STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255267	A. BUILDING _____ B. WING _____	C 03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	1120 RITCHIE AVE CLARKSDALE, MS 38614

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F 000	INITIAL COMMENTS	F 000		

Complaint Investigation (CI) MS #17663 was conducted by the State Agency (SA) on 03-23-2021 through 03-31-2021. During the survey, the facility was found to not be in compliance with regulations implemented by the Centers for Medicare and Medicaid (CMS). CI MS #17663 was substantiated, related to Resident Neglect, and Quality of Care and Treatment, with deficiencies cited at F600, F693, and F760.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 03-03-2021 when the facility failed to provide goods and services to residents related to enteral feedings, water flushes, and diabetic medications necessary to avoid physical harm and the resident was hospitalized with hyperglycemia.

The facility's failure to follow CMS guidelines for preventing resident neglect resulted in three (3) residents not receiving adequate enteral feedings and water flushes daily, and five (5) residents not receiving insulin as ordered for their Diabetes. These actions resulted in the hospitalization of two (2) residents for critical Glucose levels, with one passing away. These actions placed all residents receiving enteral feedings and requiring insulin in a situation that was likely to cause serious harm, injury, impairment, and further death.

On 03-26-2021 at 2:45 PM, the SA notified the Administrator of the Immediate Jeopardy (IJ) and SQC and the IJ template was provided to the Administrator.

The IJ and SQC existed at:

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

Electronically Signed | 04/27/2021

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F 000	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation (F600) §483.25(g)(5) Enteral Nutrition (F693) §483.45(f)(2) Residents are free of any significant medication errors (F760) The facility submitted an acceptable Removal Plan on 03-30-2021, at 11:30 AM, in which the facility alleged all corrective actions to remove the IJ were completed on 03-30-2021 and the IJ was removed on 03-30-2021. The State Agency (SA) validated the Removal Plan on 03-31-2021, and determined the IJ was removed on 03-30-2021, prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.12 Freedom from Abuse, Neglect, and Exploitation (F600), 42 CFR(s): §483.25(g)(5) Enteral Nutrition (F693), and 42 CFR(s): §483.45(f)(2) Residents are free of any significant medication errors (F760) and were lowered from a "K" to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility had a census of 54 with license for 72 beds.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		4/30/21

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includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff interview, and facility policy review, the facility failed to provide goods and services related to enteral feedings and water flushes for three (3) out of four (4) residents reviewed of eight (8) residents requiring enteral feedings: Resident #1, #2 and #3, and failed to provide goods and services related to diabetic medications for five (5) of eight (8) residents reviewed of 11 insulin dependent diabetics, Residents #1, #2, #4, #5 and #6.

The facility's failure to provide goods and services related to enteral feedings, enteral water flushes and diabetic medications placed residents at risk, and in a situation, which caused serious injury and death for one (1) resident, Resident #1, hospitalization of Resident #2, and was likely to cause serious injury, harm, impairment, or death for other residents requiring enteral feedings and insulin.

The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 03-03-2021, when the facility failed to provide goods and services related to enteral feedings, enteral water flushes

Free from Abuse and Neglect

1)Resident #1 went to the hospital on March 17, 2021 and expired. Resident #2 was admitted to the hospital on March 23, 2021 and returned to the facility on April 5, 2021. Resident #2 was assessed on return by Registered Nurse #3 and #4 along with Licensed Practical Nurse #1 and all enteral feeding orders were reviewed to ensure they were being followed per physician's orders. Resident #3 was assessed By Registered Nurses #3 and #4 along with Licensed Practical Nurse #1 on March 25, 2021, to ensure orders related to their enteral feedings were being properly administered and that there were no negative outcomes. Residents #2, #4, #5 and #6 were assessed by Registered Nurses #3 and #4 along with Licensed Practical Nurse #1 along with their diabetic orders to ensure their were no negative outcomes and all orders were being administered per physician's orders.

2)All residents that have orders related to

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F 600	Continued From page 3 and diabetic medications and the resident was hospitalized with hyperglycemia. This failure resulted in the hospitalization of two (2) residents for critical blood glucose levels, with one passing away. These actions placed all residents receiving enteral feedings and requiring insulin in a situation that was likely to cause serious harm, injury, impairment, and further death. On 03-26-2021 at 2:45 PM, SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the NHA with the IJ template. The IJ and SQC existed at: §483.12 Freedom from Abuse, Neglect, and Exploitation (F600) - Scope and Severity - "K" The facility submitted a credible Removal Plan on 03-30-2021 at 9:00 AM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 03-30-2021. The SA validated the Removal Plan on 03-31-2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.12 Freedom from Abuse, Neglect, and Exploitation (F600) was lowered from a "K" level of scope and severity to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 600	enteral feedings and diabetes have the ability to be affected by this deficient practice. Current and future residents will have all orders clarified and during the admission process, the Licensed Practical Nurses caring for these residents will be notified of the resident's need immediately on admission by the Registered Nurse Supervisor or the Director of Nursing Services. 3)The Director of Nurses and Registered Nurse #1 initiated in-services with all Licensed Practical Nurses and Registered Nurses on March 25, 2021, at 3:10pm. This in-service covered the following topics: Tube Feeding, Drug Administration,Documentation including Electronic Medication Administration and Incident Investigation related to abuse and neglect. The Director of Nursing Services and Registered Nurse #1 initiated in-services with Licensed Practical Nurses and Registered Nurses on March 25, 2021 at 4:00PM. The topics of this in-service were: Hypoglycemia and Hyperglycemia. In-Service will continue until all Licensed Practical Nurses and Registered Nurses have attended. They will not be allowed to return to work until they have attended these in-services. On March 25, 2021, the facility moved into their electronic charting system from paper charting. In-service training for the electronic charting will be ongoing for all current and future staff. The Director of Nursing Services, Registered Nurse #4 and registered Nurse #3 will review the following electronic reports as they relate	

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F 600	Continued From page 4 Review of the facility's policy titled, "Incident Investigation & Reporting..." dated 05-2018 revealed, "1. Each resident residing in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation.... Neglect: A failure to provide good and services necessary to avoid physical harm, pain, mental anguish, or emotional distress." Review of the facility's policy titled, "Tube Feedings" dated 12-2015 revealed, "1. All tube feedings will be administered in accordance with verified medical necessity...3. Physician's orders for tube feeding will include, tube type, tube size, kind of feeding, caloric value, volume, duration, mechanisms of administration and flushes. A specific physicians' order will be obtained before attempts to discontinue a tube feeding...6. Tube feeding, I&O (intake and output) should be documented each shift in the electronic medical record for electronic facilities. Non-electronic facilities should document I&O each shift using "FORM NS-683 - Tube Feeding Records." Review of the facility's policy titled, "Intake and Output Measurement" dated 10-2017, revealed, "Purpose: 1. To maintain an accurate measurement of the resident's intake and output to assess fluid balance...Procedure... 3. Measure and record all liquids ingested...8. When enteral nutritional therapy, hypodermoclysis or intravenous fluid is administered, record amount on individual record...11. Document intake and/or output. 12. Intake and output are totaled every twenty-four hours. 13. The nurse is responsible to evaluate the total I&O per shift. If the intake and output is not adequate, notify the nursing	F 600	to the following for omissions and discrepancies: enteral feedings and flushes, insulin administration and blood glucose results. The Director of Nursing Services will monitor from March 29, 2021, daily the Electronic Medication Administration Record (EMAR) for every resident with orders for tube feeding, flushes, blood glucose reading and insulin administration. If any errors are found the employee will be re-educated and/or disciplined. The Director of Nursing services will continue to monitor the EMAR until substantial compliance is achieved. (Substantial compliance will be met when documented action entered into the computer either through the EMAR or in a nurses' note match the physicians order). Then the Director of Nursing services will review documentation related to tube feeders and insulin dependent diabetics on the following schedule: Weekly for four (4) weeks, then monthly for four (4) months, then quarterly thereafter. The Director of Nursing Services will report any discrepancies to the facility's Quality Assurance Committee for further recommendations. 4)The Facility Quality Assurance Committee Met March 25, 2021, at 3:50PM. The members present were the facility Administrator, Director of Nursing Services, the Medical Director, the Infection Preventionist, Registered nurses #1, #2, #3 and #4 along with Licensed Practical Nurse #1. Topics discussed included the following: Enteral Feedings, Insulin Administration and Neglect.	

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F 600	Continued From page 5 supervisor and the physician..." Review of the facility's policy titled, "Drug Administration and Documentation" dated 11-2017, revealed, "Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given... For electronic medication administration (EMAR), any medication not administered is indicated by an "N" in the block with a note of explanation as to why medication was not administered..." Resident #1 Review of Resident #1's Face Sheet revealed, she was admitted to the facility on 04-28-2014 with diagnoses of Anemia, Type 2 Diabetes, Hypertension, Hyperlipidemia, Heart Failure, Depression, Chronic Kidney Disease (stage 3), and Long-Term Use of Insulin and Oral Hypoglycemic Drugs. On 03-23-2021 at 11:45 AM, during an interview with Resident #1's daughter, she stated the following, " I received a phone call from the facility at a few minutes till 9:00 at night that my mom was unresponsive. I asked the nurse what that meant, and she said she is not responding when we touch her or talk to her, she is just staring at	F 600	Policies related to these topics were on hand during the meeting. The Facility Quality Assurance Committee will meet monthly for the next three months to ensure that substantial compliance has been met and maintained. (Substantial compliance will be met when documented action entered into the computer either through the EMAR or in a nurses' note match the physicians order). Any issues that arise will be addressed and plans implemented to make the appropriate changes.	

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the ceiling and breathing funny. The nurse said she was calling 911 and sending her out to the hospital. I waited a little bit and then called the emergency room to see how my mom was. A male nurse answered the phone, I told him who I was and asked if my mother was there. He told me to wait a minute. A doctor, I think his name was (formal name) got on the phone and told me I needed to come to the hospital as quickly as I could. I asked him why, is my mother already gone? He told me she was gone and had been gone for a little while. He said she was DOA (dead on arrival), and they worked on her for about 15 minutes. They had to give her 4 epinephrine shots and that did not work. I asked him if he knew her blood sugar was sky high and registered "HI" on the glucometer when she left the nursing home. He stated he was not aware of her high sugar. They were focused on doing CPR and trying to resuscitate her at the time. The doctor stated her blood sugar was elevated when she had been in the emergency room a week and a half prior, and that one of two things was happening. Either the nurses were not giving my mother her water in the tube and giving her concentrated feeding would cause her blood sugars to be high, or they were not giving her the diabetic insulin or pills in the tube. She was getting all her food through the tube, so it was not like she was eating a piece of pie or sugar. The facility should have been able to regulate her blood sugar better than they did. I am convinced the facility has not been feeding and giving my mom water like they should be, and they are not giving her the insulin and pills like they should be either. "

Review of Resident #1's "Physician Orders" dated March 2021, revealed orders for the following:

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"Full Code, NPO (Nothing by mouth), Flush G-tube (gastric tube) with 200 cc (cubic centimeters) H2O (water) every 4 hours, Nova Source Renal 50 cc/hr. (Cubic Centimeters an Hour) continuous via #20 fr (French), Blood Sugar after breakfast every 2 weeks at 9:00 AM, call Dr (Formal name) with results if <60 or >400, call s/s (signs and symptoms) if needed, Lantus 24 units sub Q (subcutaneous) at 9:00 PM. Rotate SQ site, and Onglyza 5 mg (milligram) tablet per (by) G-tube daily at 9:00 AM."

Review of Resident #1's "Medication Administration Record (MAR) for the month of February, prior to her hospitalization on March 3rd, 2021, revealed, from February 5th, 2021 through February 16th, 2021, there were no initials of completion for the following: "Flush G-tube with 250 milliliters (ml) H2O (water) three times a day at 5 AM, 1 PM, and 5 PM via #20 FR (French) tube 10 CC (cubic centimeters) Bulb" on 02-13-2021 at both 5:00 AM and 9:00 PM; "Flush G-tube with 30 cc H2O ACPC (before and after) meds" for "night" shift on 02-13-2021, "days" and "evening" shifts on 02-14-2021, and "evening" shift on 02-15-2021; "Flush G-tube with 5 ml H2O between each medication" on "night" shift 02-13-2021, "day" shift on 02-14-2021, and "evening" shift on 02-15-2021; "Onglyza 5 mg tablet 1 per G-tube daily @ 9 AM" for 02-14-2021; "Lantus 24 units sub Q at 9:00 PM, Rotate SQ site" for 02-13-2021; Diabetasource 25 ML per #20 FR tube continuous at 11:00pm on 02-13-2021, 3:00pm and 11:00pm on 02-15-2021.

Further review of Resident #1's February MAR, upon her return to the facility, revealed multiple days with "N" recorded in the boxes".

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During an interview with Medical Records (MR) on 03-26-2021 at 11:30 AM, revealed, the "N" meant "Not Administered" and if a nurse put "N" in the box, she was to put an explanation why it was not done or given in the "detail notes". If there was no documentation in the "detail notes" there was no other place to document, why it was not given. It was noted that all the days with "N" recorded, the nurse's initials were all the same. When asked by the SA, why the same initials were on all three shift and different days, Medical Records stated, "when we went to electronic MAR's when a medication was not given, it will flash red on the screen because it is overdue. The Director of Nursing (DON) got tired of seeing the screen flash red, so she went into the MAR and filled in all the holes with an "N" so it would clear her screen up."

Review of Resident #1's February 2021 MAR from 02-24-2021 through 02-28-2021 revealed an order for "Lantus 24 units SUB Q at 9:00 PM, Rotate SQ site" with "N"s for 02-26-2021, 02-27-2021, and 02-28-2021. Review of the detail notes revealed no documentation as to the reason why the Lantus was not given. An order to "Flush G-tube with 200 cc H2O every 4 hours (dated 02-23-21 and discontinued on 02-27-2021)" had "N"s documented on 02-26-2021 at 5:00 PM and 9:00 PM, and 02-27-2021 at 5:00 AM; review of the detail notes revealed no documentation as to the reason why the flushes were not administered. A new order to "Flush G-tube with 200 ML H2O every six hours had "N"s at 6:00 PM on 02-27-2021 and 6:00 PM on 02-28-2021. Review of the detail notes revealed no documentation as to the reason why the flushes had not been administered; An order

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for "Diabetasource 55 cc/hr. continuous via #20 FR until Novasource Renal is available" with an "N" at 2:00pm on 02-27-2021; an order to "flush G-tube with 50 cc H2O ACPC (before and after) meds" with "N"s at 3:00 PM on 02-26-21, 02-27-2021 and 02-28-2021; review of the detail notes revealed no documentation as to why the flushes were not administered; An order to "flush G-tube with 5 ML H2O between each medication" had "N"s for 3:00 PM on 02-26-2021, 02-27-2021, and 02-28-2021; review of the detail notes revealed no documentation as to the reason why the flushes were not administered."

The facility was transitioning from paper MARs to electronic MARs in the month of February. Resident #1's "Tube Feeding Records" where intake and output were to be recorded manually, and her "Tube Feeding Report Roster" where intake and output were to be recorded in the computer were compared to reveal a lack of documentation for night shift on 02-05-2021 and 02-06-2021; day shift and evening shift on 02-10-2021; day shift on 02-11-2021; evening and night shift on 02-14-2021; evening and night shift on 02-15-2021; evening shift on 02-24-2021; evening and night shift on 02-25-2021; and night shift on 02-28-2021.

Resident #1's 24-hour totals for enteral feeding and water flushes were to be:
02-05-2021 through 02-26-2021 - 250 cc flushes three times a day to equal 750 cc, and 25 cc an hour of Diabetasource continuous to equal 600 cc. Together Resident #1 should have received 1350 cc total through her G-tube. Review of her daily intakes revealed she did not meet this amount on 02-11-2021 at 680 cc, 02-12-2021 at 732 cc, and 02-14-2021 at 500 cc.

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For the dates of 02-24-21 through 02-28-2021, Resident #1's 24-hour totals for enteral feeding and water flushes were to be: 200 cc flushes four times a day to equal 800 cc, and 55 cc an hour of Diabetasource to equal 1320 cc. Together, Resident #1 should have received 2120 cc total through her G-tube. Review of her daily intakes revealed she did not meet this amount on 02-24-2021 at 757 cc, 02-25-2021 at 1561 cc, 02-27-2021 at 1186 cc and 02-28-2021 at 1152 cc.

Review of Resident #1's MAR for March 2021 revealed an order for "Lantus 24 units SUB Q at 9:00 PM, with an "N" marked on 03-01-2021. There was no documentation in the detailed notes of the reason it was not administered; an order for "Diabetasource 50 cc/hr. continuous via #20 FR until Novasource Renal is available" with "N"'s at 6:00 AM and 10:00 PM on 03-01-2021 and 6:00 AM and 2:00 PM on 03-02-2021; an order to "Flush G-tube with 200 ML H2O every six hours" with "N"s on 03-01-2021 at 12:00 AM and at 6:00 PM. Review of the detailed notes for these days revealed there was no reason documented for why the enteral feeding and flushes were not administered.

Review of Resident #1's "Tube Feeding Report Roster" for March 2021 revealed the total intake of enteral feedings and enteral water flushes to be 1180 cc on 03-01-2021, and 800 cc on 03-02-2021. Resident #1 should have received 2120 cc of feeding and water for each day.

