

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Twin Pines North Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Mallette Drive Victoria, TX 77904	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 8 residents (Resident #274) reviewed for accommodation of needs.</p> <p>The facility failed to ensure Resident #274's call light was within reach while he was lying on his bed in his room on 04/06/2025 at 11:45 a.m.</p> <p>This failure could place residents at risk for delay in care and services, and increased risk of falls and injuries.</p> <p>The findings included:</p> <p>Record review of Resident # 274's Admission Record dated 04/07/2025 revealed he was a [AGE] year-old man initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities); Legal blindness; acquired absence of right leg above knee; and acquired absence of left leg below knee.</p> <p>Record review of Resident #274's 5-day MDS assessment dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Further review revealed Resident #274 was assessed as being dependent for all his hygiene, dressing and transfer needs, and required use of a mechanical lift for transfers.</p> <p>Record review of Resident #274's Care Plan initiated 01/28/2025 revealed he had impaired cognitive function/dementia, impaired visual function and had a communication problem, with interventions which included Ensure/provide a safe environment: Call light in reach .</p> <p>Observation and Interview of Resident #274 in his room on 04/06/2025 at 11:45 a.m. revealed his call light was looped over and behind the bed frame at head of his bed, not within reach of Resident #274. Resident #274 was only able to answer in one-word answers to questions and when asked if he could use his call light, Resident #274 moved his hand around on the bed as if looking for the call light, then stopped, but did not answer.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview with LVN-I in Resident #274's room on 04/06/2025 at 11:49 a.m., LVN-I stated they had just cleaned and changed Resident #274 earlier that morning and must have moved the call light out of the way while they were cleaning him and forgot to replace the call light within his reach afterwards. LVN-I removed the call light from the bed frame at head of bed and secured it to the linens next to Resident #274's hand. LVN-I stated Resident #274 had a visual impairment and needed total care, and without his call light in reach would not be able to call for help if needed.</p> <p>During an interview with the Regional Compliance Nurse on 04/06/2025 at 11:52 a.m., she stated that Resident #274's call light should have been replaced and secured within his reach after they had completed cleaning and changing him and before leaving the room. The Regional Compliance Nurse stated that without his call light in reach, Resident #274 would not be able to call for help.</p> <p>During a follow-up interview with the Regional Compliance Nurse and the DON on 04/08/2025 at 4:30 p.m., the Regional Compliance Nurse stated the facility does not have a policy on Call Lights.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</p> <p>Based on interviews and record reviews the facility failed to review and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 26 residents (Resident #126) reviewed for care plans.</p> <p>The facility failed to revise a care plan to address Resident #126's oxygen usage.</p> <p>This failure could have placed residents at risk of not having their needs identified and met.</p> <p>The findings were:</p> <p>Record review of Resident #126's face sheet, dated 4/9/25, revealed an original admitted [DATE] with diagnoses that included: cerebral infarction (a condition in which blood flow to the brain is blocked), atherosclerotic heart disease (a condition in which there is damage to the major blood vessels of the heart), and type 2 diabetes (a condition in which the body has trouble controlling the blood sugar).</p> <p>Record review of Resident's #126's Re-admission MDS assessment, dated 2/7/25, revealed a BIMS score of 14 which indicated intact cognition.</p> <p>Record review of Resident #126's Physician's orders initiated on 2/7/25 revealed Resident #126 could receive oxygen up to 5 liters as needed.</p> <p>Record review of Resident #126's ongoing care plan initiated on 2/10/25 revealed that the Resident's oxygen's use was not documented in the care plan.</p> <p>During an interview with MDS LVN-D on 4/9/25 at 10:00am she stated Resident # 126's oxygen use was not documented on his current care plan. She stated having the oxygen usage on the care plan was important for care staff to be aware of the resident's care needs so that the needs are met.