STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675800	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA VIDA SERENA NURSING AND REHABILITATION	**711 KINGS WAY DEL RIO, TX 78840**

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures for administration of all drugs) to meet the needs of each resident for 1 of 1 resident (Resident #2) reviewed for medications, in that: Resident #2's insulin was not administered as ordered by the physician. This deficient practice could place residents who receive insulin and place them at risk of not receiving a therapeutic effect or being over medicated. The findings were: Record review of Resident #2's admission record dated 4/14/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's physician's order dated 4/14/2020 revealed [MEDICATION NAME] R solution 100 unit/ml (insulin regular human) inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units >350 = 15 units, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus notify MD if BS <60 or >400. Observation on 4/14/2020 at 11:14 AM revealed LVN A drew up 6 units of [MEDICATION NAME] R into a insulin syringe in the hallway. In an interview on 4/14/2020 at 11:14 AM LVN A confirmed she drew up 6 units of [MEDICATION NAME] R for Resident #2. Observation on 4/14/2020 at approximately 11:17 AM revealed LVN A brought a glucometer, lancet, blood sugar strip, and the insulin syringe with 6 units of [MEDICATION NAME] R to Resident #2's room. Observation on 4/14/2020 at 11:18 AM revealed LVN A checked Resident #2's blood sugar and the result on the glucometer read 189. In an interview on 4/14/2020 at 11:18 AM, LVN A confirmed Resident #2's blood sugar was 189. Observation on 4/14/2020 at 11:19 AM, revealed LVN A administered the insulin to Resident #2. In an interview on 4/14/2020 at 11:22 AM, LVN A stated she squirted out some insulin and administered 4 unit of [MEDICATION NAME] R to Resident #2. Record review of Resident #2's treatment administration record for April 2020 revealed on 4/14/20 at 10:45 AM LVN A documented Resident #2's blood sugar was 201 and she had documented administered 6 Units of [MEDICATION NAME] R for Resident #2. In an interview on 4/14/2020 at 11:23 AM LVN A confirmed she administered 4 units of [MEDICATION NAME] R to Resident #2 at 11:19 AM and should have only administered 3 units based on sliding scale order. In an interview on 4/14/2020 at 5:04 PM LVN A confirmed she documented Resident #2's blood sugar was 201 at 10:45 AM. LVN A further confirmed she documented she administered 6 units of [MEDICATION NAME] R to Resident #2. Record review of the facility policy titled Medication Administration Procedure dated 10/25/2017 revealed After the resident has been identified, administer the medication and immediately chart doses administered on the Medication Administration Record [REDACTED]. Right drug, 2. Right dose, 3. Right Resident, 4 Right time, 5. Right route.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Residents #1 and #2) reviewed for infection control, in that: 1. LVN A exited Resident #1's room without removing soiled gloves and washing or sanitizing her hands after performing blood sugar check for Resident #1. 2. a. LVN A exited Resident #2's room without removing soiled gloves and washing or sanitizing her hands after performing blood sugar check for Resident #2. b. LVN A did not disinfect the glucometer - blood glucose monitoring machine after checking Resident #2's blood sugar. These deficient practices could place residents in the facility who received blood sugar monitoring and insulin at risk for infection. The findings were: 1. Record review of Resident #1's admission record dated 4/14/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's physician order [REDACTED].= 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units >350 = 15 units, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus without complications. Notify MD if BS <60 or >400. Observation on 4/14/2020 at 10:56 AM revealed LVN A checked Resident #1's blood sugar and exited Resident #1's room without removing her soiled gloves and washing or sanitizing her hands. Further observation revealed LVN A removed her soiled gloves at the medication cart, which was parked in a hallway. In an interview on 4/14/2020 at 11:23 AM LVN A confirmed she did not remove her soiled gloves and did not wash or sanitize her hands after checking Resident #1's blood sugar and before exiting Resident #1's room. 2. Record review of Resident #2's admission record dated 4/14/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's physician's orders [REDACTED].= 0 units; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units >350 = 15 units, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus notify MD if BS <60 or >400. Record review of Resident #2's treatment administration record for April 2020 with revealed LVN A documented on 4/14/20 Resident #2's blood sugar was 201 and documented she had administered 6 Units of [MEDICATION NAME] R to Resident #2. Observation on 4/14/2020 at 11:19 AM revealed LVN A removed her soiled gloves and exited Resident #2's room without washing or sanitizing her hands, after LVN A checked Resident #2 blood sugar and administered insulin to Resident #2. Further observation on 4/14/2020 at 11:20 AM revealed LVN A placed the glucometer inside the medication cart without disinfecting the glucometer after checking Resident #2's blood sugar. In an interview on 4/14/2020 at 11:24 AM LVN A confirmed she did not wash or sanitize her hands before exiting Resident #2's room. In an interview on 4/14/2020 at 11:26 AM LVN A confirmed she did not disinfect the glucometer after checking Resident #2 blood sugar and before placing the glucometer inside the medication cart. In an interview on 4/14/2020 at 3:11 PM the DON stated LVN A should have removed soiled gloves and washed or sanitized her hands before exiting Resident #1 and Resident #2's room. Further interview with the DON confirmed LVN A should have disinfected the glucometer after checking Resident #2's blood sugar. Record review of Infection Prevention during Blood Glucose Monitoring and Insulin Administration retrieved on 4/21/2020 from the CDC website https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html revealed Blood Glucose Meters: .If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared. Record review of Hand Hygiene in Healthcare Setting retreived on 4/21/2020 from the CDC website https://www.cdc.gov/Handhygiene revealed Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal.

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.