Review of Resident #1's "Admission History and Physical" dated 03-03-2021, revealed Resident #1 was admitted to the hospital on 03-03-2021 for

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Urosepsis, Hyperglycemia, and an Acute Kidney Injury requiring a bolus of three (3) liters of fluid in the Emergency Room.

Further review of Resident #1's "Admission History and Physical" dated 03-03-21 she had been brought to the Emergency Room (ER)with "reports of fever and tachycardia", and her labs revealed "lactic acidosis, leukocytosis, hyperglycemia, and an acute kidney injury." Further review revealed her Sodium Level was 146 (high), and her glucose was 524 (high). Under an "Assessments" section she had the follow diagnoses, "Sepsis, Urinary Tract Infectious Disease, Lactic Acidosis, Hyperglycemia and Hypernatremia." Under the "Plan:" section it stated, "74-year-old African American female admitted with Urosepsis and Acute Kidney Injury...Patient now status post 3 liters of normal saline in the ER. Will continue IV (intravenous) hydration...Hypernatremia: Serum Sodium 146 on admission. Will adjust fluids as needed...Hyperglycemia: Known history of Diabetes Mellitus. Glucose 524 on arrival to the ER. Patient now s/p (status post) 3L (liters) NS (normal saline). Ordering Accuchecks Q 4 (every 4) hours and Humalog per sliding scale. Holding Lantus until tube feeds are resumed..."

On 03-25-2021 at 3:15 PM, in an interview with the Director of Nursing (DON), when asked if the facility could show Resident #1 had received her enteral feeding, water flushes and diabetic medications from 02-24-2021 through 03-02-2021, to help prevent her hospitalization on 03-03-2021, she stated, "not if it is not written in the nurses notes or on the MAR. The nurses should be putting that information into the computer. I am not sure what the "N" means.

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This computer system is new, and I do not know anything at all about it yet. When asked how high a blood glucose had to register for the meter to state "HI", she indicated she would have to check the user guide and let me know."

On 03-25-2021 at 4:00 PM, the DON brought the User Guide for the "Rosie Smart Meter" which revealed, "The testing range of the meter is from 20 to 600 mg/dl (milligrams per deciliter). If HI is displayed, your blood glucose result may be higher than 600 mg/dl. If LO is displayed, your blood glucose result may be lower than 20 mg/dl."

Review of Resident #1's Nurses notes dated 03-17-2021 at 10:53 PM revealed, "7:20 PM - Summoned to resident's room per C.N.A. (Certified Nurse Aide), resident noted lying in bed, increased resp (respirations) sweating. Blood sugar called for primary nurse. Checked registered HI on the blood glucose meter. She did not respond to verbal or tactile stimuli..."

Review of Resident #1's Nurses Notes dated 03-17-2021 at 11:04 PM revealed, "Summoned to resident room after supervisor noted that resident was not responding. Resident was still breathing but not responding, cold sweats noted coming from resident blood sugar check and were unreadable, 911 called immediately. Around 7:30 PM ambulance arrived and headed to ER with resident, received a called from ER, nurse stated that resident had coded and passed away. Family members notified."

Neither nurses note regarding the event made mention of notifying the Physician of Resident #1's condition, departure for the emergency room, or later demise.

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Review of Resident #1's "Physician Documentation" from the Emergency Department revealed, "Arrival date: 03-17-2021 at 9:04 PM... Location: Morgue, Pronouncing Physician: (Formal Name), Time of Death: 9:06 PM, Diagnosis - Cardiac Arrest, Acute Respiratory Failure... 74-year-old female who presents to the emergency room in respiratory distress with palpable pulses initially. Pulse's loss CPR initiated. Patient intubated. CPR performed for 14 minutes with multiple rounds of epinephrine and 1 of bicarb given. 1 Liter bolus began. Patient pronounced at 9:06 PM. Patient without any palpable pulses or visible chest rise. Patient without an auditory breath sounds or cardiac sounds. Patient pupils fixed and dilated. No corneal reflex of patient are responsive to verbal or painful stimuli. Family notified."

On 03-26-2021 at 11:45 AM, during an interview with Resident #1's physician, the Medical Director of the facility, she indicated, she was not fully aware of the entire incident with (formal name) (Resident #1), with all the details. When Resident #1's current diabetic orders and enteral feeding orders were reviewed with the physician, she stated, the orders were not correct. She would not give blood sugar check orders like they were written. She indicated the order should have read to "check blood glucose every morning at 9:00 AM, and to send them to the doctor every two weeks for review. If blood sugar is <60 or >400, notified the Physician." She indicated the blood sugar check order written as it was, did not make any sense with regard to glucose control. She indicated she was not aware the Residents blood sugar had read "HI" prior to being sent out and stated that Resident #1's blood sugars had not

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been being sent to her office for review. She stated she had Resident #1's chart in front of her as she spoke on the phone, and there were no reports of staff calling blood glucose results to her office for review. She indicated she had a Nurse Practitioner (NP) that worked with her, and both had been doing virtual visits with the residents due to COVID-19, so they were relying on the staff to tell them what was going on with the residents in order to know what orders to write. She stated the staff had not made her aware the Resident was missing enteral feedings, water flushes and her diabetic meds from time to time, and definitely not for several days in a row prior to her last hospitalization. She stated, had she been made aware of the resident's elevated blood sugar, she would have written orders accordingly. When the SA informed her of the daughter's concerns, and the items mentioned to her by the Emergency Room Physician, she agreed with the resident having a controlled food and fluid source and should have been better regulated with her glucose levels. She agreed that giving the concentrated enteral feeding without the proper water or not giving Resident #1 her insulin and oral medications could affect her blood sugar levels and cause them to run high.

Resident #2

Review of Resident #2's Face Sheet revealed she was admitted to the facility on 01-28-2010 with diagnoses of Dysphagia following a Cerebrovascular Disease, Type 2 Diabetes Mellitus, Glaucoma, Hyperlipidemia, Adult Failure to Thrive, Vascular Dementia, Long term (current) use of Insulin, Depression, Anxiety, Hypertension, and Gastrostomy Tube.

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Review of Resident #2's "Physician Orders" dated for March 2021 revealed orders for "Full Code, BGFS (Blood Glucose Finger Stick) every other day at 6 AM and 4 PM; notify MD (Medical Doctor) if BS (blood sugar) <60 or >500, Report blood sugar to MD every 2 weeks; Levemir Flex pen 28 units SUB Q twice a day with Novofine needle. Rotate site; Januvia 100 mg tablet by mouth daily; and Metformin HCL (Hydrochloride) 500 mg tablet by mouth twice a day; Push by mouth fluids, give six (6) 16 oz (ounce) of water per day; and Record I&O Q shift with 24-hour total."

Review of Resident #2's MAR for February 2021 revealed, missing blood glucose readings for 4:00 PM on 02-15-2021, and 6:00 AM and 4:00 PM blood glucose readings on 02-21-2021, 02-23-2021, 02-25-2021, and 02-27-2021; Levemir Flex pen 28 units SUB Q twice a day with Novofine needle. Rotate SQ site, with missing initials of completion at 9:00 PM on 02-15-2021, 9:00 AM on 02-17-2021, and 9:00 AM and 9:00 PM for 02-24-2021, 02-25-2021, 02-26-2021, 02-27-2021, and 02-28-2021; Report blood sugar to MD every 2 weeks, with missing initials of completion on 02-12-2021 and 02-26-2021; Push by mouth fluids, give (6) 16 oz. of water per day - there were no initials of completion for all three shifts for the entire month.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-24-2021 revealed, Resident #2 had 3 Levemir 100 units/ML Flex Pen ordered. Each Flex Pen holds 3 ML of insulin, to equal 300 ML of insulin per pen.

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Review of Resident #2's Physicians Orders revealed, an order for "Levemir Flex pen 28 units Sub Q twice a day with Novofine Needle. Rotate SQ site." The order was dated 09-15-2019 to present. She experienced multiple hospitalizations over the last six months and was not in the building from 01-29-2021 through 02-09-2021, from 02-18-2021 through 02-20-2021, and 03-02-2021 through 03-09-2021. The sum total of days she was not in the facility in the last 6 months equals 20 days. There have been 205 days in the last 6 months, minus the 20 days Resident #2 was out of the building equals 185 days. 185 days multiplied by the 56 units of Levemir needed a day for Resident #2 to receive her ordered amount equaled 10,360 units. With each Levemir Flex Pen holding 300 Units each, Resident #2 should have had 35 Flex Pens ordered from the pharmacy, and only had 3 ordered.

During a joint interview with the Administrator and DON on 03-26-2021, at 1:30 PM, the calculations were shared by the SA, and that the facility was 32 Flex Pens short of insulin for Resident #2. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, it means she didn't get all of her insulin like she should have."

Review of Resident #2's "Intake/Output" record for February 2021 was completely blank for the entire month.

Review of Resident #2's MAR for March 2021 revealed, "Report Blood sugar to MD every two weeks" with missing initials for 03-09-2021 or 03-23-2021; Levemir 28 units SubQ at bedtime, rotate SUBQ sites, with missing initials for

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03-01-2021 at 9:00 AM; Januvia 100 mg tablet by mouth daily with missing initials for 03-01-2021 at 9:00 AM; Metformin HCL 500 mg tablet by mouth twice a day, with missing initials for 9:00 AM and 5:00 PM on 03-01-2021.

Resident #2 was hospitalized from 03-02-2021 through 03-09-2021 for the placement of a Gastric Tube to help supplement her intakes.

Review of Resident #2's March MAR after her return on 03-09-2021 revealed orders for Novasource Renal Bolus 1 can (250 ML) Q 6 hours, providing 2000 KCAL (kilocalories), 91 G (grams) of protein, 1855 ML H2O, to equal 2135 ML of fluid and 100% of RDI (recommended daily intake); with missing initials for 03-16-2021 at 6:00 AM with no detailed nurses notes for why it was not administered; Another order to Flush tube with 100 ML H2O every 4 hours, with missing initials on 03-16-2021 at 5:00 AM, and on 03-18-2021 at 5:00 AM and 9:00 PM; and an order to report blood sugars to MD every 2 weeks on the 9th and 23rd of every month. Both dates were missing initials of completion for the month of March 2021.

Review of Resident #2's "Tube Feeding Report Roster" revealed no intake and output were recorded for her from her readmission on 03-09-2021 through 03-15-2021. Her daily intake of fluids between her enteral feeding and water flushes was to be 2135 ML per her orders. Her intake recorded for 03-16-2021 was 537 ml; for 03-17-2021 through 03-19-2021 there was no intake recorded; for 03-20-2021 it was 397 ml; for 03-21-2021 it was 567 ML; for 03-22-2021 it was 1141 ML.

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Review of Resident #2's weight record revealed, on 10-12-2020, she weighed 162.0 pounds, on 11-02-2020, she weighed 161.5 pounds, on 12-01-2020, she weighed 160.5 pounds, on 01-01-2021, she weighed 162.0 pounds, on 02-17-2021 she weighed 136.5 pounds, and on 03-16-2021, she weighed 146.0 pounds. Resident had a gastric tube placed during a hospitalization on 03-09-2021. The weight loss noted between January and February was due to her lack of appetite with COVID-19, double lung Pneumonia, and lethargy.

Review of Resident #2's Departmental Notes, dated, 03-01-2021 at 1:50 PM revealed, "Resident remains lethargic, did not eat breakfast or lunch, unable to administer medications due to resident is not alert enough at this time."

Review of Resident #2's Departmental Notes, dated 03-02-2021 at 10:35 AM, revealed, "DON spoke with family member, NP at Dr (Doctor's formal name) office and the ER (Emergency Room) Director regarding tube placement for resident. Plan: Resident departed facility at 10:05 AM with (Ambulance Company Name), 1 female and 1 male attendant, to ER Clarksdale for tube placement evaluation ..."

Review of Resident #2's "Admission History and Physical" dated 01-30-2021, revealed, she was admitted with a fever of 102.4 degrees. She tested positive for COVID-19. "Imaging Results: CXR (chest X-ray) - bilateral pneumonia consistent with COVID-19. Discharge Diagnosis: Acute Renal Failure Syndrome, Inadequate Oral Intake, Sepsis - Resolved, and Bacteremia. Hospital Summary: 84 y/o female admitted to COVID unit due to COVID positive testing with

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UTI (urinary tract infection), Sepsis and staph epi bacteremia ...Pt. (patient) also noted to have decreased oral intake which contributed to dehydration and ARF (acute renal failure) on admission. This has improved to baseline. Pt. still has decreased oral intake but will drink fluids and take meds with some prompting. Pt is COVID positive and will need COVID testing to be negative prior to consideration for PEG placement. Health Concerns: Inadequate oral intake."

Review of Resident #2's Physician's Orders, dated February 2021, revealed, orders for a "house supplement, 4 oz (ounces) by mouth daily. The order was changed on 02-028-2021 to "House Supplement 2 oz. by mouth three times a day - Chart 1-25%, 2-50%, 3- 75%, 4- 100%, and 5 - refused."

Resident #2 was sent to the Emergency Room (ER) on 03-23-2021 for a blood glucose that read "HI" on the glucometer.

Review of Resident #2's Nurses notes dated 03-23-2021, at 6:56 AM, revealed, "Resident remains on observation for COVID precautions, no s/s (sign or symptoms) of COVID noted at this time. Informed MD of Blood sugar reading of HI. Received new orders to start Levemir 10 units @ HS (hour of sleep). Novolog with sliding scale and send her to the ER now for elevated blood sugar. Attempted to inform RR (Resident Representative) of new orders and unable to reach him at this time. (formal name of ambulance) called for transfer..."

Review of nurses notes dated 03-23-2021, at 8:58 AM revealed, "7:25 AM resident exited fac

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(facility) per (ambulance formal name) accompanied per 2 female EMT's (Emergency Medical Team). No acute distress noted at this time.

Review of nurse's notes dated 03-23-2021, at 12:30 PM revealed, "RR (Resident Representative) returned call to fac, informed him of order to send to ER for eval secondary to elevated BS (blood sugar)."

Review of Resident #2's "Physician Documentation" from the Emergency Room dated 03-23-2021 revealed, "Arrival Date 03-23-2021, Time: 07:44 AM, Hospitalization Status: Inpatient Admission, Current Condition: Serious, Diagnosis: Anemia, Bladder Infection, Severe Sepsis without septic shock, Pneumonia Bacterial, Acute Renal/Kidney Failure. There was a high probability of clinically significant/life threatening deterioration in the patient's condition which required my urgent intervention. This 84-year-old black female presents to ER via EMS ground with complaints of High Blood Sugar. Associated symptoms of diaphoresis. Patient was found hypoglycemic today, and she was also tachycardic on arrival of EMS. Fluid started by EMS and patient transported here. Correct hyperglycemia initially with fluids and consider insulin when potassium is known... There are signs of severe sepsis in the setting of acute renal failure... At 07:51 AM Blood Glucose: 466 mg/dl, critical glucose levels for an adult: <60 (below 60) or >300 mg/dl (above 300)."

On 03-26-2021, at 11:45 AM, during an interview with Resident #2's physician, the Medical Director of the facility, she indicated, she was made aware of the blood sugar reading of "HI" and remembers

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giving new orders for her insulin and sending her to the Emergency Room to be evaluated. She stated she had Resident #2's chart in front of her as she spoke on the phone, and there were no prior reports of staff calling blood glucose results to her office for review. She indicated she had a Nurse Practitioner (NP) that worked with her, and both had been doing virtual visits with the residents due to COVID-19, so they were relying on the staff to tell them what was going on with the residents in order to know what orders to write. She stated the staff had not made her aware the resident was missing enteral feedings and water flushes from time to time. She stated giving the concentrated enteral feeding without the proper water or not giving Resident #2 her insulin and oral medications could affect her blood sugar levels and cause them to run high.

Resident #2 remained in the hospital throughout the remainder of the survey.

Resident #3

Review of Resident #3's Face Sheet revealed she was admitted to the facility on 11-03-2011 with diagnoses of Dementia with Lewy Bodies, Depression, Hypertension, Gastrostomy Status, and Chronic Kidney Disease.

Observation on 03-24-2021, during morning rounds at 10:00 AM, Resident #3 was noted to be in her bed, lying on her back with eyes closed. Her mouth was slightly open with dry oral mucosa, with dry, scaly lips. G-tube feeding running at 40 ML per hour.

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Observation on 03-25-2021, during rounds at 2:15 PM, Resident #3 was noted to be in bed, on her left side, with her eyes closed. Mouth remains with dry scaly lips. Mouth is closed at this time, cannot visualize oral mucosa.

Review of Resident #3's Physician Orders revealed orders for the following: Isosource per Kangaroo Pump at 40 ML per hour for 22 hours via #20 FR G-tube to provide 1320 cal, 59 Grams protein, 1909 free H2O/2100 total FLD (fluid), 90% RDI (Recommended Daily Intake).

During an interview with the DON on 03-25-2021, at 3:15 PM, when asked by the SA how intake was calculated, and what do the initials on the MAR mean for the enteral feeding orders, she stated they are checking to make sure the pump is on and running at the rate it is supposed to be running at. When asked how the nurses are to know if the resident has received the required amount of enteral feeding and fluid for the day, she stated they would rely on the intake and output record to tell that.

The facility was transitioning from paper MARs to electronic MAR's in the month of February. Resident #3's "Tube Feeding Records" where intake and output were to be recorded manually, and her "Tube Feeding Report Roster" where intake and output were to be recorded in the computer were compared to reveal a lack of documentation for 02-10-2021 for day and night shifts, 02-11-2021 for day and evening shifts, 02-12-2021 for day shift, 02-13-2021 for day shift, 02-14-2021 for day shift, 02-15-2021 for day and evening shifts, 02-16-2021 for day and evening shifts, 02-17-2021 for evening shift, 02-19-2021 for day shift, 02-21-2021 for evening shift, and

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02-24-2021 for evening shift.

