STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHARTON NURSING AND REHABILITATION CENTER	**1220 SUNNY LANE WHARTON, TX 77488**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services as outlined by the comprehensive care plan, to meet professional standards of quality for 1 of 24 residents (Resident #1) reviewed for care plans. -The facility failed to administer insulin to Resident #1 according to physician's orders [REDACTED]. Findings include: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident 1's Quarterly MDS assessment dated [DATE] revealed a BIMS of 14 out of 15 indicating the resident was cognitively intact. He had an active [DIAGNOSES REDACTED]. Resident #1 required two-person assistance for bed mobility, transfers, and toileting. He required one-person assistance for dressing, personal hygiene and set up assistance for eating. Record review of Resident #1's care plan dated 4/24/20 revealed the following: Resident #1 was at risk for unstable blood glucose levels. The goal was for resident #1 to be free from any signs or symptoms of [MEDICAL CONDITION], [DIAGNOSES REDACTED], with no complications related to diabetes. The intervention was to administer medications per physician order's; and administer medication ([MEDICATION NAME] R) as ordered. Record Review of Resident #1's physician orders [REDACTED].= 0 [DIAGNOSES REDACTED] Protocol; 61 - 150 = 0; 151 - 200 = 3 units; 201 - 250 = 5 units ; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units ; 401 - 450 = 15 units ; 451 - 999 = 18 units Call NP/MD , subcutaneously before meals and at bedtime for Diabetes BS 110 Record review of Resident #1's MAR dated 6/1/20 to 6/30/20 revealed [MEDICATION NAME] R Solution was not administered according to physician orders [REDACTED]. The MAR had blanks indicating Resident #1 did not receive his insulin before breakfast, lunch and dinner as prescribed by the physician. Record review of MAR dated 8/1/20 to 8/31/20 revealed [MEDICATION NAME] R Solution was not administered according to physician orders [REDACTED].#1 received did not receive his insulin at bedtime as prescribed by the physician. Record review of the facility's Weights and Vital Summary log revealed glucose levels were check on 6/6/20 at 11:22 pm and on 6/7/20 at 10:32 pm which was consistent with Resident #1 not receiving his insulin before breakfast, lunch and dinner as prescribed by physician. Record review of the facility's Weights and Vital Summary log revealed glucose levels were check on 8/7/20 at 10:17 am; 12:19 pm; and 5:34 pm which was consistent with Resident #1 not receiving his insulin before bedtime as prescribed by physician. In an interview on 8/31/20 at 5:45 pm with LVN, she said she had been working at the facility for a couple of months. She said Resident #1 had physician orders [REDACTED]. She said she did not know why Resident #1's glucose levels were checked only once on 6/6/20 and 6/7/20. She said it was important to follow physician orders [REDACTED]. She could not recall the last time she was in-serviced for glucose monitoring and/or following physician orders. In an interview on 8/31/20 at 6:33 pm with RN, she said she had returned to the facility this month. She said the charge nurses were responsible for ensuring physician orders [REDACTED]. She said Resident #1 used to be on hallway 400. She said she oversaw hallway 400. She said she used Resident #1's care plan and MAR to know how to provide care for him. She said it was important to follow physician orders, so the resident got the proper care. She said it was important to ensure that glucose levels were monitored according to physician orders [REDACTED]. She said she had not been in-serviced since she returned to work at the facility. She said if residents are on insulin, the charge nurse checks the blood sugar with the glucometer and then administers insulin as ordered according the sliding scale per physician orders. She said if sugar levels continued to be high after insulin was administered, they continue to follow physician's orders [REDACTED]. If the condition continues, then protocol was to call the physician. She said she could not say why Resident #1's blood sugar levels were checked less than ordered and why insulin was given only once on 6/6/20 and 6/7/20 because she was not working at the facility at the time. She could not explain why Resident #1 did not get his insulin at bedtime on 8/7/20. Observation and interview on 9/1/20 at 2:44 pm of Resident #1 revealed him lying in local hospital bed. He had a surgical face mask on his forehead. He was holding on tight to the call light. He had a lunch tray containing pork rib, green beans, soup, two apple juices, sugar free jello and sugar free shortbread cookies that had not been touched. He said he did not feel like eating. He said Medicare placed him at the facility because it was the only place they would approve. He said his Medicaid application was pending. He said the facility checked his blood sugars all the time. He said he was supposed to get insulin and have his blood sugars checked three times per day. Then, he said he could not recall when he was supposed to have his blood sugars and/or insulin administered. When this Surveyor asked him if he had any concerns about his treatment at the facility, Resident #1 responded, Yes. Resident #1 said the facility did not always check his blood sugar levels and/or give him his insulin. He said he would tell all the staff, but they did nothing about it. He said the facility would run out of briefs on the weekend. He said it stressed him out and he felt neglected. He said he would be returning to the facility. In an interview on 8/31/20 at 6:58 pm with the DON, she said Resident #1's sugar levels were managed according to the physician's sliding scale order for insulin. She said the charge nurses were responsible for ensuring that glucose monitoring occurred according to physician orders. She said nursing staff were responsible to ensure physician orders [REDACTED]. She confirmed Resident #1 did not receive insulin on 8/7/20 at bedtime. She said she felt bad because they were doing so well. She said it was important for nursing staff to follow physician orders [REDACTED]. She said the blanks on the MAR meant two things: if the nurse had to pull the meds, then medication techs were unable to sign the MAR, so the nurse was responsible to go back and sign the MAR. She said, if it's not documented; it didn't happen. She said if it was not documented, there was no way to tell if medications were given. She said the last time nursing staff was in-serviced for following physician orders [REDACTED]. She said the facility had a QAPI meeting that resulted in the facility having to conduct a medication audit weekly to ensure that orders were fulfilled and signed off on them. She said a nurse manager would be responsible for that role. She said nurse managers were responsible prior to the medication audit initiative but, it was not consistent. Record review of the facility's policy and procedure for following physician orders [REDACTED]. It read in part, .The medical care of each resident is under the supervision of a License Physician. Physician orders [REDACTED]. .
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical records were accurately documented for 1 of 5 residents (Resident #1) reviewed for clinical records in that: -Resident #1's medication orders were not accurately documented; there were blanks on the MAR. This failure placed all residents receiving medications at risk of medication errors, and having incomplete medical records. Findings include: Resident #1 Record review of the face sheet for Resident #1 revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident 1's Quarterly MDS assessment dated [DATE] revealed a BIMS of 14 out of 15 indicating the resident was cognitively intact. Resident #1 required two-person assistance for bed mobility, transfers, and toileting. He required one-person assistance

