to ensure that safe practice is always followed.*If a medication error occurs, report it immediately to the DON/ADON. While not all medication errors can cause harm, all must be taken seriously and reported.*If you have a question about an order or medication, please get in touch with the DON/ADON or even another seasoned nurse to ensure we are practicing safe practices.*Best practices include: *Clarifying unclear orders *Know what you are administering *Verify allergies *Verifying the 5 rights to medication administration.*If it feels unsafe, stop and clarify. If medication is not available, get with the DON/ADON who can get into contact with the MD/NP and get clarification and new orders.