</p> <p>During an interview with the ADON on 4/9/25 at 10:20 a.m., she stated Resident #126's oxygen's use was not documented on his current care plan. She stated the Resident's oxygen usage should have been documented on the resident's care plan and it had been omitted. She stated that having this information documented on the resident's care plan by nursing staff would allow the resident care needs to be met.</p> <p>Record review of the facility's policy titled Comprehensive Care Planning-GP-MC 03-18.0 in the Nursing Policy and Procedure Manual that was undated revealed The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment and revised based on changing goals, preferences and needs of the resident and in response to current interventions.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident # 274) reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #274's oxygen was set at the correct oxygen setting of 3 L/min as ordered by the physician, instead of 10 L/min, which it was set at on 04/06/2025 at 11:45 a.m.</p> <p>This failure could place resident at risk of developing respiratory complications, and experiencing adverse side effects.</p> <p>The findings included:</p> <p>Record review of Resident # 274's Admission Record dated 04/07/2025 revealed he was a [AGE] year old man initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: Chronic obstructive Pulmonary Disease (COPD - a group of lung disease that block airflow and make it difficult to breathe).</p> <p>Record review of Resident #274's 5-day MDS assessment dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Further review revealed Resident #274 was assessed as being dependent for all his hygiene, dressing and transfer needs.</p> <p>Record review of Resident #274's Care Plan initiated 01/28/2025 revealed he had impaired cognitive function/dementia, impaired visual function and had oxygen via nasal prongs at 3-4 L/min. The Care Plan also addressed his removal of his oxygen at times with interventions to notify the Nurse if the oxygen was off the resident.</p> <p>Record review of Resident #274's Order Summary Report dated 04/07/2025 revealed orders for:</p> <p>- May use oxygen @ 3-4 l/m via nasal canula every shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE; and</p> <p>-O2 at (3-4) liters per (NASAL CANULA)</p> <p>Observation and Interview of Resident #274 in his room on 04/06/2025 at 11:45 a.m. revealed his nasal canula was around his neck, resting on his chest, with the nasal prongs at the back of his head. Observation of his oxygen concentrator revealed his oxygen was set at 10 L/min. Resident #274 did not appear to be in any distress or have any difficulty breathing, and was able to verbally state no when asked if he was having trouble breathing or having shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview with LVN-E in Resident #274's room on 04/06/2025 at 11:49 a.m., LVN-E stated Resident #274 will sometimes remove his oxygen tubing and stated they had just cleaned and changed Resident #274 earlier that morning and he had the nasal canula on then. LVN-E proceeded to correctly place the nasal canula on Resident #274, and then after being asked what setting his oxygen was supposed to be set at, she stated 3 liters and checked his oxygen setting, and stated it had been set at 10 L/min, and immediately changed the setting to 3 L/min. LVN-E stated that sometimes Resident #274's family member will increase his oxygen setting thinking he needs more oxygen, but stated she had not seen Resident #274's family member there that morning and could not remember if she had checked his oxygen setting after cleaning him earlier that morning. LVN-E stated that with his oxygen setting set to 10 L/min and no humidification, it could have dried out his nasal membranes and caused nose bleeds.</p> <p>During an interview on 04/06/2025 at 11:52 a.m. with the Regional Compliance Nurse, she stated that Resident #274's oxygen should not have been set at 10 L/min, and that the Nurse should check his oxygen setting each time she works with the resident and check his oxygen saturation levels at least once per shift and as needed. The Regional Compliance Nurse further stated she will address the oxygen setting with the Nurse and noted that humidification was not needed for oxygen settings less than 4 L/min.</p> <p>Observation of Resident #274's room on 04/07/2025 at 3:11 p.m. revealed Resident #274's nasal canula was dangling off the side of the bed, and his oxygen was set at 3 L/min. The DON entered the room, observed the nasal canula dangling off the side of the bed, and she stated that he frequently removes his nasal canula. The DON obtained a pulse oximeter (device used to measure saturation of oxygen in a person's blood) to check his oxygen saturation level and stated it was 98% on room air, within normal limits. The DON stated she would contact the doctor to see if Resident #274 needed to continue to receive oxygen therapy since he was maintaining adequate oxygen saturation levels without the oxygen.