Resident #3, per her Physicians Orders, was to receive 2100 ML of fluid a day between her enteral feeding and her water flushes. In the month of February, there were 12 days in which she received significantly less than her allotted amount: 02-10-2021 at 675 cc, 02-11-2021 at 720 cc, 02-12-2021 at 1,402 cc, 02-13-2021 at 1,325 cc, 02-14-2021 at 1,451 cc, 02-15-2021 at 739 cc, 02-16-2021 at 835 cc, 02-17-2021 at 1,555 cc, 02-20-2021 at 1,344 cc, 02-21-21 at 1,384 cc, 02-24-2021 at 1,081 cc, and 02-25-2021 at 1,647 cc.

Review of Resident #3's "Tube Feeding Report Roster" for the month of March 2021 revealed a lack of documentation on 03-02-2021 for day shift, and on 03-20-2021 for evening shift.

Further review of Resident #3's "Tube Feeding Report Roster" for the month of March 2021 revealed 10 days from 03-01-2021 through 03-24-2021, in which she received significantly less than her allotted amount: 03-02-2021 at 1,220 cc, 03-03-2021 at 1,781 cc, 03-05-2021 at 1,576 cc, 03-07-2021 at 1,760 cc, 03-08-2021 at 1,798 cc, 03-09-2021 at 1,131 cc, 03-11-2021 at 1,542 cc, 03-15-2021 at 1,193 cc, 03-17-2021 at 1,587 cc, 03-20-2021 at 1,001 cc, and 03-22-2021 at 1,748 cc.

Resident #4

Review of Resident #4's Face Sheet revealed she was admitted to the facility on 02-14-2018 with diagnoses of Heart Failure, Hypertension, Peripheral Vascular Disease, Cerebral Infarct, Type 2 Diabetes Mellitus, Hyperlipidemia,

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Depression, and Chronic Kidney Disease.

Review of Resident #4's Physicians Orders for March 2021 revealed the following orders: Blood sugar checks ACHS (before meals and at hour of sleep); notify MD if BS <60 and >500; Levemir 45 units subQ every morning at 9:00 AM. Rotate SQ site, and Tradjenta 5 MG tablet, give 1 tab (tablet) by mouth once daily.

Review of Resident #4's MAR for March 2021 revealed "N"s (Not Administered) for Tradjenta 5 MG at 9:00 AM on 03-20-2021, 03-21-21, and 03-24-2021 and Levemir 45 units Sub Q at 9:00 AM for 03-20-2021, 03-21-2021, 03-22-2021, 03-23-2021, and 03-24-2021. Review of the detailed notes for these days revealed no documentation as to why the medications were not given.

Review of Resident #4's list of Minimum Data Set (MDS) completion dates revealed no transfers/discharges from the facility for any reason since 03-13-2019.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-24-2021 revealed, Resident #4 had 6 bottles of Levemir 100 units/ml ordered. Each bottle of Levemir has 10 ML in it to total 1,000 units per bottle.

Resident #4 has an order dated 12-08-2020 through present for Levemir 45 units every morning at 9:00 AM. From September 1st, 2020 through March 4th, 2021, there have been 205 days. 205 days multiplied by 45 units a day equals 9,225 units required to meet her insulin needs over the last 6 months. At 1,000 units per

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bottle, it would have required 10 bottles of Levemir to be ordered, and only 6 bottles had been ordered and sent.

During a joint interview with the Administrator and DON on 03-26-2021, at 1:30 PM, the calculations were shared by the SA, and that the facility was 4 bottles short of insulin for Resident #4. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, or took a bottle from house stock and didn't assign it to her, it means she didn't get all of her insulin like she should have."

Resident #5

Review of Resident #5's Face Sheet revealed she was admitted to the facility on 03-28-2016 with diagnoses of Alzheimer's, Parkinson's, Anxiety, Type 2 Diabetes Mellitus, Depression, Personality Disorder, Long Term use of Insulin, and Heart Failure.

Review of Resident #5's Physician Orders March 2021 revealed orders for the following: Blood Sugars before meals and at bedtime. Notify MD if BS blood sugar <60 or >400; and Levemir 55 units SubQ at bedtime, rotate SQ site.

Review of Resident #5's March 2021 MAR revealed an "N" (not administered) on 03-03-2021 for both 4:00 PM and 8:00 PM for Blood Sugar checks before meals and at bedtime. Another order was noted for Levemir 55 units at bedtime, with an "N" marked for 03-03-2021 at 8:00 PM.

Review of Resident #5's list of Minimum Data Set

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(MDS) completion dates from 09-01-2020 through 03-25-2021, revealed a one day discharge from the facility from 01-21-2021 through 01-22-2021.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-24-2021 revealed, Resident #5 had 7 bottles of Levemir 100 units/ml ordered. Each bottle of Levemir has 10 ML in it to total 1,000 units per bottle.

Resident #5 had an order dated 07-16-2020, through present, for Levemir 55 units daily at bedtime. From September 1st, 2020 through March 24th, 2021, she has been in the facility 204 days. 204 days multiplied by 55 units a day equals 11,220 units required to meet her insulin needs over the past 6 months. At 1,000 units per bottle, it would have required 12 bottles of Levemir to be ordered, and only 7 bottles had been ordered and sent.

During a joint interview with the Administrator and DON on 03-26-2021 at 1:30 PM, the calculations were shared by the SA, and that the facility was 5 bottles short of insulin for Resident #5. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, or took a bottle from house stock and didn't assign it to her, it means she didn't get all of her insulin like she should have."

Resident #6

Review of Resident #6's Face Sheet revealed, she was admitted to the facility on 06-22-2005, with diagnoses of Dementia, Cerebral Aneurysm,

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Epilepsy, Anxiety, Depression, Type 2 Diabetes Mellitus, Heart Failure, Hypertension, and Long-Term use of Insulin.

Review of Resident #6's Physicians Orders March 2021 revealed orders for the following: BGFS before meals and at bedtime with the following Novolog 70/30 mix 25 units with supper rotate SQ site; and Novolog 70/30 50 units Sub Q with breakfast, rotate SQ site.

Review of Resident #6's March 2021 MAR revealed no missed doses of insulin.

Review of Resident #6's Minimum Data Set (MDS) completion dates revealed he had been discharged from the facility from 02-13-2021 through 03-03-2021, for a total of 20 days.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-25-2021 revealed, Resident #6 had 8 bottles of Novolog 70/30 Mix 100 units/ml ordered. Each bottle of Novolog has 10 ML in it to total 1,000 units per bottle.

Resident #6 had an order dated 07-16-2020, through present, for Levemir 55 units daily at bedtime. From September 1st, 2020 through March 24th, 2021, he had been in the facility 187 days. His insulin needs changed to reflect: From 09-01-2020 through 11-12-2020 he required 40 units of Novolog 70/30 at Breakfast, and 20 units of Novolog 70/30 at supper to equal 60 units a day. 60 units a day multiplied by 73 days equals 4,380 units of insulin. From 11-12-2020 through 02-13-2021, when he was discharged to the hospital, he required 45 units of Novolog 70/30 at breakfast, and 25 units of Novolog 70/30 at

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supper time to equal 70 units a day. 70 units a day multiplied by 64 days equals 4,480 units of insulin. From 03-03-2021 through 03-12-2021 he required 45 units of Novolog 70/30 at breakfast, and 25 units of Novolog 70/30 at supper to equal 70 units per day. 70 units per day multiplied by 9 days equals 630 units of insulin. From 03-12-2021 through 03-24-2021 he required 50 units of Novolog 70/30 for breakfast, and 25 units of Novolog 70/30 for supper to equal 900 units of insulin. So, from 09-01-2021 through 03-24-2021, Resident #6 required 10,390 units of insulin to meet his needs over the last 6 months. At 1,000 units per bottle, he would have required 11 bottles of Novolog 70/30 to be ordered, and only 8 bottles were ordered and sent.

During a joint interview with the Administrator and DON on 03-26-2021 at 1:30 PM, the calculations were shared by the SA, and that the facility was 3 bottles short of insulin for Resident #5. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, or took a bottle from house stock and didn't assign it to him, since there were no holes in the MAR, they were signing they gave him the insulin and then didn't administer it."

On 3/31/21 at 10:15 AM during an interview and observation with the Director of Nursing (DON) on the North Nursing station in the Medication Room revealed, no Stock Insulin in the medication refrigerator, the emergency drug kit, the emergency intravenous (IV) drug kit or anywhere else in the medication room. DON stated she could not find where there was any stock insulin in the medication room. SA and DON reviewed the list of medications stored in the Emergency

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Drug Kit (EDK) and no insulin was listed. DON and SA walked to South wing and looked through the medication storage room and no stock insulin was found in the refrigerator on in the room. The DON revealed that when the nurse removes a drug from the EDK they must fill out a form listing the drug, the resident's name and the date and time. The form is then faxed to the Pharmacy so they can have a record and replace the drug. The DON revealed she has the copy of all the forms in a binder in her office.

Record review of the fax transmission list, with the DON revealed no forms faxed to the Pharmacy for February and March revealed any Insulin taken from the EDK.

On 3/31/21 at 10:25 AM an interview and observation with LPN #3 and the medication nurse revealed there was no Insulin in the North medication room, the EDK box or in the IV EDK box. LPN revealed no Insulin listed on the list of medications on the outside of the EDK box or inside of the EDK IV box.

On 3/31/21 at 10:35 AM during an interview with the Pharmacist at the Pharmacy that supplies stock medications in the EDK boxes and for the facility, he revealed they stopped suppling stock insulin years ago because it would not be used, would expire, and the insurance company would not pay for it and they would be stuck with a $300.00 vial they had to destroy. The Pharmacist revealed when they get a new order for a sliding scale Insulin, they send an ordered insulin vial to the facility and then the facility lets them know when the Insulin needs to be replaced.

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The facility provided an acceptable removal plan on 03-30-2021, for the IJ and review of the facility's removal plan revealed the facility took the following actions to remove the IJ:

Removal Plan

On March 25, 2021 at 2:45pm State Agency notified the Administrator that the facility was in an Immediate Jeopardy (IJ) and templates were provided to the Administrator.
The facility failed to appropriately document the amount of enteral feedings, and flushes for Resident #1 and Resident The facility failed to maintain Resident's blood glucose levels within an acceptable parameter for Resident #1 and Resident #2. The facility failed to provide appropriate goods and services to Residents necessary to avoid physical harm, pain, mental anguish, or emotional distress by not providing enteral feedings, water flushes and insulin per physician orders.

1. On March 17, 2021, at 7:20PM Resident #1 was found unresponsive. A blood glucose was checked on Resident #1 with a blood glucose testing device indicating a "HI" reading. Emergency services were notified at approximately 7:20PM and Resident #1 was transported by ambulance to local hospital #1. Resident #1 expired on March 17, 2021 at approximately 9:06PM in the emergency room at local hospital #1. On March 23, 2021 at 6:50 AM blood glucose was checked on Resident #2 with a blood glucose testing device indicating a "HI" reading. Physician #1 was notified on March 23, 2021 at approximately 6:56am and orders were received to transfer Resident #1 to local hospital

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#1. Resident #2 was transferred on March 23, 2021 at approximately 7:25am by ambulance to the Emergency Room of local hospital #1. Resident # 2 remains in the hospital at this time.

2. Director of Nurses (DON) and Registered Nurse (RN) #2 immediately initiated in-services with Registered Nurses and Licensed Nurses on March 25, 2021, at 3:10PM on Tube Feedings, Drug Administration & Documentation including electronic medication administration records and Incident Investigation & Reporting, related to abuse and neglect Director of Nurses (DON) and Registered Nurse (RN) #2 initiated in-services with Registered Nurses and Licensed Nurses on March 26, 2021 at 4:00PM on Hypoglycemia and Hyperglycemia. In-services will be on-going, and no nurses win be allowed to work until participation of the in-services for Tube Feedings, Drug Administration & Documentation including electronic medication administration records, and Incident Investigation & Reporting related to abuse and neglect, Hypoglycemia and Hyperglycemia. During the week of February 22, 2021 through February 26, 2021 initial training was provided to all nursing department staff concerning implementation of the new electronic charting system and the electronic Medication Administration Record by Registered Nurse (RN) #2. This training is an ongoing process for all new staff and existing staff as changes are made to the system.

3. The facility Quality Assurance Committee Meeting was held on Thursday, March 25, 2021, at 3:50PM, with the committee consisting of facility Director of Nurses, Nursing Home Administrator, Medical Director Infection Preventionist, Registered Nurses (RN)

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Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, and Licensed Practical Nurse (LPN) #1. Topics discussed included Enteral Feedings, Insulin Administration, and Neglect with the following policies reviewed Tube Feedings, Drug Administration & Documentation, and Incident Investigation & Reporting, related to abuse, and neglect. No policy changes were indicated however, facility made procedural changes on March 25, 2021 to medication administration monitoring to include electronic medication charting reviews. The Director of Nurses (DON), Registered Nurse (RN) #3 and Registered Nurse (RN) #4 with review electronically generated reports for omissions and discrepancies with enteral feedings and flushes, insulin administration, and blood glucose results.

4. On March 25, 2021 from 4:30PM to 9:00PM, Registered Nurses (RN) #3, Registered Nurse (RN) #4 and Licenses Practical Nurse (LPN) #1 physically assessed and observed all Residents receiving enteral feedings with no significant findings identified. They also, physically assessed and observed ad diabetic Residents with insulin with no significant findings identified. On March 25, 2021 and March 28, 2021, the Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records Clerk audited the electronic medical records, the enteral feeding orders, medication administration records, and intake records for any Resident on enteral feeding for omissions and discrepancies from February 5, 2021 to present. Omissions of enteral feedings and flushes were noted on the audit for four of eight Residents. The physician was notified of all

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four of eight Residents with omissions March 29, 2021 with no new orders received. The Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records also audited the physician orders, electronic records, and medication administration of all insulin dependent diabetics for omissions and discrepancies from February S, 2021 to present. Omissions were noted for fourteen of twenty-six Residents blood glucose results and two of seventeen insulin administrations. The physician was notified of all fourteen Residents with omissions March 29, 2021 with no new orders received. One of seventeen Residents audited was noted with a discrepancy in blood glucose results documentation. The physician was notified of the Resident discrepancy on March 29, 2021 with no new orders received. On March 25, 2021, Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 and Registered Nurse (RN) #1 checked insulin supplies for all insulin dependent diabetics to ensure they had the proper amount in the facility per physician's orders. Licensed Practical Nurse (LPN) #1 contacted three local pharmacies to ensure that the facility will have an adequate backup supply.

5. Licensed Practical Nurse (LPN) #3 was disciplined for improper documentation on March 25, 2021. LPN # 4, LPN #5, LPN #6, LPN #10, RN # 5, RN #6, and RN # 7 received an employee written warning discipline on March 29, 2021* The Mississippi State Board of Nursing was called regarding LPN #3 at 5:42PM unable to leave a message. Return call made on March 26, 2021 at 9:12Am. The Mississippi State Board of Nursing was called regarding Licensed Nurses #4

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-10 and Registered Nurses #5-7 on March 29, 2021. The following agencies were notified on March 25, 2021. Mississippi State Department of Health Abuse Hotline was called at 5:39PM. Mississippi State Board of Nursing Home Administrators was called at 5:43PM. The Office of the Attorney General was called at 6:05PM. The local Police Department was contacted on March 26, 2021 at 9:19 am.

The facility alleges removal of the immediacy as of March 30, 2021, at 8:00am.

The SA validated all corrective actions had been completed as of March 30, 2021, and the IJ was removed as of 03-31-2021.

1. On March 17, 2021, at 7:20PM Resident #1 was found unresponsive. A blood glucose was checked on Resident #1 with a blood glucose testing device indicating a "HI" reading. Emergency services were notified at approximately 7:20PM and Resident #1 was transported by ambulance to local hospital #1. Resident #1 expired on March 17, 2021 at approximately 9:06PM in the emergency room at local hospital #1. On March 23, 2021 at 6:50 AM blood glucose was checked on Resident #2 with a blood glucose testing device indicating a "HI" reading. Physician #1 was notified on March 23, 2021 at approximately 6:56am and orders were received to transfer Resident #1 to local hospital #1. Resident #2 was transferred on March 23, 2021 at approximately 7:25am by ambulance to the Emergency Room of local hospital #1. Resident # 2 remains in the hospital at this time.
-Validated through observation, record review and interview that Resident #2 remains in the hospital and that Physician #1 was notified.

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2. Director of Nurses (DON) and Registered Nurse (RN) #2 immediately initiated in-services with Registered Nurses and Licensed Nurses on March 25, 2021, at 3:10PM on Tube Feedings, Drug Administration & Documentation including electronic medication administration records and Incident Investigation & Reporting, related to abuse and neglect. Director of Nurses (DON) and Registered Nurse (RN) #2 initiated in-services with Registered Nurses and Licensed Nurses on March 26, 2021 at 4:00PM on Hypoglycemia and Hyperglycemia. In-services will be on-going, and no nurses will be allowed to work until participation of the in-services for Tube Feedings, Drug Administration & Documentation including electronic medication administration records, and Incident Investigation & Reporting related to abuse and neglect, Hypoglycemia and Hyperglycemia. During the week of February 22, 2021 through February 26, 2021 initial training was provided to all nursing department staff concerning implementation of the new electronic charting system and the electronic Medication Administration Record by Registered Nurse (RN) #2. This training is an ongoing process for all new staff and existing staff as changes are made to the system.
-Validated through record review and interviews that in-services regarding Tube Feedings, Drug Administration, Documentation in the Electronic Medical Record and Incident reporting and investigation related to abuse and neglect, Hypoglycemia and Hyperglycemia. Interviews were held with the DON, Administrator, LPN #5, LPN #6, RN #1, RN #2, the QA nurse, and LPN #7. All verified that they have been in-serviced.