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

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.

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) for dressing, personal hygiene and set up assistance for eating. Record Review of Resident #1's care plan dated 4/24/20 revealed the following: Resident #1 was at risk for unstable blood glucose levels. The goal was for resident #1 to be free from any signs or symptoms of [MEDICAL CONDITION], [DIAGNOSES REDACTED], with no complications related to diabetes. The intervention was to administer medications per physician order's; and administer medication ([MEDICATION NAME] R) as ordered. Record review of Resident #1's MAR dated 6/1/20 to 6/30/20 revealed blanks for [MEDICATION NAME] R Solution on 6/6/20 and 6/7/20. The MAR had blanks indicating Resident #1 did not receive his insulin before breakfast, lunch, and dinner as prescribed by the physician. Record review of Resident #1's MAR dated 8/1/20 to 8/31/20 revealed [MEDICATION NAME] R Solution on 8/7/20. The MAR had a blank indicating Resident #1 did not receive his insulin at bedtime as prescribed by the physician. Record review of the facility's Weights and Vital Summary log revealed glucose levels were checked on 6/6/20 at 11:22 pm and on 6/7/20 at 10:32 pm which was consistent with the blanks on the MAR. Record review of the facility's Weights and Vital Summary log revealed glucose levels were check on 8/7/20 at 10:17 am; 12:19 pm; and 5:34 pm which was consistent with the blanks on the MAR Record Review of Resident #1's physician orders [REDACTED].= 0 [DIAGNOSES REDACTED] Protocol; 61 - 150 = 0; 151 - 200 = 3 units; 201 - 250 = 5 units ; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units ; 401 - 450 = 15 units ; 451 - 999 = 18 units Call NP/MD , subcutaneously before meals and at bedtime for Diabetes BS 110 Observation and interview of Resident #1 on 9/1/20 at 2:44 pm revealed him lying in local hospital bed. He had a surgical face mask on his forehead. He was holding on tight to the call light. He had a lunch tray containing pork rib, green beans, soup, two apple juices, sugar free jello and sugar free shortbread cookies that had not been touched. He said he did not feel like eating. He said Medicare placed him at the facility because it was the only place they would approve. He said his Medicaid application was pending. He said the facility checked his blood sugars all the time. He said he was supposed to get insulin and have his blood sugars checked three times per day. Then, he said he could not recall when he was supposed to have his blood sugars and/or insulin administered. When this Surveyor asked him if he had any concerns about his treatment at the facility, Resident #1 responded, Yes. Resident #1 said the facility did not always check his blood sugar levels and/or give him his insulin. He said he would tell all the staff, but they did nothing about it. He said the facility would run out of briefs on the weekend. He said it stressed him out and he felt neglected. He said he would be returning to the facility. In an interview on 8/31/20 at 6:58 pm with the DON, she confirmed there were blanks on the MAR indicating the resident did not receive insulin on 6/6/20 and 6/7/20 before breakfast, lunch, and dinner. She confirmed there was a blank on 8/7/20 indicating Resident #1 did not receive insulin at bedtime. She said she felt bad because they were doing so well. She said it was important for nursing staff to follow physician orders [REDACTED]. She said the blanks on the MAR meant two things: if the nurse had to pull the meds, then medication techs were unable to sign the MAR, so the nurse was responsible to go back and sign the MAR. She said, if it's not documented; it didn't happen. She said if it was not documented, there was no way to tell if medications were given. She said the last time nursing staff was in-serviced for clinical documentation was on 3/13/20. She said the facility had a QAPI meeting that resulted in the facility having to conduct a medication audit weekly to ensure that orders were fulfilled and that they were signed off on the MAR. She said a nurse manager would be responsible for that role. She said nurse managers were responsible prior to the medication audit initiative but, it was not consistent. Record review of facility's policy and procedure for following physician orders [REDACTED]. It read, The medical care of each resident is under the supervision of a License Physician. Physician orders [REDACTED]. .