</p> <p>Record review of the facility policy titled Oxygen Administration revised 03/21/2023, revealed The amount of oxygen by percent of concentration of L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. Further review revealed Turn on oxygen after properly setting for volume and place device in position.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>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 drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #53) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #53's Insulin Lispro was acquired and available per physician's orders.</p> <p>This failure could place residents at risk of not receiving their prescribed medications and a decreased quality of life.</p> <p>The findings included:</p> <p>Record review of Resident # 53's Admission Record dated 04/07/2025 revealed a [AGE] year-old man admitted to the facility on [DATE] and readmitted [DATE] with diagnosis of Type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood).</p> <p>Record review of Resident #53's 5-day MDS assessment dated [DATE] revealed he had a BIMS score of 15 indicating intact cognition and was assessed as having Diabetes Mellitus and receiving insulin injections.</p> <p>Record review of Resident #53's Care Plan initiated 03/07/2025 revealed he had Diabetes Mellitus with interventions for diabetes medication as ordered by the doctor.</p> <p>Record review of Resident #53's Order Summary Report dated 04/07/2025 revealed an order for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 150-199=1 UNIT; 200-249= 2 UNITS; 250-299=3 UNITS; [PHONE NUMBER]=4 UNITS, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS .</p> <p>During an observation on 04/07/2025 at 04:41 p.m., LVN-C was observed to administer 2 units of Insulin Lispro into Resident #53's left deltoid (upper arm) with an Insulin Lispro pen labeled with a pharmacy label for Resident #274. Further observation of the Insulin Lispro pen revealed that the pharmacy label with Resident #274's name was on the lower end of the insulin pen and handwritten on the outside of the cap of the insulin pen, in black permanent marker was Resident #53's last name.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN-C on 04/07/2025 at 4:46 p.m. LVN-C stated she used Resident #274's Insulin Lispro pen for Resident #53, because Resident #53 was out of his insulin Lispro, but it was the same medication, and she did not want Resident #53 to go without his insulin. She stated she had checked the extra supply in the refrigerator in the medication room and Resident #53 did not have any Insulin Lispro there, and when she checked the order for his medication found it was supposed to be delivered later that night, but since his insulin was due before evening meal and he did not have any, she used the Insulin Lispro pen labeled for Resident #274 to administer insulin to Resident #53 because it was the same type insulin that Resident #53 receives. She stated she sanitized and put a new pen needle on the pen and wrote Resident #53's last name on the cap of the pen.</p> <p>The Regional Compliance Nurse approached during this interview and when shown the Insulin Lispro pen, she stated LVN-C should not have used an insulin pen labeled for one resident to be used for a different resident, even if it was the same medication. She stated this could result in Resident #247 running out of his medication early and stated that LVN-C should have used insulin from the stat-safe (an emergency kit that contains a small quantity of medications that can be dispensed when pharmacy services not available).</p> <p>During a joint interview with the DON and Regional Compliance Nurse on 04/08/2025 at 3:00 p.m., the DON stated that each Nurse is responsible for ordering medications when they see that the medication is starting to get low. The DON noted that when insulin is given per sliding scale, the amount of insulin administered varies, and this can make knowing when to re-order difficult, but stated that each insulin pen is only good for 30 days after it is opened. The Regional Compliance Nurse stated that they would need to review their medication order procedure.</p> <p>Record review of the facility policy titled Medication Administration Procedures revised 10/25/2017 revealed the following:</p> <ul style="list-style-type: none"> - Medications prescribed for one resident are not to be administered to any other resident; and - It is prohibited from borrowing one resident's medication to be used for a different resident. 		