3. The facility Quality Assurance Committee

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Meeting was held on Thursday, March 25, 2021, at 3:50PM, with the committee consisting of facility Director of Nurses, Nursing Home Administrator, Medical Director, Infection Preventionist, Registered Nurses (RN) #1, Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, and Licensed Practical Nurse (LPN) #1. Topics discussed included Enteral Feedings, Insulin Administration, and Neglect with the following policies reviewed Tube Feedings, Drug Administration & Documentation, and Incident Investigation & Reporting, related to abuse, and neglect. No policy changes were indicated however, facility made procedural changes on March 25, 2021 to medication administration monitoring to include electronic medication charting reviews. The Director of Nurses (DON), Registered Nurse (RN) #3 and Registered Nurse (RN) #4 will review electronically generated reports for omissions and discrepancies with enteral feedings and flushes, insulin administration, and blood glucose results.
-Validated through record review and interview with the QA Nurse, DON, and the Medical Director, that the QA meeting was held on 03/25/21 and verified through a sign in sheet that the facility met the requirements of the QA meeting and that the issues regarding Enteral Feedings, Insulin Administration, Neglect, Drug Administration and Documentation along with incident investigation and reporting as it relates to abuse, and neglect were all issues that were discussed and reviewed.

4. On March 25, 2021 from 4:30PM to 9:00PM, Registered Nurses (RN) #3, Registered Nurse (RN) #4 and Licenses Practical Nurse (LPN) #1 physically assessed and observed all Residents

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receiving enteral feedings with no significant findings identified. They also, physically assessed and observed all diabetic Residents with insulin with no significant findings identified. On March 25, 2021 and March 28, 2021, the Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records Clerk audited the electronic medical records, the enteral feeding orders, medication administration records, and intake records for any Resident on enteral feeding for omissions and discrepancies from February 5, 2021 to present. Omissions of enteral feedings and flushes were noted on the audit for four of eight Residents. The physician was notified of all four of eight Residents with omissions March 29, 2021 with no new orders received. The Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records also audited the physician orders, electronic records, and medication administration of all insulin dependent diabetics for omissions and discrepancies from February 5, 2021 to present. Omissions were noted for fourteen of twenty-six Residents blood glucose results and two of seventeen insulin administrations. The physician was notified of all fourteen Residents with omissions March 29, 2021 with no new orders received. One of seventeen Residents audited was noted with a discrepancy in blood glucose results documentation. The physician was notified of the Resident discrepancy on March 29, 2021 with no new orders received. On March 25, 2021, Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 and Registered Nurse (RN) #1 checked insulin supplies for all insulin

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dependent diabetics to ensure they had the proper amount in the facility per physician's orders. Licensed Practical Nurse (LPN) #1 contacted three local pharmacies to ensure that the facility will have an adequate backup supply.
-Validated through record review, observation, and interviews that the audits were completed for residents receiving accuchecks and insulin, eternal feedings and eternal flushes and verified through interview with the DON that she is responsible for checking the MAR/TAR daily for documentation going forward. Interview with the MD stated that he was notified regarding any discrepancies and omissions in the medical record.

5. Licensed Practical Nurse (LPN) #3 was disciplined for improper documentation on March 25, 2021. LPN # 4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, LPN #10, RN # 5, RN #6, and RN # 7 received an employee written warning discipline on March 29, 2021. The Mississippi State Board of Nursing was called regarding LPN #3 at 5:42PM unable to leave a message. Return call made on March 26, 2021 at 9:12Am. The Mississippi State Board of Nursing was called regarding Licensed Nurses #4-10 and Registered Nurses #5-7 on March 29, 2021. The following agencies were notified on March 25, 2021. Mississippi State Department of Health Abuse Hotline was called at 5:39PM. Mississippi State Board of Nursing Home Administrators was called at 5:43PM. The Office of the Attorney General was called at 6:05PM. The local Police Department was called on March 26, 2021 at 9:19am.
-Validated through record review and interview with the DON, RN#7, LPN #4 that the employees LPN 4-10 and RN 5-7 had received written

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F 600	Continued From page 39 warnings for disciplines and were reported to the Board of Nursing for failure to document in the medical record. Record review validated that the MSDH hotline, The AG office, and the local police dept were all notified. The facility alleges removal of the immediacy as of March 30, 2021 8:00am. The SA validated all actions were completed to remove the IJ on March 31, 2021.	F 600		
F 693 SS=K	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff	F 693	Tube Feeding Mgmt/Restore Eating Skills	4/30/21

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F 693	Continued From page 40 interview, and facility policy review, the facility failed to provide treatment and services related to enteral feedings and enteral water flushes for three (3) out of four (4) residents reviewed of eight (8) residents requiring enteral feedings, Residents #1, #2 and #3. The facility's failure to provide goods and services related to enteral feedings and enteral water flushes placed residents at risk, and in a situation, which caused serious injury and death for one (1) resident, Resident #1, hospitalization of Resident #2, and was likely to cause serious injury, harm, impairment, or death for other residents requiring enteral feedings. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 03-03-2021 when the facility failed to provide goods and services related to enteral feedings and enteral water flushes and the resident was hospitalized with hyperglycemia. This failure resulted in the hospitalization of two (2) residents for critical blood glucose levels, with one passing away. These actions placed all residents receiving enteral feedings and requiring insulin in a situation that was likely to cause serious harm, injury, impairment, and further death. On 03-26-2021, at 2:45 PM, SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the NHA with the IJ template. The IJ and SQC existed at: §483.25(g)(5) Assisted Nutrition and Hydration	F 693	1) Resident #1 went to the hospital on March 17, 2021 and expired. Resident #2 was admitted to the hospital on March 23, 2021 and returned to the facility on April 5, 2021. Resident #2 was assessed on return by Registered Nurse #3 and #4 along with Licensed Practical Nurse #1 and all enteral feeding orders were reviewed to ensure they were being followed per physician's orders. Resident #3 was assessed By Registered Nurses #3 and #4 along with Licensed Practical Nurse #1 on March 25, 2021, to ensure orders related to their enteral feedings were being properly administered and that there were no negative outcomes and all orders were being administered per physician's orders. 2)All residents that have orders related to enteral feedings have the ability to be affected by this deficient practice. Current and future residents will have all orders clarified and during the admission process, the Licensed Practical Nurses caring for these residents will be notified of the resident's need immediately on admission by the Registered Nurse Supervisor or the Director of Nursing Services. 3)The Director of Nurses and Registered Nurse #1 initiated in-services with all Licensed Practical Nurses and Registered Nurses on March 25, 2021, at 3:10pm. This in-service covered the following topics: Tube Feeding, Drug Administration, Documentation including	

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F 693	Continued From page 41 (F693) - Scope and Severity - "K " The facility submitted a credible Removal Plan on 03-30-2021, at 9:00 AM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 03-30-2021. The SA validated the Removal Plan on 03-31-2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.25(g)(5) Assisted Nutrition and Hydration (F693) was lowered from a "K" level of scope and severity to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled, "Tube Feedings" dated 12-2015 revealed, "1. All tube feedings will be administered in accordance with verified medical necessity...3. Physician's orders for tube feeding will include, tube type, tube size, kind of feeding, caloric value, volume, duration, mechanisms of administration and flushes. A specific physicians' order will be obtained before attempts to discontinue a tube feeding...6. Tube feeding, I&O (intake and output) should be documented each shift in the electronic medical record for electronic facilities. Non-electronic facilities should document I&O each shift using "FORM NS-683 - Tube Feeding Records." Review of the facility's policy titled, "Intake and Output Measurement" dated 10-2017, revealed, "Purpose: 1. To maintain an accurate	F 693	Electronic Medication Administration and Incident Investigation related to abuse and neglect. In-service will continue until all licensed Practical Nurses and Registered Nurses have attended. They will not be allowed to return to work until they have attended these in-services. On March 25, 2021, the facility moved into their electronic charting system from paper charting. In-service training for the electronic charting will be ongoing for all current and future staff. The Director of Nursing Services, Registered Nurse #3 and Registered Nurse #4 will review the following electronic reports as they relate to the following for omission and discrepancies: Enteral feedings and flushes. If any errors are found the employee will be re-educated and/or disciplined. The Director of Nursing Services will continue to monitor the EMAR until substantial compliance is achieved. (substantial compliance will be met when documented action entered into the computer either through the EMAR or in a nurses' note match the physicians order). Then the Director of Nursing services will review documentation related to tube feeders on the following schedule: weekly for four(4) weeks, then monthly for four (4) months, then quarterly thereafter. The Director of Nursing Services will report any discrepancies to the facility's Quality Assurance Committee for further recommendations. 4) The facility Quality Assurance Committee met on March 25, 2021, at 3:50pm. The members present were the	

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F 693	Continued From page 42 measurement of the resident's intake and output to assess fluid balance...Procedure... 3. Measure and record all liquids ingested...8. When enteral nutritional therapy, hypodermoclysis or intravenous fluid is administered, record amount on individual record...11. Document intake and/or output. 12. Intake and output are totaled every twenty-four hours. 13. The nurse is responsible to evaluate the total I&O per shift. If the intake and output is not adequate, notify the nursing supervisor and the physician..." Resident #1 Review of Resident #1's Face Sheet revealed, she was admitted to the facility on 04-28-2014 with diagnoses of Anemia, Type 2 Diabetes, Hypertension, Hyperlipidemia, Heart Failure, Depression, Chronic Kidney Disease (stage 3), and Long-Term Use of Insulin and Oral Hypoglycemic Drugs. On 03-23-2021, at 11:45 AM, during an interview with Resident #1's daughter, she stated the following, " I received a phone call from the facility at a few minutes till 9:00 at night that my mom was unresponsive. I asked the nurse what that meant, and she said she is not responding when we touch her or talk to her, she is just staring at the ceiling and breathing funny. The nurse said she was calling 911 and sending her out to the hospital. I waited a little bit and then called the emergency room to see how my mom was. A male nurse answered the phone, I told him who I was and asked if my mother was there. He told me to wait a minute. A doctor, I think his name was (formal name) got on the phone and told me I needed to come to the hospital as quickly as I could. I asked him why, is my mother already	F 693	facility Administrator, Director of Nursing Services, the Medical Director, the Infection Preventionist, Registered nurses #1,#2,#3 and #4 along with Licensed Practical Nurse #1. Topics discussed included the following: Enteral Feedings, and Neglect. Policies related to these topics were on hand during the meeting. The Facility Quality Assurance Committee will meet monthly for the next three months to ensure that substantial compliance has been met and maintained. (Substantial compliance will be met when documented action entered into the computer either through the EMAR or in a nurses' note match the physician's order). Any issues that arise will be addressed and plans implemented to make the appropriate changes.	

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gone? He told me she was gone and had been gone for a little while. He said she was DOA (dead on arrival), and they worked on her for about 15 minutes. They had to give her 4 epinephrine shots and that did not work. I asked him if he knew her blood sugar was sky high and registered "HI" on the glucometer when she left the nursing home. He stated he was not aware of her high sugar. They were focused on doing CPR and trying to resuscitate her at the time. The doctor stated her blood sugar was elevated when she had been in the emergency room a week and a half prior, and that one of two things was happening. Either the nurses were not giving my mother her water in the tube and giving her concentrated feeding would cause her blood sugars to be high, or they were not giving her the diabetic insulin or pills in the tube. She was getting all her food through the tube, so it was not like she was eating a piece of pie or sugar. The facility should have been able to regulate her blood sugar better than they did. I am convinced the facility has not been feeding and giving my mom water like they should be, and they are not giving her the insulin and pills like they should be either. "

Review of Resident #1's "Physician Orders" revealed orders for the following: "Full Code, NPO (Nothing by mouth), Flush G-tube (gastric tube) with 200 cc (cubic centimeters) H2O (water) every 4 hours, Nova Source Renal 50 cc/hr. (Cubic Centimeters an Hour) continuous via #20 fr (French).

Review of Resident #1's "Medication Administration Record (MAR) for the month of February, prior to her hospitalization on March 3rd, 2021, revealed, from February 5th, 2021

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through February 16th, 2021, there were no initials of completion for the following: "Flush G-tube with 250 milliliters (ml) H2O (water) three times a day at 5 AM, 1 PM, and 5 PM via #20 FR (French) tube 10 CC (cubic centimeters) Bulb" on 02-13-2021 at both 5:00 AM and 9:00 PM; "Flush G-tube with 30 cc H2O ACPC (before and after) meds" for "night" shift on 02-13-2021, "days" and "evening" shifts on 02-14-2021, and "evening" shift on 02-15-2021; "Flush G-tube with 5 ml H2O between each medication" on "night" shift 02-13-2021, "day" shift on 02-14-2021, and "evening" shift on 02-15-2021.

Further review of Resident #1's February MAR, upon her return to the facility, revealed multiple days with "N" recorded in the boxes".

During an interview with Medical Records (MR) on 03-26-2021 at 11:30 AM, revealed, the "N" meant "Not Administered" and if a nurse put "N" in the box, she was to put an explanation why it was not done or given in the "detail notes". If there was no documentation in the "detail notes" there was no other place to document, why it was not given. It was noted that all the days with "N" recorded, the nurse's initials were all the same. When asked by the SA, why the same initials were on all three shift and different days, Medical Records stated, "when we went to electronic MAR's when a medication was not given, it will flash red on the screen because it is overdue. The Director of Nursing (DON) got tired of seeing the screen flash red, so she went into the MAR and filled in all the holes with an "N" so it would clear her screen up."

Review of Resident #1's February 2021 MAR from 02-24-2021 through 02-28-2021 revealed an

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order to "Flush G-tube with 200 cc H2O every 4 hours (dated 02-23-21 and discontinued on 02-27-2021)" had "N"s documented on 02-26-2021 at 5:00 PM and 9:00 PM, and 02-27-2021 at 5:00 AM; review of the detail notes revealed no documentation as to the reason why the flushes were not administered. A new order to "Flush G-tube with 200 ML H2O every six hours had "N"s at 6:00 PM on 02-27-2021 and 6:00 PM on 02-28-2021. Review of the detail notes revealed no documentation as to the reason why the flushes had not been administered; An order for "Diabetasource 55 cc/hr. continuous via #20 FR until Novasource Renal is available" with an "N" at 2:00pm on 02-27-2021; an order to "flush G-tube with 50 cc H2O ACPC (before and after meds) meds" with "N"s at 3:00 PM on 02-26-21, 02-27-2021 and 02-28-2021; review of the detail notes revealed no documentation as to why the flushes were not administered; An order to "flush G-tube with 5 ML H2O between each medication" had "N"s for 3:00 PM on 02-26-2021, 02-27-2021, and 02-28-2021; review of the detail notes revealed no documentation as to the reason why the flushes were not administered."

The facility was transitioning from paper MARs to electronic MARs in the month of February. Resident #1's "Tube Feeding Records" where intake and output were to be recorded manually, and her "Tube Feeding Report Roster" where intake and output were to be recorded in the computer were compared to reveal a lack of documentation for night shift on 02-05-2021 and 02-06-2021; day shift and evening shift on 02-10-2021; day shift on 02-11-2021; evening and night shift on 02-14-2021; evening and night shift on 02-15-2021; evening shift on 02-24-2021; evening and night shift on 02-25-2021; and night

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shift on 02-28-2021.

Resident #1's 24-hour totals for enteral feeding and water flushes were to be:
02-05-2021 through 02-26-2021 - 250 cc flushes three times a day to equal 750 cc, and 25 cc an hour of Diabetasource continuous to equal 600 cc. Together Resident #1 should have received 1350 cc total through her G-tube. Review of her daily intakes revealed she did not meet this amount on 02-11-2021 at 680 cc, 02-12-2021 at 732 cc, and 02-14-2021 at 500 cc.

For the dates of 02-24-21 through 02-28-2021, Resident #1's 24-hour totals for enteral feeding and water flushes were to be: 200 cc flushes four times a day to equal 800 cc, and 55 cc an hour of Diabetasource to equal 1320 cc. Together, Resident #1 should have received 2120 cc total through her G-tube. Review of her daily intakes revealed she did not meet this amount on 02-24-2021 at 757 cc, 02-25-2021 at 1561 cc, 02-27-2021 at 1186 cc and 02-28-2021 at 1152 cc.

Review of Resident #1's MAR for March 2021 revealed an order for "Diabetasource 50 cc/hr. continuous via #20 FR until Novasource Renal is available" with "N"'s at 6:00 AM and 10:00 PM on 03-01-2021 and 6:00 AM and 2:00 PM on 03-02-2021; an order to "Flush G-tube with 200 ML H2O every six hours" with "N"s on 03-01-2021 at 12:00 AM and at 6:00 PM. Review of the detailed notes for these days revealed there was no reason documented for why the enteral feeding and flushes were not administered.

