STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455989	A. Building B. Wing	04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Borger Healthcare Center	1316 S Florida 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.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32393 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of significant medication errors for 1 of 5 residents (Resident # 1) reviewed for medications. The facility failed to ensure Resident #1's hospital discharge medication orders were followed for insulin from his admitted [DATE] until he was found unresponsive and sent to the hospital on [DATE]. Resident #1 was not administered his scheduled insulin at night for 3 nights nor did he receive his insulin per sliding scale three times a day, missing 8 total doses. Resident #1 expired on [DATE]. An Immediate Jeopardy was identified on [DATE] at 4:30 PM as having occurred from [DATE] - [DATE]. However, the facility remained out of compliance at a severity level of actual harm not IJ with a scope of isolated because the facility had not had time to monitor their plan of removal for effectiveness. This failure placed current and future diabetic residents at risk for elevated blood sugars, coma, and death. Findings included: Closed record review of Resident #1's Face Sheet dated [DATE] indicated a [AGE] year-old male admitted on [DATE] with diagnoses that included: wedge compression fracture of third lumbar vertebra, initial encounter for closed fracture, unspecified dementia with behavioral disturbance, Type 2 diabetes mellitus without complications, heart failure, unspecified, essential (primary) hypertension (high blood pressure), ischemic cardiomyopathy (A condition of weakened heart muscles due to heart attack or coronary heart disease), hypothyroidism (decreased production of thyroid hormones), and presence of cardiac pacemaker. Resident #1's Face Sheet also revealed he was discharged to the hospital on [DATE]. Record review of Resident #1's admission MDSs dated [DATE] and [DATE] indicated they were still in process and were incomplete. Record review of Resident #1's care plan dated [DATE] indicated the following: Problem: Diabetes (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: No Complications Approach: Labs as ordered, Observe for S/S of hypo/hyperglycemia (low blood sugar/high blood sugar) Closed record review of the Discharge Instructions for Resident #1 from the hospital dated [DATE] provided by the DON indicated an order for insulin that read as follows: Home Medications Continue these medications Insulin Lispro (Humalog) 100 Unit/1 Ml Cartridge, Dose: Unknown Dose, SUB-Q, TID Per Sliding Scale New Prescriptions Insulin Glargine, Hum.Rec.Anlog (Lantus) 100 Unit/1 Ml Vial, Dose: 20 Unit, SUB-Q, HS for 30 days Stop taking these medications Insulin Glargine, Hum.Rec.Anlog (Lantus) 100 Unit/1 Ml Vial, Dose: 9 Unit, SUB-Q, HS Record review of Resident #1's Medication Administration Record from [DATE] - [DATE] revealed there were no orders for insulin or blood sugar checks. Type 2 diabetes mellitus was listed as a diagnosis in this record. Record review of Resident #1's Progress Note dated [DATE] at 3:53 PM written by the on-call physician documented the following: Chief Complaint : Altered Mental Status Patient is a 79yearold male with respiratory failure is currently on oxygen. Patient has had decreased responsiveness since this afternoon, difficult to arouse and is hypotensive (low blood pressure). Transfer to Emergency Department Record review of Resident #1's Visit Summary from the hospital's emergency room he was sent to on [DATE] revealed the following: admitted : [DATE] at 5:10 PM Diagnosis: Type 1 Diabetes Mellitus with Ketoacidosis with Coma Serum Glucose at 5:28 PM on [DATE] was greater than 625, reference range ,d+[DATE] (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LVN B on [DATE] at 11:21 AM she said the first day she worked with Resident #1 was on [DATE], the day he was sent to the hospital. She took her lunch break and when she came back, she said LVN A told her Resident #1 was unresponsive and that she already took his vitals. LVN B went ahead and took his vitals again herself. She said he was not responding, and his oxygen was low, around , d+[DATE]. She said she got it up to only ,d+[DATE] at 4 liters of oxygen. She was doing a sternal rub to him but that didn't arouse him. She said the on-call physician was called and said to send Resident #1 to the emergency room . LVN B said there were no blood sugar checks done; there were no orders for insulin or blood sugar checks. LVN B said LVN A worked with him for his first few days at the facility and would have more information about him. During an interview with LVN A on [DATE] at 11:26 AM she said Resident #1 was admitted Thursday, [DATE] and she admitted him. She said she got report from the nurse at the hospital and was told his primary diagnosis was L3 compression fx and his secondary diagnosis was hyperglycemia. She said she was told they treated him at the hospital for hyperglycemia and that they got it under control. She said they didn't need to do finger sticks to