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 5 residents (Resident #53) reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN C did not handwrite Resident #53's last name on the cap of an Insulin Lispro pen (a rapid-acting insulin used to lower blood sugar levels in people with diabetes) which was labeled with a pharmacy label for a different resident (Resident #274) and administer insulin from that Insulin Lispro pen labeled for Resident #274 to Resident #53.</p> <p>This failure could affect residents prescribed medications in the facility and place them at risk for not receiving the correct medications due to incorrect labelling or not having their medications available when needed.</p> <p>Findings Included:</p> <p>Record review of Resident # 53's Admission Record dated 04/07/2025 revealed a [AGE] year-old man admitted to the facility on [DATE] and readmitted [DATE] with diagnosis of Type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood).</p> <p>Record review of Resident #53's 5-day MDS assessment dated [DATE] revealed he had a BIMS score of 15 indicating intact cognition, and was assessed as having Diabetes Mellitus and receiving insulin injections.</p> <p>Record review of Resident #53's Care Plan initiated 03/07/2025 revealed he had Diabetes Mellitus with interventions for diabetes medication as ordered by the doctor.</p> <p>Record review of Resident #53's Order Summary Report dated 04/07/2025 revealed an order for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 150-199=1 UNIT; 200-249= 2 UNITS; 250-299=3 UNITS; [PHONE NUMBER]=4 UNITS, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS .</p> <p>During an observation on 04/07/2025 at 04:41 p.m., LVN-C was observed to administer 2 units of Insulin Lispro into Resident #53's left deltoid (upper arm) with an Insulin Lispro pen labeled with a pharmacy label for Resident #274. Further observation of the Insulin Lispro pen revealed that the pharmacy label with Resident #274's name was on the lower end of the insulin pen and handwritten on the outside of the cap of the insulin pen, in black permanent marker was Resident #53's last name.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 of 7 residents (Residents #52 and #53) reviewed for infection control.</p> <ol style="list-style-type: none"> The facility failed to ensure CNA A and CNA B wore gowns while in providing care to Resident #52 who was on EBP. The facility failed to ensure LVN C did not administer insulin Lispro (a rapid-acting insulin used to lower blood sugar levels in people with diabetes) to Resident #53, from an insulin pen labelled for a different resident (Resident #274). <p>These failures could place residents at risk for cross contamination and infection.</p> <p>The finding included:</p> <ol style="list-style-type: none"> Record review of Resident #52's Admission Record, dated 04/08/2025, revealed a [AGE] year-old male admitted on [DATE] with re-admission on 02/27/2025 with diagnoses which included: Dementia (a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life); Injury of Urethra (tube that carries urine from bladder out of the body); Urinary Tract Infection (a bacterial infection that occurs in any part of the urinary system); Obstructive and Reflux Uropathy (condition characterized by urinary tract blockage and/or backflow of urine). <p>Record review of Resident #52's 5-day MDS assessment dated [DATE] revealed the resident had a BIMS score of 09 indicating Moderate Cognitive Impairment, and was assessed as having an indwelling catheter.</p> <p>Record review of Resident #52's care plan initiated 01/13/2025 revealed the resident had an indwelling catheter and was on enhanced barrier precautions with interventions which included Gloves and gown should be donned if any of the following activities are to occur: toileting/incontinent care .catheter care.</p> <p>Record review of Resident #52's Order Summary Report dated 04/08/2025 revealed orders which included:</p> <ul style="list-style-type: none"> - Provide catheter care every shift related to URINARY TRACT INFECTION, SITE NOT SPECIFIED (order date 02/27/2025) - ENHANCED BARRIER PRECAUTIONS (order date 02/28/2025) <p>Observation on 04/08/2025 at 10:50 a.m. revealed CNA-A and CNA-B sanitized their hands and put on gloves to perform peri-care and catheter care for Resident #52 but did not wear a gown. There was an EBP sign posted on entrance door to Resident #52's room and a supply of PPE next to the door.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Twin Pines North Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Mallette Drive Victoria, TX 77904	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview on 04/08/2025 at 11:03 a.m. with CNA-A and CNA-B, both stated they had received training on EBP, and knew they were supposed to put on both a gown and gloves when working directly with any resident with a catheter but had just gotten nervous and forgot. CNA-A stated that by not following EBP, it could result in spread of germs and infection.