Review of Resident #1's "Tube Feeding Report Roster" for March 2021 revealed the total intake

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of enteral feedings and enteral water flushes to be 1180 cc on 03-01-2021, and 800 cc on 03-02-2021. Resident #1 should have received 2120 cc of feeding and water for each day.

Review of Resident #1's "Admission History and Physical" dated 03-03-2021, revealed Resident #1 was admitted to the hospital on 03-03-2021 for Urosepsis, Hyperglycemia, and an Acute Kidney Injury requiring a bolus of three (3) liters of fluid in the Emergency Room.

Further review of Resident #1's "Admission History and Physical" dated 03-03-2021, revealed she had been brought to the Emergency Room (ER)with "reports of fever and tachycardia", and her labs revealed "lactic acidosis, leukocytosis, hyperglycemia, and an acute kidney injury." Further review revealed her Sodium Level was 146 (high), and her glucose was 524 (high). Under an "Assessments" section she had the follow diagnoses, "Sepsis, Urinary Tract Infectious Disease, Lactic Acidosis, Hyperglycemia and Hypernatremia." Under the "Plan:" section it stated, "74-year-old African American female admitted with Urosepsis and Acute Kidney Injury...Patient now status post 3 liters of normal saline in the ER. Will continue IV (intravenous) hydration...Hypernatremia: Serum Sodium 146 on admission. Will adjust fluids as needed...Hyperglycemia: Known history of Diabetes Mellitus. Glucose 524 on arrival to the ER. Patient now s/p (status post) 3L (liters) NS (normal saline). Ordering Accuchecks Q 4 (every 4) hours and Humalog per sliding scale. Holding Lantus until tube feeds are resumed..."

On 03-25-2021, at 3:15 PM, in an interview with the Director of Nursing (DON), when asked if the

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facility could show Resident #1 had received her enteral feeding, water flushes and diabetic medications from 02-24-2021 through 03-02-2021, to help prevent her hospitalization on 03-03-2021, she stated, "not if it is not written in the nurses notes or on the MAR. The nurses should be putting that information into the computer. I am not sure what the "N" means. This computer system is new, and I do not know anything at all about it yet. When asked how high a blood glucose had to register for the meter to state "HI", she indicated she would have to check the user guide and let me know."

On 03-25-2021, at 4:00 PM, the DON brought the User Guide for the "Rosie Smart Meter" which revealed, "The testing range of the meter is from 20 to 600 mg/dl (milligrams per deciliter). If HI is displayed, your blood glucose result may be higher than 600 mg/dl. If LO is displayed, your blood glucose result may be lower than 20 mg/dl."

Review of Resident #1's Nurses notes dated 03-17-2021 at 10:53 PM revealed, "7:20 PM - Summoned to resident's room per C.N.A. (Certified Nurse Aide), resident noted lying in bed, increased resp (respirations) sweating. Blood sugar called for primary nurse. Checked registered HI on the blood glucose meter. She did not respond to verbal or tactile stimuli..."

Review of Resident #1's Nurses Notes dated 03-17-2021 at 11:04 PM revealed, "Summoned to resident room after supervisor noted that resident was not responding. Resident was still breathing but not responding, cold sweats noted coming from resident blood sugar check and were unreadable, 911 called immediately. Around 7:30 PM ambulance arrived and headed to ER with

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resident, received a called from ER, nurse stated that resident had coded and passed away. Family members notified."

Neither nurses note regarding the event made mention of notifying the Physician of Resident #1's condition, departure for the emergency room, or later demise.

Review of Resident #1's "Physician Documentation" from the Emergency Department revealed, "Arrival date: 03-17-2021 at 9:04 PM... Location: Morgue, Pronouncing Physician: (Formal Name), Time of Death: 9:06 PM, Diagnosis - Cardiac Arrest, Acute Respiratory Failure... 74-year-old female who presents to the emergency room in respiratory distress with palpable pulses initially. Pulses loss CPR initiated. Patient intubated. CPR performed for 14 minutes with multiple rounds of epinephrine and 1 of bicarb given. 1 Liter bolus began. Patient pronounced at 9:06 PM. Patient without any palpable pulses or visible chest rise. Patient without an auditory breath sounds or cardiac sounds. Patient pupils fixed and dilated. No corneal reflex of patient are responsive to verbal or painful stimuli. Family notified."

On 03-26-2021, at 11:45 AM, during an interview with Resident #1's physician, the Medical Director of the facility, she indicated, she was not fully aware of the entire incident with (formal name) (Resident #1), with all the details. When Resident #1's current diabetic orders and enteral feeding orders were reviewed with the physician, she stated, the orders were not correct. She would not give blood sugar check orders like they were written. She indicated the order should have read to "check blood glucose every morning at 9:00

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AM, and to send them to the doctor every two weeks for review. If blood sugar is <60 or >400, notified the Physician." She indicated the blood sugar check order written as it was, did not make any sense with regard to glucose control. She indicated she was not aware the Residents blood sugar had read "HI" prior to being sent out and stated that Resident #1's blood sugars had not been being sent to her office for review. She stated she had Resident #1's chart in front of her as she spoke on the phone, and there were no reports of staff calling blood glucose results to her office for review. She indicated she had a Nurse Practitioner (NP) that worked with her, and both had been doing virtual visits with the residents due to COVID-19, so they were relying on the staff to tell them what was going on with the residents in order to know what orders to write. She stated the staff had not made her aware the Resident was missing enteral feedings, water flushes and her diabetic meds from time to time, and definitely not for several days in a row prior to her last hospitalization. She stated, had she been made aware of the resident's elevated blood sugar, she would have written orders accordingly. When the SA informed her of the daughter's concerns, and the items mentioned to her by the Emergency Room Physician, she agreed with the resident having a controlled food and fluid source and should have been better regulated with her glucose levels. She agreed that giving the concentrated enteral feeding without the proper water or not giving Resident #1 her insulin and oral medications could affect her blood sugar levels and cause them to run high.

Resident #2

Review of Resident #2's Face Sheet revealed she

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was admitted to the facility on 01-28-2010 with diagnoses of Dysphagia following a Cerebrovascular Disease, Type 2 Diabetes Mellitus, Glaucoma, Hyperlipidemia, Adult Failure to Thrive, Vascular Dementia, Long term (current) use of Insulin, Depression, Anxiety, Hypertension, and Gastrostomy Tube.

Review of Resident #2's "Physician Orders" March 2021 revealed orders for "Full Code, Push by mouth fluids, give six 16 oz (ounce) of water per day; Flush G-tube with 250 ML H2O three times a day at 5 AM, 1 PM, and 5 PM via #20 FR Tube 10 cc bulb and Record I&O Q shift with 24-hour total."

Review of Resident #2's MAR for February 2021 revealed an order to "Push by mouth fluids, give 6 16 oz. of water per day". There were no initials of completion for all three shifts for the entire month.

Review of Resident #2's "Intake/Output" record for February 2021 was completely blank for the entire month.

Resident #2 was hospitalized from 03-02-2021 through 03-09-2021 for the placement of a Gastric Tube to help supplement her intakes.

Review of Resident #2's March MAR after her return on 03-09-2021 revealed orders for Novasource Renal Bolus 1 can (250 ML) Q 6 hours, providing 2000 KCAL (kilocalories), 91 G (grams) of protein, 1855 ML H2O, to equal 2135 ML of fluid and 100% of RDI (recommended daily intake); with missing initials for 03-16-2021 at 6:00 AM with no detailed nurses notes for why it was not administered; Another order to Flush tube with 100 ML H2O every 4 hours, with

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missing initials on 03-16-2021 at 5:00 AM, and on 03-18-2021 at 5:00 AM and 9:00 PM.

Review of Resident #2's "Tube Feeding Report Roster" revealed no intake and output were recorded for her from her readmission on 03-09-2021 through 03-15-2021. Her daily intake of fluids between her enteral feeding and water flushes was to be 2135 ML per her orders. Her intake recorded for 03-16-2021 was 537 ml; for 03-17-2021 through 03-19-2021 there was no intake recorded; for 03-20-2021 it was 397 ml; for 03-21-2021 it was 567 ML; for 03-22-2021 it was 1141 ML.

Review of Resident #2's weight record revealed, on 10-12-2020, she weighed 162.0 pounds, on 11-02-2020, she weighed 161.5 pounds, on 12-01-2020, she weighed 160.5 pounds, on 01-01-2021, she weighed 162.0 pounds, on 02-17-2021 she weighed 136.5 pounds, and on 03-16-2021, she weighed 146.0 pounds. Resident had a gastric tube placed during a hospitalization on 03-09-2021. The weight loss noted between January and February was due to her lack of appetite with COVID-19, double lung Pneumonia, and lethargy.

Review of Resident #2's Departmental Notes, dated, 03-01-2021 at 1:50 PM revealed, "Resident remains lethargic, did not eat breakfast or lunch, unable to administer medications due to resident is not alert enough at this time."

Review of Resident #2's Departmental Notes, dated 03-02-2021 at 10:35 AM, revealed, "DON spoke with family member, NP at Dr (Doctor's formal name) office and the ER (Emergency Room) Director regarding tube placement for

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resident. Plan: Resident departed facility at 10:05 AM with (Ambulance Company Name), 1 female and 1 male attendant, to ER Clarksdale for tube placement evaluation ..."

Review of Resident #2's "Admission History and Physical" dated 01-30-2021, revealed, she was admitted with a fever of 102.4 degrees. She tested positive for COVID-19. "Imaging Results: CXR (chest X-ray) - bilateral pneumonia consistent with COVID-19. Discharge Diagnosis: Acute Renal Failure Syndrome, Inadequate Oral Intake, Sepsis - Resolved, and Bacteremia. Hospital Summary: 84 y/o female admitted to COVID unit due to COVID positive testing with UTI (urinary tract infection), Sepsis and staph epi bacteremia ...Pt. (patient) also noted to have decreased oral intake which contributed to dehydration and ARF (acute renal failure) on admission. This has improved to baseline. Pt. still has decreased oral intake but will drink fluids and take meds with some prompting. Pt is COVID positive and will need COVID testing to be negative prior to consideration for PEG placement. Health Concerns: Inadequate oral intake."

Review of Resident #2's Physician's Orders, dated February 2021, revealed, orders for a "house supplement, 4 oz (ounces) by mouth daily. The order was changed on 02-028-2021 to "House Supplement 2 oz. by mouth three times a day - Chart 1-25%, 2-50%, 3- 75%, 4- 100%, and 5 - refused."

Resident #2 was sent to the Emergency Room (ER) on 03-23-2021 for a blood glucose that read "HI" on the glucometer.

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Review of Resident #2's Nurses notes dated 03-23-2021, at 6:56 AM, revealed, "Resident remains on observation for COVID precautions, no s/s (sign or symptoms) of COVID noted at this time. Informed MD of Blood sugar reading of HI. Received new orders to start Levemir 10 units @ HS (hour of sleep). Novolog with sliding scale and send her to the ER now for elevated blood sugar. Attempted to inform RR (Resident Representative) of new orders and unable to reach him at this time. (formal name of ambulance) called for transfer..."

Review of nurses notes dated 03-23-2021, at 8:58 AM revealed, "7:25 AM resident exited fac (facility) per (ambulance formal name) accompanied per 2 female EMT's (Emergency Medical Team). No acute distress noted at this time."

Review of nurse's notes dated 03-23-2021, at 12:30 PM revealed, "RR (Resident Representative) returned call to fac, informed him of order to send to ER for eval secondary to elevated BS (blood sugar)."

Review of Resident #2's "Physician Documentation" from the Emergency Room dated 03-23-2021 revealed, "Arrival Date 03-23-2021, Time: 07:44 AM, Hospitalization Status: Inpatient Admission, Current Condition: Serious, Diagnosis: Anemia, Bladder Infection, Severe Sepsis without septic shock, Pneumonia Bacterial, Acute Renal/Kidney Failure. There was a high probability of clinically significant/life threatening deterioration in the patient's condition which required my urgent intervention. This 84-year-old black female presents to ER via EMS ground with complaints of High Blood Sugar.

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Associated symptoms of diaphoresis. Patient was found hypoglycemic today, and she was also tachycardic on arrival of EMS. Fluid started by EMS and patient transported here. Correct hyperglycemia initially with fluids and consider insulin when potassium is known... There are signs of severe sepsis in the setting of acute renal failure... At 07:51 AM Blood Glucose: 466 mg/dl, critical glucose levels for an adult: <60 (below 60) or >300 mg/dl (above 300)."

On 03-26-2021, at 11:45 AM, during an interview with Resident #2's physician, the Medical Director of the facility, she indicated, she was made aware of the blood sugar reading of "HI" and remembers giving new orders for her insulin and sending her to the Emergency Room to be evaluated. She stated she had Resident #2's chart in front of her as she spoke on the phone, and there were no prior reports of staff calling blood glucose results to her office for review. She indicated she had a Nurse Practitioner (NP) that worked with her, and both had been doing virtual visits with the residents due to COVID-19, so they were relying on the staff to tell them what was going on with the residents to know what orders to write. She stated the staff had not made her aware the resident was missing enteral feedings and water flushes from time to time. She stated giving the concentrated enteral feeding without the proper water or not giving Resident #2 her insulin and oral medications could affect her blood sugar levels and cause them to run high.

Resident #2 remained in the hospital throughout the remainder of the survey.

Resident #3

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Review of Resident #3's Face Sheet revealed she was admitted to the facility on 11-03-2011 with diagnoses of Dementia with Lewy Bodies, Depression, Hypertension, Gastrostomy Status, and Chronic Kidney Disease.

Observation on 03-24-2021, during morning rounds at 10:00 AM, Resident #3 was noted to be in her bed, lying on her back with eyes closed. Her mouth was slightly open with dry oral mucosa, dry, scaly lips. G-tube feeding running at 40 ML per hour.

Observation on 03-25-2021, during rounds at 2:15 PM, Resident #3 was noted to be in bed, on her left side, with her eyes closed. Mouth remains with dry scaly lips. Mouth is closed at this time, cannot visualize oral mucosa.

Review of Resident #3's Physician Orders revealed orders for the following: Isosource per Kangaroo Pump at 40 ML per hour for 22 hours via #20 FR G-tube to provide 1320 cal, 59 Grams protein, 1909 free H2O/2100 total FLD (fluid), 90% RDI (Recommended Daily Intake).

During an interview with the DON on 03-25-2021, at 3:15 PM, when asked by the SA how intake was calculated, and what do the initials on the MAR mean for the enteral feeding orders, she stated they are checking to make sure the pump is on and running at the rate it is supposed to be running at. When asked how the nurses are to know if the resident has received the required amount of enteral feeding and fluid for the day, she stated they would rely on the intake and output record to tell that.

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The facility was transitioning from paper MARs to electronic MARs in the month of February. Resident #3's "Tube Feeding Records" where intake and output were to be recorded manually, and her "Tube Feeding Report Roster" where intake and output were to be recorded in the computer were compared to reveal a lack of documentation for 02-10-2021 for day and night shifts, 02-11-2021 for day and evening shifts, 02-12-2021 for day shift, 02-13-2021 for day shift, 02-14-2021 for day shift, 02-15-2021 for day and evening shifts, 02-16-2021 for day and evening shifts, 02-17-2021 for evening shift, 02-19-2021 for day shift, 02-21-2021 for evening shift, and 02-24-2021 for evening shift.

Resident #3, per her Physicians Orders, was to receive 2100 ML of fluid a day between her enteral feeding and her water flushes. In the month of February, there were 12 days in which she received significantly less than her allotted amount: 02-10-2021 at 675 cc, 02-11-2021 at 720 cc, 02-12-2021 at 1,402 cc, 02-13-2021 at 1,325 cc, 02-14-2021 at 1,451 cc, 02-15-2021 at 739 cc, 02-16-2021 at 835 cc, 02-17-2021 at 1,555 cc, 02-20-2021 at 1,344 cc, 02-21-21 at 1,384 cc, 02-24-2021 at 1,081 cc, and 02-25-2021 at 1,647 cc.

Review of Resident #3's "Tube Feeding Report Roster" for the month of March 2021 revealed a lack of documentation on 03-02-2021 for day shift, and on 03-20-2021 for evening shift.

Further review of Resident #3's "Tube Feeding Report Roster" for the month of March 2021 revealed 10 days from 03-01-2021 through 03-24-2021, in which she received significantly less than her allotted amount: 03-02-2021 at

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1,220 cc, 03-03-2021 at 1,781 cc, 03-05-2021 at 1,576 cc, 03-07-2021 at 1,760 cc, 03-08-2021 at 1,798 cc, 03-09-2021 at 1,131 cc, 03-11-2021 at 1,542 cc, 03-15-2021 at 1,193 cc, 03-17-2021 at 1,587 cc, 03-20-2021 at 1,001 cc, and 03-22-2021 at 1,748 cc.

The facility provided an acceptable removal plan on 03-30-2021, for the IJ and review of the facility's removal plan revealed the facility took the following actions to remove the IJ:

Removal Plan

On March 25, 2021 at 2:45pm State Agency notified the Administrator that the facility was in an Immediate Jeopardy (IJ) and templates were provided to the Administrator.
The facility failed to appropriately document the amount of enteral feedings, and flushes for Resident #1 and Resident The facility failed to maintain Resident's blood glucose levels within an acceptable parameter for Resident #1 and Resident #2. The facility failed to provide appropriate goods and services to Residents necessary to avoid physical harm, pain, mental anguish, or emotional distress by not providing enteral feedings, water flushes and insulin per physician orders.

