STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676396	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S.P.J.S.T. Rest Home 3	248 Wisteria Lane El Campo, TX 77437

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** 48863 Based on observation, interview, and record review the facility failed to ensure residents were free of significant medication errors for 1 (Resident #8) of 6 residents reviewed for medication errors. -LVN A attempted to administer the wrong dose of insulin to Resident #8 before Surveyor intervention. This failure placed resident at risk for inadequate therapeutic outcomes and decline in health. Findings included: Record review of Resident #8's face sheet revealed an [AGE] year-old female admitted on [DATE]. Her diagnoses included: Type 2 diabetes mellitus with diabetic chronic kidney disease. Record review of Resident #8's annual MDS assessment dated [DATE] revealed a BIMS score of 08 indicating moderate cognitive impairment. Record review of Resident #8's care plan revised on 5/2/2019 read in part, . (Resident #8) is at risk for unstable glucose level r/t dm2 . Interventions/Tasks . Diabetes medication as ordered by doctor . Record review of Resident #8's Order Summary Report dated August 8, 2024, read in part, Novolin R Solution 100 unit/ml (insulin aspart) inject as per sliding scale: if 150 - 199 = 4 units; 200 - 249 = 6 units; 250 - 299 = 9 units; 300 - 349 = 9 units; 350 - 999 = 15 units; IF BS above 349 give 15 UNITS AND CALL MD subcutaneously before meals related to type 2 diabetes mellitus with unspecified complications . order date, 8/31/2021 . Record review of Resident #8's MAR dated August 2024 revealed a blood sugar level of 249 on 08/07/24 at 4:30 p.m. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and Interview on 08/07/24 at 4:40 p.m. with LVN A, the Surveyor observed LVN A draw 9 units insulin from multidose vial. LVN A said that Resident #8's blood sugar was 249 and she was to receive 9 units of Novolog according to the sliding scale order. Observed her turn towards the resident to administer the insulin. Surveyor intervened and asked the nurse to check the MAR/Order. LVN A said that the amount of insulin in the syringe was more than prescribed by the doctor. LVN A discarded the additional 3 units of insulin that were prepared after surveyor intervention. LVN A administered 6 units into resident's right upper arm. Interview on 8/07/24 at 5:07 p.m. with LVN A who said she was PRN staff and she said she came out of retirement to cover some shifts. Interview on 08/08/24 at 2:08 p.m. with the DON, who said the expectation was for nurses to give insulin correctly. She said, the nurses should take time to ensure that the correct insulin dose is administered. The DON verbalized the last time there was an insulin in-service was 09/11/23 with return demonstration on insulin pen and insulin Vials. She said the risk of administering Insulin outside of the parameters can cause hypoglycemia (low blood sugar levels below the standard range). She said some of the side effects of hypoglycemia could ultimately result in death. Interview on 8/08/24 at 2:47 p.m. with the administrator, she said nursing staff were to check a minimal of five rights of medication administration, which included the right dose. Record review of the facility's General Guidelines for Medication Administration policy revised 08/2020 read in part, . Procedure . 4. At a minimum, the 5 Rights-right resident, right drug, right dose, right route, and right time-should be applied to all medication administration . Record review of the facility's Insulin Administration policy revised 10/2010 read in part, Steps in the Procedure (Insulin Injection via syringe) . 8. Check order for the amount of insulin .12. Double check the order for the amount of insulin .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 16989 Based on observation, interview, and record review, the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for two of four medication carts. -The keys to the [NAME] medication cart and the East medication carts were hanging on a hook inside of the [NAME] nurses' station, which was not locked, and the keys were within reach of persons outside the nurses' station. The failure placed the two medication carts at risk for drug diversion. Findings include: Observation on 08/07/24 at 1:30 p.m. of the [NAME] nurses' station revealed two sets of keys hanging on hooks on the inside of the counter. They were visible from the hallway. They were within reach of persons on the other side of the counter. The nurses' station had a gate that was approximately waist-high. It was unlocked. There were no staff within sight of the nurses' station. There was a locked medication cart just outside of the nurses' station. There was a locked medication cart inside of the nurses' station. There were tags on the keys. One tag read [NAME] Med Cart. The other read East CMA Cart. Observation and interview on 08/07/24 at 1:38 p.m. revealed the DON walked up to the [NAME] nurses' station. When the Surveyor asked about the keys, the DON said LVN L and MA H were probably eating lunch. The DON tried the keys in the medication cart in the nurses' station. The cart did not unlock. She then tried to unlock the medication cart outside of the nurses' station. The key on one of the sets of keys unlocked the cart. There were medications in the cart. The DON then went to the dining room. There were residents in the dining room. Observation revealed there was a medication cart in the dining room. The key on one of the sets of keys unlocked the cart. There were medications in the cart. The DON said that medications could have been taken from the carts if someone had taken the keys. In an interview on 08/07/24 at 1:50 p.m., LVN L said she usually would give the keys to another nurse when she left. LVN L said, I had to step out so I hung them up. She said she had both sets of keys. The facility policy Storage of Medications (revised April 2007) read, in part, .10. Only persons authorized to prepare and administer medications shall have access to the medication room , including keys.