check his blood sugar because he had a device in his arm for checking his blood glucose levels. She was told by the nurse at the hospital to get with his doctor and decide if they wanted to use this device or not. She never did . She called the NP and went over his list of meds from the hospital. She said his insulin was listed as new/continue but also on the discontinue list. She took that as to discontinue his insulin and she said that was what she relayed to the NP. She said she failed to look at the whole dosage and just looked at the medicine listed. She didn't see that it said to start 20 units and down at the bottom of the list it said discontinue 9 units. He was previously on 9 units and was ordered to take 20 units. She said she made a mistake when she looked at the orders wrong. She said because she told the NP the insulin was discontinued, the NP said they would see how he does and didn't order to do the finger sticks to check his blood sugar. The NP did order to get his Hemoglobin A1C labs, however this was never done. When he became unresponsive on [DATE] while his nurse was out for lunch, LVN A took his vitals and she administered oxygen to him. When his nurse came back from lunch, she told her what was going on and left him to the care of his nurse. LVN A said she was sure it was all respiratory issues since was oxygen level was low. During a confidential interview on [DATE] at 11:45 AM, Individual stated Resident #1 was still in the hospital and his kidneys were failing. He wasn't expected to survive. Individual said before Resident #1 was admitted to the nursing facility his blood sugar was checked at least 4 times a day and was administered insulin shots 4 times a day. Individual said he got a scheduled amount and then a sliding scale dose on top of that. Individual said Resident #1 had diabetes for [AGE] years and was insulin dependent. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 2:15 PM she said that no lab work was done for Resident #1, including his hemoglobin A1C that was ordered on [DATE] when he was admitted . She said their scheduled lab days were Monday - Thursday. He would have had his lab done on [DATE] but he went to the hospital on [DATE]. During a simultaneous interview with LVN A, both where asked who wrote a note on Resident #1's Discharge Instructions from the hospital that read, Is DM but no FS rt now. At first LVN A denied writing the note but after closer inspection and the DON saying it looked like her handwriting, LVN A said she wrote the handwritten note. When asked what was said and what it meant, she said, Is diabetic but no finger sticks right now. DON said she usually double checks the orders of the newly admitted residents, but she didn't work again until Monday, [DATE]. She said normally, if she doesn't review the orders, then the ADON would review them. She said the ADON didn't review them either because she was working the night shift as a floor nurse. When asked what could happen to a person with diabetes if they were supposed to have insulin every day but don't get it for 3 days, both said a person with diabetes could go into a diabetic coma. When asked if this situation could have been prevented, DON said it could have been prevented and should have been found within 24 hours if someone had reviewed Resident #1's admission paperwork and orders. During an interview with NP on [DATE] at 2:55 pm, she said she expects the nurses to give her the correct information from the hospital's discharge orders. She said she remembered ordering Resident #1's hemoglobin A1C and that lab work should have been done the next day, not wait until Monday on their routine lab days. She said she went off of what the nurse said and that she never saw Resident #1, nor did she have any paperwork on him. During an interview with DON on [DATE] at 3:40 pm, she said they didn't do any finger stick blood sugar checks on Resident #1 because LVN A said the hospital wasn't doing them, so they didn't do them at the nursing facility either. She said Resident #1 had a device in his arm that checked his blood sugars, and it was read from an unknown agency. They didn't know where that information was sent, and they didn't have access to that information. DON said they should have been finding out what his glucose levels were. Record review of the facility's Admission Assessment and Follow Up: Role of the Nurse policy and procedure, revised February 2022 revealed the following: 11. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to the established procedures. 12. Contact the Attending Physician or after hours Telehealth provider to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. Record review of the facility's Nursing Care of the Older Adult with Diabetes Mellitus policy and procedure revised [DATE] revealed the following: Symptoms Associated with Diabetes 1. Hyperglycemia. Uncontrolled diabetes from lack of insulin or inadequate insulin results in hyperglycemia (blood sugar above target levels). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a confidential interview on [DATE] at 10:12 AM, Individual said Resident #1 passed away on the night of [DATE].