1. On March 17, 2021, at 7:20PM Resident #1 was found unresponsive. A blood glucose was checked on Resident #1 with a blood glucose testing device indicating a "HI" reading. Emergency services were notified at approximately 7:20PM and Resident #1 was transported by ambulance to local hospital #1. Resident #1 expired on March 17, 2021 at approximately 9:06PM in the emergency room at

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local hospital #1. On March 23, 2021 at 6:50 AM blood glucose was checked on Resident #2 with a blood glucose testing device indicating a "HI" reading. Physician #1 was notified on March 23, 2021 at approximately 6:56am and orders were received to transfer Resident #1 to local hospital #1. Resident #2 was transferred on March 23, 2021 at approximately 7:25am by ambulance to the Emergency Room of local hospital #1. Resident # 2 remains in the hospital at this time.

2. Director of Nurses (DON) and Registered Nurse (RN) #2 immediately initiated in-services with Registered Nurses and Licensed Nurses on March 25, 2021, at 3:10PM on Tube Feedings, Drug Administration & Documentation including electronic medication administration records and Incident Investigation & Reporting, related to abuse and neglect Director of Nurses (DON) and Registered Nurse (RN) #2 initiated in-services with Registered Nurses and Licensed Nurses on March 26, 2021 at 4:00PM on Hypoglycemia and Hyperglycemia. In-services will be on-going, and no nurses win be allowed to work until participation of the in-services for Tube Feedings, Drug Administration & Documentation including electronic medication administration records, and Incident Investigation & Reporting related to abuse and neglect, Hypoglycemia and Hyperglycemia. During the week of February 22, 2021 through February 26, 2021 initial training was provided to all nursing department staff concerning implementation of the new electronic charting system and the electronic Medication Administration Record by Registered Nurse (RN) #2. This training is an ongoing process for all new staff and existing staff as changes are made to the system.

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3. The facility Quality Assurance Committee Meeting was held on Thursday, March 25, 2021, at 3:50PM, with the committee consisting of facility Director of Nurses, Nursing Home Administrator, Medical Director Infection Preventionist, Registered Nurses (RN) Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, and Licensed Practical Nurse (LPN) #1. Topics discussed included Enteral Feedings, Insulin Administration, and Neglect with the following policies reviewed Tube Feedings, Drug Administration & Documentation, and Incident Investigation & Reporting, related to abuse, and neglect. No policy changes were indicated however, facility made procedural changes on March 25, 2021 to medication administration monitoring to include electronic medication charting reviews. The Director of Nurses (DON), Registered Nurse (RN) #3 and Registered Nurse (RN) #4 with review electronically generated reports for omissions and discrepancies with enteral feedings and flushes, insulin administration, and blood glucose results.

4. On March 25, 2021 from 4:30PM to 9:00PM, Registered Nurses (RN) #3, Registered Nurse (RN) #4 and Licenses Practical Nurse (LPN) #1 physically assessed and observed all Residents receiving enteral feedings with no significant findings identified. They also, physically assessed and observed ad diabetic Residents with insulin with no significant findings identified. On March 25, 2021 and March 28, 2021, the Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records Clerk audited the electronic medical records, the enteral feeding orders,

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medication administration records, and intake records for any Resident on enteral feeding for omissions and discrepancies from February 5, 2021 to present. Omissions of enteral feedings and flushes were noted on the audit for four of eight Residents. The physician was notified of all four of eight Residents with omissions March 29, 2021 with no new orders received. The Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records also audited the physician orders, electronic records, and medication administration of all insulin dependent diabetics for omissions and discrepancies from February S, 2021 to present. Omissions were noted for fourteen of twenty-six Residents blood glucose results and two of seventeen insulin administrations. The physician was notified of all fourteen Residents with omissions March 29, 2021 with no new orders received. One of seventeen Residents audited was noted with a discrepancy in blood glucose results documentation. The physician was notified of the Resident discrepancy on March 29, 2021 with no new orders received. On March 25, 2021, Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 and Registered Nurse (RN) #1 checked insulin supplies for all insulin dependent diabetics to ensure they had the proper amount in the facility per physician's orders. Licensed Practical Nurse (LPN) #1 contacted three local pharmacies to ensure that the facility will have an adequate backup supply.

5. Licensed Practical Nurse (LPN) #3 was disciplined for improper documentation on March 25, 2021. LPN # 4, LPN #5, LPN #6, LPN #10, RN # 5, RN #6, and RN # 7 received an

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employee written warning discipline on March 29, 2021* The Mississippi State Board of Nursing was called regarding LPN #3 at 5:42PM unable to leave a message. Return call made on March 26, 2021 at 9:12Am. The Mississippi State Board of Nursing was called regarding Licensed Nurses #4 -10 and Registered Nurses #5-7 on March 29, 2021. The following agencies were notified on March 25, 2021. Mississippi State Department of Health Abuse Hotline was called at 5:39PM. Mississippi State Board of Nursing Home Administrators was called at 5:43PM. The Office of the Attorney General was called at 6:05PM. The local Police Department was contacted on March 26, 2021 at 9:19 am.

The facility alleges removal of the immediacy as of March 30, 2021, at 8:00am.

The SA validated all corrective actions had been completed as of March 30, 2021, and the IJ was removed as of 03-31-2021.

1. On March 17, 2021, at 7:20PM Resident #1 was found unresponsive. A blood glucose was checked on Resident #1 with a blood glucose testing device indicating a "HI" reading. Emergency services were notified at approximately 7:20PM and Resident #1 was transported by ambulance to local hospital #1. Resident #1 expired on March 17, 2021 at approximately 9:06PM in the emergency room at local hospital #1. On March 23, 2021 at 6:50 AM blood glucose was checked on Resident #2 with a blood glucose testing device indicating a "HI" reading. Physician #1 was notified on March 23, 2021 at approximately 6:56am and orders were received to transfer Resident #1 to local hospital #1. Resident #2 was transferred on March 23,

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2021 at approximately 7:25am by ambulance to the Emergency Room of local hospital #1. Resident # 2 remains in the hospital at this time.
-Validated through observation, record review and interview that Resident #2 remains in the hospital and that Physician #1 was notified.

2. Director of Nurses (DON) and Registered Nurse (RN) #2 immediately initiated in-services with Registered Nurses and Licensed Nurses on March 25, 2021, at 3:10PM on Tube Feedings, Drug Administration & Documentation including electronic medication administration records and Incident Investigation & Reporting, related to abuse and neglect. Director of Nurses (DON) and Registered Nurse (RN) #2 initiated in-services with Registered Nurses and Licensed Nurses on March 26, 2021 at 4:00PM on Hypoglycemia and Hyperglycemia. In-services will be on-going, and no nurses will be allowed to work until participation of the in-services for Tube Feedings, Drug Administration & Documentation including electronic medication administration records, and Incident Investigation & Reporting related to abuse and neglect, Hypoglycemia and Hyperglycemia. During the week of February 22, 2021 through February 26, 2021 initial training was provided to all nursing department staff concerning implementation of the new electronic charting system and the electronic Medication Administration Record by Registered Nurse (RN) #2. This training is an ongoing process for all new staff and existing staff as changes are made to the system.
-Validated through record review and interviews that in-services regarding Tube Feedings, Drug Administration, Documentation in the Electronic Medical Record and Incident reporting and investigation related to abuse and neglect,

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Hypoglycemia and Hyperglycemia. Interviews were held with the DON, Administrator, LPN #5, LPN #6, RN #1, RN #2, the QA nurse, and LPN #7. All verified that they have been in-serviced.

3. The facility Quality Assurance Committee Meeting was held on Thursday, March 25, 2021, at 3:50PM, with the committee consisting of facility Director of Nurses, Nursing Home Administrator, Medical Director, Infection Preventionist, Registered Nurses (RN) #1, Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, and Licensed Practical Nurse (LPN) #1. Topics discussed included Enteral Feedings, Insulin Administration, and Neglect with the following policies reviewed Tube Feedings, Drug Administration & Documentation, and Incident Investigation & Reporting, related to abuse, and neglect. No policy changes were indicated however, facility made procedural changes on March 25, 2021 to medication administration monitoring to include electronic medication charting reviews. The Director of Nurses (DON), Registered Nurse (RN) #3 and Registered Nurse (RN) #4 will review electronically generated reports for omissions and discrepancies with enteral feedings and flushes, insulin administration, and blood glucose results.
-Validated through record review and interview with the QA Nurse, DON, and the Medical Director, that the QA meeting was held on 03/25/21 and verified through a sign in sheet that the facility met the requirements of the QA meeting and that the issues regarding Enteral Feedings, Insulin Administration, Neglect, Drug Administration and Documentation along with incident investigation and reporting as it relates to abuse, and neglect were all issues that were

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discussed and reviewed.

4. On March 25, 2021 from 4:30PM to 9:00PM, Registered Nurses (RN) #3, Registered Nurse (RN) #4 and Licenses Practical Nurse (LPN) #1 physically assessed and observed all Residents receiving enteral feedings with no significant findings identified. They also, physically assessed and observed all diabetic Residents with insulin with no significant findings identified. On March 25, 2021 and March 28, 2021, the Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records Clerk audited the electronic medical records, the enteral feeding orders, medication administration records, and intake records for any Resident on enteral feeding for omissions and discrepancies from February 5, 2021 to present. Omissions of enteral feedings and flushes were noted on the audit for four of eight Residents. The physician was notified of all four of eight Residents with omissions March 29, 2021 with no new orders received. The Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records also audited the physician orders, electronic records, and medication administration of all insulin dependent diabetics for omissions and discrepancies from February 5, 2021 to present. Omissions were noted for fourteen of twenty-six Residents blood glucose results and two of seventeen insulin administrations. The physician was notified of all fourteen Residents with omissions March 29, 2021 with no new orders received. One of seventeen Residents audited was noted with a discrepancy in blood glucose results

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documentation. The physician was notified of the Resident discrepancy on March 29, 2021 with no new orders received. On March 25, 2021, Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 and Registered Nurse (RN) #1 checked insulin supplies for all insulin dependent diabetics to ensure they had the proper amount in the facility per physician's orders. Licensed Practical Nurse (LPN) #1 contacted three local pharmacies to ensure that the facility will have an adequate backup supply.
-Validated through record review, observation, and interviews that the audits were completed for residents receiving accuchecks and insulin, eternal feedings and eternal flushes and verified through interview with the DON that she is responsible for checking the MAR/TAR daily for documentation going forward. Interview with the MD stated that he was notified regarding any discrepancies and omissions in the medical record.

5. Licensed Practical Nurse (LPN) #3 was disciplined for improper documentation on March 25, 2021. LPN # 4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, LPN #10, RN # 5, RN #6, and RN # 7 received an employee written warning discipline on March 29, 2021. The Mississippi State Board of Nursing was called regarding LPN #3 at 5:42PM unable to leave a message. Return call made on March 26, 2021 at 9:12Am. The Mississippi State Board of Nursing was called regarding Licensed Nurses #4-10 and Registered Nurses #5-7 on March 29, 2021. The following agencies were notified on March 25, 2021. Mississippi State Department of Health Abuse Hotline was called at 5:39PM. Mississippi State Board of Nursing Home Administrators was called at 5:43PM. The Office of the Attorney General

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F 693	Continued From page 67 was called at 6:05PM. The local Police Department was called on March 26, 2021 at 9:19am. -Validated through record review and interview with the DON, RN#7, LPN #4 that the employees LPN 4-10 and RN 5-7 had received written warnings for disciplines and were reported to the Board of Nursing for failure to document in the medical record. Record review validated that the MSDH hotline, The AG office, and the local police dept were all notified. The facility alleges removal of the immediacy as of March 30, 2021 8:00am. The SA validated all actions were completed to remove the IJ on March 31, 2021.	F 693		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide goods and services related to diabetic medications for five (5) of eight (8) residents reviewed of 11 insulin dependent diabetics, Residents #1, #2, #4, #5 and #6. The facility's failure to provide goods and services related to diabetic medications placed residents at risk, and in a situation, which caused serious injury and death for one (1) resident, Resident #1, hospitalization of Resident #2, and was likely to cause serious injury, harm, impairment, or death for other residents requiring enteral feedings and	F 760	Residents are Free of Significant Med Errors 1)Resident #1 went to the hospital on March 17, 2021 and expired. Residents #2 was admitted to the hospital on March 23, 2021 and returned to us on April 5, 2021. Resident #2, #4, #5 and #6 were assessed by Registered Nurses #3 and #4 along with Licensed Practical Nurse #1 along with their diabetic orders to ensure there were no negative outcomes and all orders were being administered per physician's orders.	4/30/21

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F 760	Continued From page 68 insulin. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 03-03-2021 when the facility failed to provide goods and services related to diabetic medications and the resident was hospitalized with hyperglycemia. This failure resulted in the hospitalization of two (2) residents for critical high blood glucose levels, with one passing away. These actions placed all residents receiving diabetic medications and requiring insulin in a situation that was likely to cause serious harm, injury, impairment, and further death. On 03-26-2021, at 2:45 PM, SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the NHA with the IJ template. The IJ and SQC existed at: §483.45(f)(2) Residents are free of any significant medication errors (F760) - Scope and Severity - "K". The facility submitted a credible Removal Plan on 03-30-2021 at 9:00 AM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 03-30-2021. The SA validated the Removal Plan on 03-31-2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.45(f)(2) Residents are free of any significant medication errors (F760) was	F 760	2) All residents that have orders related to diabetes have the ability to be affected by this deficient practice. Current and Future residents will have all orders clarified and during the admission process, the licensed practical nurses caring for these residents will be notified of the resident's need immediately on admission by the registered nurse supervisor or the director of Nursing Services. 3) The Director of Nurses and Registered Nurse #1 initiated in-services with all Licensed Practical Nurses and Registered Nurses on March 25, 2021, at 3:10pm. This in-service covered the following topics: Drug Administration, Documentation including Electronic Medication Administration and Incident Investigation related to abuse and neglect. The Director of Nursing Services and Registered Nurse #1 initiated in-services with Licensed Practical Nurses and Registered Nurses on March 25, 2021 at 4:00PM. The topics of this in-service were: Hypoglycemia and Hyperglycemia. In-Service will continue until all Licensed Practical Nurses and Registered Nurses have attended. They will not be allowed to return to work until they have attended these in-services. On March 25, 2021, the facility moved into their electronic charting system from paper charting. In-service training for the electronic charting will be ongoing for all current and future staff. The Director of Nursing Services, Registered Nurse #4	

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lowered from a "K" level of scope and severity to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility's policy titled, "Drug Administration and Documentation" dated 11-2017, revealed, "Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given... For electronic medication administration (EMAR), any medication not administered is indicated by an "N" in the block with a note of explanation as to why medication was not administered..."

Resident #1

Review of Resident #1's Face Sheet revealed, she was admitted to the facility on 04-28-2014 with diagnoses of Anemia, Type 2 Diabetes, Hypertension, Hyperlipidemia, Heart Failure, Depression, Chronic Kidney Disease (stage 3), and Long-Term Use of Insulin and Oral Hypoglycemic Drugs.

On 03-23-2021 at 11:45 AM, during an interview with Resident #1's daughter, she stated the following, " I received a phone call from the facility

and registered Nurse #3 will review the following electronic reports as they relate to the following for omissions and discrepancies: insulin administration and blood glucose results. The Director of Nursing Services will monitor from March 29, 2021, daily the Electronic Medication Administration Record (EMAR) for every resident with orders for blood glucose reading and insulin administration. If any errors are found the employee will be re-educated and/or disciplined. The Director of Nursing services will continue to monitor the EMAR until substantial compliance is achieved. (Substantial compliance will be met when documented action entered into the computer either through the EMAR or in a nurses' note match the physicians order). Then the Director of Nursing services will review documentation related to tube insulin dependent diabetics on the following schedule: Weekly for four (4) weeks, then monthly for four (4) months, then quarterly thereafter. The Director of Nursing Services will report any discrepancies to the facility's Quality Assurance Committee for further recommendations.

4)The Facility Quality Assurance Committee met on March 25, 2021, at 3:50PM. The members present were the facility Administrator, Director of Nursing Services, the Medical Director, the Infection Preventionist, Registered nurses #1, #2, #3 and #4 along with Licensed Practical Nurse #1. Topics discussed included the following: Insulin Administration and Neglect. Policies

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F 760	Continued From page 70 at a few minutes till 9:00 at night that my mom was unresponsive. I asked the nurse what that meant, and she said she is not responding when we touch her or talk to her, she is just staring at the ceiling and breathing funny. The nurse said she was calling 911 and sending her out to the hospital. I waited a little bit and then called the emergency room to see how my mom was. A male nurse answered the phone, I told him who I was and asked if my mother was there. He told me to wait a minute. A doctor, I think his name was (formal name) got on the phone and told me I needed to come to the hospital as quickly as I could. I asked him why, is my mother already gone? He told me she was gone and had been gone for a little while. He said she was DOA (dead on arrival), and they worked on her for about 15 minutes. They had to give her 4 epinephrine shots and that did not work. I asked him if he knew her blood sugar was sky high and registered "HI" on the glucometer when she left the nursing home. He stated he was not aware of her high sugar. They were focused on doing CPR and trying to resuscitate her at the time. The doctor stated her blood sugar was elevated when she had been in the emergency room a week and a half prior, and that one of two things was happening. Either the nurses were not giving my mother her water in the tube and giving her concentrated feeding would cause her blood sugars to be high, or they were not giving her the diabetic insulin or pills in the tube. She was getting all her food through the tube, so it was not like she was eating a piece of pie or sugar. The facility should have been able to regulate her blood sugar better than they did. I am convinced the facility has not been feeding and giving my mom water like they should be, and they are not giving her the insulin and pills like they should be	F 760	related to these topics were on hand during the meeting. The Facility Quality Assurance Committee will meet monthly for the next three months to ensure that substantial compliance has been met and maintained. (Substantial compliance will be met when documented action entered into the computer either through the EMAR or in a nurses' note match the physicians order). Any issues that arise will be addressed and plans implemented to make the appropriate changes.	