</p> <p>During an interview with the DON on 04/08/2025 at 11:47 a.m., the DON stated that both CNA's should have followed EBP by wearing both a gown and gloves to provide foley care to Resident #52, and that both CNA's had received training on infection control including EBP. The DON stated that not following EBP could increase the risk of the spread of infection.</p> <p>Record review of the facility policy titled Enhanced Barrier Precautions and dated 04/01/2024 revealed:</p> <ul style="list-style-type: none"> - EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing; and - EBP are indicated for resident with any of the following . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. <p>2. Record review of Resident # 53's Admission Record dated 04/07/2025 revealed a [AGE] year old man admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood).</p> <p>Record review of Resident #53's 5-day MDS assessment dated [DATE] revealed he had a BIMS score of 15 indicating intact cognition, and was assessed as having Diabetes Mellitus and receiving insulin injections.</p> <p>Record review of Resident #53's Care Plan initiated 03/07/2025 revealed he had Diabetes Mellitus with interventions for diabetes medication as ordered by the doctor.</p> <p>Record review of Resident #53's Order Summary Report dated 04/07/2025 revealed an order for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 150-199=1 UNIT; 200-249= 2 UNITS; 250-299=3 UNITS; [PHONE NUMBER]=4 UNITS, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS .</p> <p>During an observation on 04/07/2025 at 04:41 p.m., LVN-C was observed to administer 2 units of Insulin Lispro into Resident #53's left deltoid (upper arm) with an Insulin Lispro pen labelled for Resident #274. Further observation of the Insulin Lispro pen revealed that the pharmacy label with Resident #274's name was on the lower end of the insulin pen and handwritten on the outside of the cap of the insulin pen, in black permanent marker was Resident #53's last name.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN-C on 04/07/2025 at 4:46 p.m. LVN-C stated she used the Insulin Lispro pen for Resident #274 for Resident #53, because Resident #53 was out of his insulin Lispro, but it is the same medication, and she did not want Resident #52 to go without his insulin. She stated she had checked the extra supply in the refrigerator in the medication room and Resident #53 did not have any Insulin Lispro there, and when she checked the order for his medication found it was supposed to be delivered later that night, but since his insulin was due before evening meal and he did not have any, she used the Insulin Lispro pen labelled for Resident #274 to administer insulin to Resident #53 because it was the same type insulin that Resident #53 receives. She stated she sanitized and put a new pen needle on the pen and wrote Resident #53's last name on the cap of the pen.</p> <p>While conducting the interview with LVN-C on 04/07/2025 at 4:46 p.m., the Regional Compliance Nurse approached and when shown the Insulin Lispro pen labelled for Resident #247, but was used to administer insulin to Resident #53, she stated that LVN-C should not have used an insulin pen labelled for one resident to be used for a different resident, even if it was the same medication. She stated that this could result in Resident #247 running out of his medication early and stated that LVN-C should have used insulin from the stat-safe (an emergency kit that contains a small quantity of medications that can be dispensed when pharmacy services not available).</p> <p>During further interview with the Regional Compliance Nurse on 04/09/2025 at 12:31 p.m. the Regional Compliance Nurse stated that the same insulin pen should not be used for 2 different residents as it could result in spread of infection.</p> <p>Record review of the Nurse Proficiency Audit for LVN-C dated 4/1/2025 revealed LVN-C was assessed as satisfactory for tasks which included: Administers medications properly and Infection Control prevents cross contamination.</p> <p>Record review of the facility policy titled Medication Administration Procedures revised 10/25/2017 revealed the following:</p> <ul style="list-style-type: none"> - Medications prescribed for one resident are not to be administered to any other resident; and - It is prohibited from borrowing one resident's medication to be used for a different resident. <p>Record review of an article titled Sharing Insulin Pens: Are You Putting Patients at Risk? dated 10/15/2013 at https://pmc.ncbi.nlm.nih.gov/articles/PMC3816894/ revealed Backflow of blood and other biologic material into the insulin cartridge or reservoir can occur after injection (1). For this reason, insulin pens, like other injection devices, must never be used by more than one person.</p>		