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either."

Review of Resident #1's "Physician Orders" dated for March 2021, revealed orders for the following: "Full Code, NPO (Nothing by mouth), Flush G-tube (gastric tube) with 200 cc (cubic centimeters) H2O (water) every 4 hours, Nova Source Renal 50 cc/hr. (Cubic Centimeters an Hour) continuous via #20 fr (French), Blood Sugar after breakfast every 2 weeks at 9:00 AM, call Dr (Formal name) with results if <60 or >400, call s/s (signs and symptoms) if needed, Lantus 24 units sub Q (subcutaneous) at 9:00 PM. Rotate SQ site, and Onglyza 5 mg (milligram) tablet per (by) G-tube daily at 9:00 AM."

Review of Resident #1's "Medication Administration Record (MAR) for the month of February, prior to her hospitalization on March 3rd, 2021, revealed, from February 5th, 2021 through February 16th, 2021, there were no initials of completion for the following: "Flush G-tube with 250 milliliters (ml) H2O (water) three times a day at 5 AM, 1 PM, and 5 PM via #20 FR (French) tube 10 CC (cubic centimeters) Bulb" on 02-13-2021 at both 5:00 AM and 9:00 PM; "Flush G-tube with 30 cc H2O ACPC (before and after) meds" for "night" shift on 02-13-2021, "days" and "evening" shifts on 02-14-2021, and "evening" shift on 02-15-2021; "Flush G-tube with 5 ml H2O between each medication" on "night" shift 02-13-2021, "day" shift on 02-14-2021, and "evening" shift on 02-15-2021; "Onglyza 5 mg tablet 1 per G-tube daily @ 9 AM" for 02-14-2021; "Lantus 24 units sub Q at 9:00 PM, Rotate SQ site" for 02-13-2021; Diabetasource 25 ML per #20 FR tube continuous at 11:00pm on 02-13-2021, 3:00pm and 11:00pm on 02-15-2021.

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The facility was transitioning from paper MARs to electronic MARs in the month of February. Further review of Resident #1's February MAR, upon her return to the facility, revealed multiple days with "N" recorded in the boxes".

During an interview with Medical Records (MR) on 03-26-2021 at 11:30 AM, revealed, the "N" meant "Not Administered" and if a nurse put "N" in the box, she was to put an explanation why it was not done or given in the "detail notes". If there was no documentation in the "detail notes" there was no other place to document, why it was not given. It was noted that all the days with "N" recorded, the nurse's initials were all the same. When asked by the SA, why the same initials were on all three shift and different days, Medical Records stated, "when we went to electronic MAR's when a medication was not given, it will flash red on the screen because it is overdue. The Director of Nurses (DON) got tired of seeing the screen flash red, so she went into the MAR and filled in all the holes with an "N" so it would clear her screen up."

Review of Resident #1's February 2021 MAR from 02-24-2021 through 02-28-2021 revealed an order for "Lantus 24 units SUB Q at 9:00 PM, Rotate SQ site" with "N"s for 02-26-2021, 02-27-2021, and 02-28-2021. Review of the detail notes revealed no documentation as to the reason why the Lantus was not given. An order to "Flush G-tube with 200 cc H2O every 4 hours (dated 02-23-21 and discontinued on 02-27-2021)" had "N"s documented on 02-26-2021 at 5:00 PM and 9:00 PM, and 02-27-2021 at 5:00 AM; review of the detail notes revealed no documentation as to the reason why

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the flushes were not administered. A new order to "Flush G-tube with 200 ML H2O every six hours had "N"s at 6:00 PM on 02-27-2021 and 6:00 PM on 02-28-2021. Review of the detail notes revealed no documentation as to the reason why the flushes had not been administered; An order for "Diabetasource 55 cc/hr. continuous via #20 FR until Novasource Renal is available" with an "N" at 2:00pm on 02-27-2021; an order to "flush G-tube with 50 cc H2O ACPC (before and after meds) meds" with "N"s at 3:00 PM on 02-26-21, 02-27-2021 and 02-28-2021; review of the detail notes revealed no documentation as to why the flushes were not administered; An order to "flush G-tube with 5 ML H2O between each medication" had "N"s for 3:00 PM on 02-26-2021, 02-27-2021, and 02-28-2021; review of the detail notes revealed no documentation as to the reason why the flushes were not administered."

Review of Resident #1's MAR for March 2021 revealed an order for "Lantus 24 units SUB Q at 9:00 PM, with an "N" marked on 03-01-2021. There was no documentation in the detailed notes of the reason it was not administered; an order for "Diabetasource 50 cc/hr. continuous via #20 FR until Novasource Renal is available" with "N"'s at 6:00 AM and 10:00 PM on 03-01-2021 and 6:00 AM and 2:00 PM on 03-02-2021; an order to "Flush G-tube with 200 ML H2O every six hours" with "N"s on 03-01-2021 at 12:00 AM and at 6:00 PM. Review of the detailed notes for these days revealed there was no reason documented for why the enteral feeding and flushes were not administered.

Review of Resident #1's "Admission History and Physical" dated 03-03-2021, revealed Resident #1 was admitted to the hospital on 03-03-2021 for

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Urosepsis, Hyperglycemia, and an Acute Kidney Injury requiring a bolus of 3 liters of fluid in the Emergency Room.

Further review of Resident #1's "Admission History and Physical" dated 03-03-2021, revealed she had been brought to the Emergency Room (ER)with "reports of fever and tachycardia", and her labs revealed "lactic acidosis, leukocytosis, hyperglycemia, and an acute kidney injury." Further review revealed her Sodium Level was 146 (high), and her glucose was 524 (high). Under an "Assessments" section she had the follow diagnoses, "Sepsis, Urinary Tract Infectious Disease, Lactic Acidosis, Hyperglycemia and Hypernatremia." Under the "Plan:" section it stated, "74-year-old African American female admitted with Urosepsis and Acute Kidney Injury...Patient now status post 3 liters of normal saline in the ER. Will continue IV (intravenous) hydration...Hypernatremia: Serum Sodium 146 on admission. Will adjust fluids as needed...Hyperglycemia: Known history of Diabetes Mellitus. Glucose 524 on arrival to the ER. Patient now s/p (status post) 3L (liters) NS (normal saline). Ordering Accuchecks Q 4 (every 4) hours and Humalog per sliding scale. Holding Lantus until tube feeds are resumed..."

On 03-25-2021 at 3:15 PM, in an interview with the Director of Nursing (DON), when asked if the facility could show Resident #1 had received her enteral feeding, water flushes and diabetic medications from 02-24-2021 through 03-02-2021, to help prevent her hospitalization on 03-03-2021, she stated, "not if it is not written in the nurses notes or on the MAR. The nurses should be putting that information into the computer. I am not sure what the "N" means.

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This computer system is new, and I don't know anything at all about it yet..."

Review of Resident #1's Nurses notes dated 03-17-2021 at 10:53 PM revealed, "7:20 PM - Summoned to resident's room per C.N.A. (Certified Nurse Aide), resident noted lying in bed, increased resp (respirations) sweating. Blood sugar called for primary nurse. Checked registered HI on the blood glucose meter. She did not respond to verbal or tactile stimuli..."

Review of Resident #1's Nurses Notes dated 03-17-2021 at 11:04 PM revealed, "Summoned to resident room after supervisor noted that resident was not responding. Resident was still breathing but not responding, cold sweats noted coming from resident blood sugar check and were unreadable, 911 called immediately. Around 7:30 PM ambulance arrived and headed to ER with resident, received a called from ER, nurse stated that resident had coded and passed away. Family members notified."

Neither nurses note regarding the event made mention of notifying the Physician of Resident #1's condition, departure for the emergency room, or later demise.

Review of Resident #1's "Physician Documentation" from the Emergency Department revealed, "Arrival date: 03-17-2021 at 9:04 PM... Location: Morgue, Pronouncing Physician: (Formal Name), Time of Death: 9:06 PM, Diagnosis - Cardiac Arrest, Acute Respiratory Failure...74-year-old female who presents to the emergency room in respiratory distress with palpable pulses initially. Pulses loss CPR initiated. Patient intubated. CPR performed for 14

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minutes with multiple rounds of epinephrine and 1 of bicarb given. 1 Liter bolus began. Patient pronounced at 9:06 PM. Patient without any palpable pulses or visible chest rise. Patient without an auditory breath sounds or cardiac sounds. Patient pupils fixed and dilated. No corneal reflex of patient are responsive to verbal or painful stimuli. Family notified."

On 03-26-2021 at 11:45 AM, during an interview with Resident #1's physician, the Medical Director of the facility, she indicated, she was not fully aware of the entire incident with (formal name) (Resident #1), with all the details. When Resident #1's current diabetic orders and enteral feeding orders were reviewed with the physician, she stated, the orders were not correct. She would not give blood sugar check orders like they were written. She indicated the order should have read to "check blood glucose every morning at 9:00 AM, and to send them to the doctor every two weeks for review. If blood sugar is <60 or >400, notified the Physician." She indicated the blood sugar check order written as it was, did not make any sense with regard to glucose control. She indicated she was not aware the Residents blood sugar had read "HI" prior to being sent out and stated that Resident #1's blood sugars had not been being sent to her office for review. She stated she had Resident #1's chart in front of her as she spoke on the phone, and there were no reports of staff calling blood glucose results to her office for review. She indicated she had a Nurse Practitioner (NP) that worked with her, and both had been doing virtual visits with the residents due to COVID-19, so they were relying on the staff to tell them what was going on with the residents in order to know what orders to write. She stated the staff had not made her aware the

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Resident was missing enteral feedings, water flushes and her diabetic meds from time to time, and definitely not for several days in a row prior to her last hospitalization. She stated, had she been made aware of the resident's elevated blood sugar, she would have written orders accordingly. When the SA informed her of the daughter's concerns, and the items mentioned to her by the Emergency Room Physician, she agreed with the resident having a controlled food and fluid source and should have been better regulated with her glucose levels. She agreed that giving the concentrated enteral feeding without the proper water or not giving Resident #1 her insulin and oral medications could affect her blood sugar levels and cause them to run high.

Resident #2

Review of Resident #2's Face Sheet revealed she was admitted to the facility on 01-28-2010 with diagnoses of Dysphagia following a Cerebrovascular Disease, Type 2 Diabetes Mellitus, Glaucoma, Hyperlipidemia, Adult Failure to Thrive, Vascular Dementia, Long term (current) use of Insulin, Depression, Anxiety, Hypertension, and Gastrostomy Tube.

Review of Resident #2's "Physician Orders" dated for March 2021 revealed orders for "BGFS (Blood Glucose Finger Stick) every other day at 6 AM and 4 PM; notify MD (Medical Doctor) if BS (blood sugar) <60 or >500, Report blood sugar to MD every 2 weeks; Levemir Flex pen 28 units SUB Q twice a day with Novofine needle. Rotate site; Januvia 100 mg tablet by mouth daily; and Metformin HCL (Hydrochloride) 500 mg tablet by

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mouth twice a day.

Review of Resident #2's MAR for February 2021 revealed, missing blood glucose readings for 4:00 PM on 02-15-2021, and 6:00 AM and 4:00 PM blood glucose readings on 02-21-2021, 02-23-2021, 02-25-2021, and 02-27-2021; Levemir Flex pen 28 units SUB Q twice a day with Novofine needle. Rotate SQ site, with missing initials of completion at 9:00 PM on 02-15-2021, 9:00 AM on 02-17-2021, and 9:00 AM and 9:00 PM for 02-24-2021, 02-25-2021, 02-26-2021, 02-27-2021, and 02-28-2021; Report blood sugar to MD every 2 weeks, with missing initials of completion on 02-12-2021 and 02-26-2021.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-24-2021 revealed, Resident #2 had 3 Levemir 100 units/ML Flex Pen ordered. Each Flex Pen holds 3 ML of insulin, to equal 300 ML of insulin per pen.

Review of Resident #2's Physicians Orders revealed, an order for "Levemir Flex pen 28 units Sub Q twice a day with Novofine Needle. Rotate SQ site." The order was dated 09-15-2019 to 03-25-2021. She experienced multiple hospitalizations over the last six months and was not in the building from 01-29-2021 through 02-09-2021, from 02-18-2021 through 02-20-2021, and 03-02-2021 through 03-09-2021. The sum total of days she was not in the facility in the last 6 months equals 20 days. There have been 205 days in the last 6 months, minus the 20 days Resident #2 was out of the building equals 185 days. 185 days multiplied by the 56 units of Levemir needed a day for Resident #2 to receive

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her ordered amount equaled 10,360 units. With each Levemir Flex Pen holding 300 Units each, Resident #2 should have had 35 Flex Pens ordered from the pharmacy, and only had 3 ordered.

During a joint interview with the Administrator and DON on 03-26-2021, at 1:30 PM, the calculations were shared by the SA, and that the facility was 32 Flex Pens short of insulin for Resident #2. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, it means she didn't get all of her insulin like she should have."

Review of Resident #2's MAR for March 2021 revealed, "Report Blood sugar to MD every two weeks" with missing initials for 03-09-2021 or 03-23-2021; Levemir 28 units SubQ at bedtime, rotate SUBQ sites, with missing initials for 03-01-2021 at 9:00 AM; Januvia 100 mg tablet by mouth daily with missing initials for 03-01-2021 at 9:00 AM; Metformin HCL 500 mg tablet by mouth twice a day, with missing initials for 9:00 AM and 5:00 PM on 03-01-2021.

Resident #2 was hospitalized from 03-02-2021 through 03-09-2021 for the placement of a Gastric Tube to help supplement her intakes.

Review of Resident #2's March MAR after her return on 03-09-2021 revealed orders to report blood sugars to MD every 2 weeks on the 9th and 23rd of every month. Both dates were missing initials of completion for the month of March 2021. She did not return from the hospital with any insulin orders.

Resident #2 was sent to the Emergency Room

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(ER) on 03-23-2021 for a blood glucose that read "HI" on the glucometer.

Review of Resident #2's Nurses notes dated 03-23-2021, at 6:56 AM, revealed, "Resident remains on observation for COVID precautions, no s/s (sign or symptoms) of COVID noted at this time. Informed MD of Blood sugar reading of HI. Received new orders to start Levemir 10 units @ HS (hour of sleep). Novolog with sliding scale and send her to the ER now for elevated blood sugar. Attempted to inform RR (Resident Representative) of new orders and unable to reach him at this time. (formal name of ambulance) called for transfer..."

Review of nurses notes dated 03-23-2021, at 8:58 AM revealed, "7:25 AM resident exited fac (facility) per (ambulance formal name) accompanied per 2 female EMT's (Emergency Medical Team). No acute distress noted at this time."

Review of nurse's notes dated 03-23-2021, at 12:30 PM revealed, "RR returned call to fac, informed him of order to send to ER for eval secondary to elevated BS (blood sugar)."

Review of Resident #2's "Physician Documentation" from the Emergency Room dated 03-23-2021 revealed, "Arrival Date 03-23-2021, Time: 07:44 AM, Hospitalization Status: Inpatient Admission, Current Condition: Serious, Diagnosis: Anemia, Bladder Infection, Severe Sepsis without septic shock, Pneumonia Bacterial, Acute Renal/Kidney Failure. There was a high probability of clinically significant/life threatening deterioration in the patient's condition which required my urgent intervention. This

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84-year-old black female presents to ER via EMS ground with complaints of High Blood Sugar. Associated symptoms of diaphoresis. Patient was found hypoglycemic today, and she was also tachycardic on arrival of EMS. Fluid started by EMS and patient transported here. Correct hyperglycemia initially with fluids and consider insulin when potassium is known... There are signs of severe sepsis in the setting of acute renal failure... At 07:51 AM Blood Glucose: 466 mg/dl, critical glucose levels for an adult: <60 (below 60) or >300 mg/dl (above 300)."

On 03-26-2021, at 11:45 AM, during an interview with Resident #2's physician, the Medical Director of the facility, she indicated, she was made aware of the blood sugar reading of "HI" and remembers giving new orders for her insulin and sending her to the Emergency Room to be evaluated. She stated she had Resident #2's chart in front of her as she spoke on the phone, and there were no prior reports of staff calling blood glucose results to her office for review. She indicated she had a Nurse Practitioner (NP) that worked with her, and both had been doing virtual visits with the residents due to COVID-19, so they were relying on the staff to tell them what was going on with the residents in order to know what orders to write. She stated the staff had not made her aware the resident was missing enteral feedings and water flushes from time to time. She stated giving the concentrated enteral feeding without the proper water or not giving Resident #2 her insulin and oral medications could affect her blood sugar levels and cause them to run high.

Resident #2 remained in the hospital throughout the remainder of the survey.

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Resident #4

Review of Resident #4's Face Sheet revealed she was admitted to the facility on 02-14-2018 with diagnoses of Heart Failure, Hypertension, Peripheral Vascular Disease, Cerebral Infarct, Type 2 Diabetes Mellitus, Hyperlipidemia, Depression, and Chronic Kidney Disease.

Review of Resident #4's Physicians Orders for March 2021 revealed the following orders: Blood sugar checks ACHS (before meals and at hour of sleep); notify MD if BS <60 and >500; Levemir 45 units subQ every morning at 9:00 AM. Rotate SQ site, and Tradjenta 5 MG tablet, give 1 tab (tablet) by mouth once daily.

Review of Resident #4's MAR for March 2021 revealed "N"s (Not Administered) for Tradjenta 5 MG at 9:00 AM on 03-20-2021, 03-21-21, and 03-24-2021 and Levemir 45 units Sub Q at 9:00 AM for 03-20-2021, 03-21-2021, 03-22-2021, 03-23-2021, and 03-24-2021. Review of the detailed notes for these days revealed no documentation as to why the medications were not given.

Review of Resident #4's list of Minimum Data Set (MDS) completion dates revealed no transfers/discharges from the facility for any reason since 03-13-2019.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-24-2021 revealed, Resident #4 had 6 bottles of Levemir 100 units/ml ordered. Each bottle of Levemir has 10 ML in it to total 1,000 units per bottle.

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Resident #4 has an order dated 12-08-2020 through present for Levemir 45 units every morning at 9:00 AM. From September 1st, 2020 through March 4th, 2021, there have been 205 days. 205 days multiplied by 45 units a day equals 9,225 units required to meet her insulin needs over the last 6 months. At 1,000 units per bottle, it would have required 10 bottles of Levemir to be ordered, and only 6 bottles had been ordered and sent.

During a joint interview with the Administrator and DON on 03-26-2021, at 1:30 PM, the calculations were shared by the SA, and that the facility was 4 bottles short of insulin for Resident #4. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, or took a bottle from house stock and didn't assign it to her, it means she didn't get all of her insulin like she should have."

Resident #5

Review of Resident #5's Face Sheet revealed she was admitted to the facility on 03-28-2016 with diagnoses of Alzheimer's, Parkinson's, Anxiety, Type 2 Diabetes Mellitus, Depression, Personality Disorder, Long Term use of Insulin, and Heart Failure.

Review of Resident #5's Physician Orders March 2021 revealed orders for the following: Blood Sugars before meals and at bedtime. Notify MD if BS blood sugar) <60 or >400; and Levemir 55 units SubQ at bedtime, rotate SQ site.

Review of Resident #5's March 2021 MAR

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revealed an "N" (not administered) on 03-03-2021 for both 4:00 PM and 8:00 PM for Blood Sugar checks before meals and at bedtime. Another order was noted for Levemir 55 units at bedtime, with an "N" marked for 03-03-2021 at 8:00 PM.

Review of Resident #5's list of Minimum Data Set (MDS) completion dates from 09-01-2020 through 03-25-2021, revealed a one-day discharge from the facility from 01-21-2021 through 01-22-2021.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-24-2021 revealed, Resident #5 had 7 bottles of Levemir 100 units/ml ordered. Each bottle of Levemir has 10 ML in it to total 1,000 units per bottle.

Resident #5 had an order dated 07-16-2020, through present, for Levemir 55 units daily at bedtime. From September 1st, 2020 through March 24th, 2021, she has been in the facility 204 days. 204 days multiplied by 55 units a day equals 11,220 units required to meet her insulin needs over the past 6 months. At 1,000 units per bottle, it would have required 12 bottles of Levemir to be ordered, and only 7 bottles had been ordered and sent.

During a joint interview with the Administrator and DON on 03-26-2021 at 1:30 PM, the calculations were shared by the SA, and that the facility was 5 bottles short of insulin for Resident #5. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, or took a bottle from house stock and didn't assign it to her, it means she didn't get all of her insulin like she should have."

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Resident #6

Review of Resident #6's Face Sheet revealed, she was admitted to the facility on 06-22-2005, with diagnoses of Dementia, Cerebral Aneurysm, Epilepsy, Anxiety, Depression, Type 2 Diabetes Mellitus, Heart Failure, Hypertension, and Long-Term use of Insulin.

Review of Resident #6's Physicians Orders March 2021 revealed orders for the following: BGFS before meals and at bedtime with the following Novolog 70/30 mix 25 units with supper rotate SQ site; and Novolog 70/30 50 units Sub Q with breakfast, rotate SQ site.

Review of Resident #6's March 2021 MAR revealed no missed doses of insulin.

Review of Resident #6's Minimum Data Set (MDS) completion dates revealed he had been discharged from the facility from 02-13-2021 through 03-03-2021, for a total of 20 days.

During a review of an "Insulin Report" provided by the facility's pharmacy for 09-01-2020 through 03-25-2021 revealed, Resident #6 had 8 bottles of Novolog 70/30 Mix 100 units/ml ordered. Each bottle of Novolog has 10 ML in it to total 1,000 units per bottle.

Resident #6 had an order dated 07-16-2020, through present, for Levemir 55 units daily at bedtime. From September 1st, 2020 through March 24th, 2021, he had been in the facility 187 days. His insulin needs changed to reflect: From

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09-01-2020 through 11-12-2020 he required 40 units of Novolog 70/30 at Breakfast, and 20 units of Novolog 70/30 at supper to equal 60 units a day. 60 units a day multiplied by 73 days equals 4,380 units of insulin. From 11-12-2020 through 02-13-2021, when he was discharged to the hospital, he required 45 units of Novolog 70/30 at breakfast, and 25 units of Novolog 70/30 at supper time to equal 70 units a day. 70 units a day multiplied by 64 days equals 4,480 units of insulin. From 03-03-2021 through 03-12-2021 he required 45 units of Novolog 70/30 at breakfast, and 25 units of Novolog 70/30 at supper to equal 70 units per day. 70 units per day multiplied by 9 days equals 630 units of insulin. From 03-12-2021 through 03-24-2021 he required 50 units of Novolog 70/30 for breakfast, and 25 units of Novolog 70/30 for supper to equal 900 units of insulin. So, from 09-01-2021 through 03-24-2021, Resident #6 required 10,390 units of insulin to meet his needs over the last 6 months. At 1,000 units per bottle, he would have required 11 bottles of Novolog 70/30 to be ordered, and only 8 bottles were ordered and sent.

During a joint interview with the Administrator and DON on 03-26-2021 at 1:30 PM, the calculations were shared by the SA, and that the facility was 3 bottles short of insulin for Resident #5. When asked what those findings meant, the DON stated, "unless they borrowed from another resident, or took a bottle from house stock and didn't assign it to him, since there were no holes in the MAR, they were signing they gave him the insulin and then didn't administer it."

On 3/31/21, at 10:15 AM, during an interview and observation with the Director of Nursing (DON) on the North Nursing station in the Medication Room

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revealed, no Stock Insulin in the medication refrigerator, the emergency drug kit, the emergency intravenous (IV) drug kit or anywhere else in the medication room. DON stated she could not find where there was any stock insulin in the medication room. SA and DON reviewed the list of medications stored in the Emergency Drug Kit (EDK) and no insulin was listed. DON and SA walked to South wing and looked through the medication storage room and no stock insulin was found in the refrigerator on in the room. The DON revealed that when the nurse removes a drug from the EDK they must fill out a form listing the drug, the resident's name and the date and time. The form is then faxed to the Pharmacy so they can have a record and replace the drug. The DON revealed she has the copy of all the forms in a binder in her office.

Record review of the fax transmission list, with the DON revealed no forms faxed to the Pharmacy for February and March revealed any Insulin taken from the EDK.

On 3/31/21 at 10:25 AM an interview and observation with LPN #3 and the medication nurse revealed there was no Insulin in the North medication room, the EDK box or in the IV EDK box. LPN #3 revealed no Insulin listed on the list of medications on the outside of the EDK box or inside of the EDK IV box.

On 3/31/21 at 10:35 AM during an interview with the Pharmacist at the Pharmacy that supplies stock medications in the EDK boxes and for the facility, he revealed they stopped suppling stock insulin years ago because it would not be used, would expire, and the insurance company would not pay for it and they would be stuck with a

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$300.00 vial they had to destroy. The Pharmacist revealed when they get a new order for a sliding scale insulin, they send an ordered insulin vial to the facility and then the facility lets them know when the Insulin needs to be replaced.

The facility provided an acceptable removal plan on 03-30-2021, for the IJ and review of the facility's removal plan revealed the facility took the following actions to remove the IJ:

Removal Plan

On March 25, 2021 at 2:45pm State Agency notified the Administrator that the facility was in an Immediate Jeopardy (IJ) and templates were provided to the Administrator.
The facility failed to appropriately document the amount of enteral feedings, and flushes for Resident #1 and Resident The facility failed to maintain Resident's blood glucose levels within an acceptable parameter for Resident #1 and Resident #2. The facility failed to provide appropriate goods and services to Residents necessary to avoid physical harm, pain, mental anguish, or emotional distress by not providing enteral feedings, water flushes and insulin per physician orders.

1. On March 17, 2021, at 7:20PM Resident #1 was found unresponsive. A blood glucose was checked on Resident #1 with a blood glucose testing device indicating a "HI" reading. Emergency services were notified at approximately 7:20PM and Resident #1 was transported by ambulance to local hospital #1. Resident #1 expired on March 17, 2021 at approximately 9:06PM in the emergency room at local hospital #1. On March 23, 2021 at 6:50 AM

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blood glucose was checked on Resident #2 with a blood glucose testing device indicating a "HI" reading. Physician #1 was notified on March 23, 2021 at approximately 6:56am and orders were received to transfer Resident #1 to local hospital #1. Resident #2 was transferred on March 23, 2021 at approximately 7:25am by ambulance to the Emergency Room of local hospital #1. Resident # 2 remains in the hospital at this time.

2. Director of Nurses (DON) and Registered Nurse (RN) #2 immediately initiated in-services with Registered Nurses and Licensed Nurses on March 25, 2021, at 3:10PM on Tube Feedings, Drug Administration & Documentation including electronic medication administration records and Incident Investigation & Reporting, related to abuse and neglect Director of Nurses (DON) and Registered Nurse (RN) #2 initiated in-services with Registered Nurses and Licensed Nurses on March 26, 2021 at 4:00PM on Hypoglycemia and Hyperglycemia. In-services will be on-going, and no nurses win be allowed to work until participation of the in-services for Tube Feedings, Drug Administration & Documentation including electronic medication administration records, and Incident Investigation & Reporting related to abuse and neglect, Hypoglycemia and Hyperglycemia. During the week of February 22, 2021 through February 26, 2021 initial training was provided to all nursing department staff concerning implementation of the new electronic charting system and the electronic Medication Administration Record by Registered Nurse (RN) #2. This training is an ongoing process for all new staff and existing staff as changes are made to the system.

3. The facility Quality Assurance Committee

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Meeting was held on Thursday, March 25, 2021, at 3:50PM, with the committee consisting of facility Director of Nurses, Nursing Home Administrator, Medical Director Infection Preventionist, Registered Nurses (RN) Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, and Licensed Practical Nurse (LPN) #1. Topics discussed included Enteral Feedings, Insulin Administration, and Neglect with the following policies reviewed Tube Feedings, Drug Administration & Documentation, and Incident Investigation & Reporting, related to abuse, and neglect. No policy changes were indicated however, facility made procedural changes on March 25, 2021 to medication administration monitoring to include electronic medication charting reviews. The Director of Nurses (DON), Registered Nurse (RN) #3 and Registered Nurse (RN) #4 with review electronically generated reports for omissions and discrepancies with enteral feedings and flushes, insulin administration, and blood glucose results.

4. On March 25, 2021 from 4:30PM to 9:00PM, Registered Nurses (RN) #3, Registered Nurse (RN) #4 and Licenses Practical Nurse (LPN) #1 physically assessed and observed all Residents receiving enteral feedings with no significant findings identified. They also, physically assessed and observed ad diabetic Residents with insulin with no significant findings identified. On March 25, 2021 and March 28, 2021, the Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records Clerk audited the electronic medical records, the enteral feeding orders, medication administration records, and intake

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records for any Resident on enteral feeding for omissions and discrepancies from February 5, 2021 to present. Omissions of enteral feedings and flushes were noted on the audit for four of eight Residents. The physician was notified of all four of eight Residents with omissions March 29, 2021 with no new orders received. The Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records also audited the physician orders, electronic records, and medication administration of all insulin dependent diabetics for omissions and discrepancies from February S, 2021 to present. Omissions were noted for fourteen of twenty-six Residents blood glucose results and two of seventeen insulin administrations. The physician was notified of all fourteen Residents with omissions March 29, 2021 with no new orders received. One of seventeen Residents audited was noted with a discrepancy in blood glucose results documentation. The physician was notified of the Resident discrepancy on March 29, 2021 with no new orders received. On March 25, 2021, Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 and Registered Nurse (RN) #1 checked insulin supplies for all insulin dependent diabetics to ensure they had the proper amount in the facility per physician's orders. Licensed Practical Nurse (LPN) #1 contacted three local pharmacies to ensure that the facility will have an adequate backup supply.

5. Licensed Practical Nurse (LPN) #3 was disciplined for improper documentation on March 25, 2021. LPN # 4, LPN #5, LPN #6, LPN #10, RN # 5, RN #6, and RN # 7 received an employee written warning discipline on March 29,

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2021* The Mississippi State Board of Nursing was called regarding LPN #3 at 5:42PM unable to leave a message. Return call made on March 26, 2021 at 9:12Am. The Mississippi State Board of Nursing was called regarding Licensed Nurses #4 -10 and Registered Nurses #5-7 on March 29, 2021. The following agencies were notified on March 25, 2021. Mississippi State Department of Health Abuse Hotline was called at 5:39PM. Mississippi State Board of Nursing Home Administrators was called at 5:43PM. The Office of the Attorney General was called at 6:05PM. The local Police Department was contacted on March 26, 2021 at 9:19 am.

The facility alleges removal of the immediacy as of March 30, 2021, at 8:00am.

The SA validated all corrective actions had been completed as of March 30, 2021, and the IJ was removed as of 03-31-2021.

1. On March 17, 2021, at 7:20PM Resident #1 was found unresponsive. A blood glucose was checked on Resident #1 with a blood glucose testing device indicating a "HI" reading. Emergency services were notified at approximately 7:20PM and Resident #1 was transported by ambulance to local hospital #1. Resident #1 expired on March 17, 2021 at approximately 9:06PM in the emergency room at local hospital #1. On March 23, 2021 at 6:50 AM blood glucose was checked on Resident #2 with a blood glucose testing device indicating a "HI" reading. Physician #1 was notified on March 23, 2021 at approximately 6:56am and orders were received to transfer Resident #1 to local hospital #1. Resident #2 was transferred on March 23, 2021 at approximately 7:25am by ambulance to

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the Emergency Room of local hospital #1. Resident # 2 remains in the hospital at this time.
-Validated through observation, record review and interview that Resident #2 remains in the hospital and that Physician #1 was notified.

2. Director of Nurses (DON) and Registered Nurse (RN) #2 immediately initiated in-services with Registered Nurses and Licensed Nurses on March 25, 2021, at 3:10PM on Tube Feedings, Drug Administration & Documentation including electronic medication administration records and Incident Investigation & Reporting, related to abuse and neglect. Director of Nurses (DON) and Registered Nurse (RN) #2 initiated in-services with Registered Nurses and Licensed Nurses on March 26, 2021 at 4:00PM on Hypoglycemia and Hyperglycemia. In-services will be on-going, and no nurses will be allowed to work until participation of the in-services for Tube Feedings, Drug Administration & Documentation including electronic medication administration records, and Incident Investigation & Reporting related to abuse and neglect, Hypoglycemia and Hyperglycemia. During the week of February 22, 2021 through February 26, 2021 initial training was provided to all nursing department staff concerning implementation of the new electronic charting system and the electronic Medication Administration Record by Registered Nurse (RN) #2. This training is an ongoing process for all new staff and existing staff as changes are made to the system.
-Validated through record review and interviews that in-services regarding Tube Feedings, Drug Administration, Documentation in the Electronic Medical Record and Incident reporting and investigation related to abuse and neglect, Hypoglycemia and Hyperglycemia. Interviews

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were held with the DON, Administrator, LPN #5, LPN #6, RN #1, RN #2, the QA nurse, and LPN #7. All verified that they have been in-serviced.

3. The facility Quality Assurance Committee Meeting was held on Thursday, March 25, 2021, at 3:50PM, with the committee consisting of facility Director of Nurses, Nursing Home Administrator, Medical Director, Infection Preventionist, Registered Nurses (RN) #1, Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, and Licensed Practical Nurse (LPN) #1. Topics discussed included Enteral Feedings, Insulin Administration, and Neglect with the following policies reviewed Tube Feedings, Drug Administration & Documentation, and Incident Investigation & Reporting, related to abuse, and neglect. No policy changes were indicated however, facility made procedural changes on March 25, 2021 to medication administration monitoring to include electronic medication charting reviews. The Director of Nurses (DON), Registered Nurse (RN) #3 and Registered Nurse (RN) #4 will review electronically generated reports for omissions and discrepancies with enteral feedings and flushes, insulin administration, and blood glucose results.
-Validated through record review and interview with the QA Nurse, DON, and the Medical Director, that the QA meeting was held on 03/25/21 and verified through a sign in sheet that the facility met the requirements of the QA meeting and that the issues regarding Enteral Feedings, Insulin Administration, Neglect, Drug Administration and Documentation along with incident investigation and reporting as it relates to abuse, and neglect were all issues that were discussed and reviewed.

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4. On March 25, 2021 from 4:30PM to 9:00PM, Registered Nurses (RN) #3, Registered Nurse (RN) #4 and Licenses Practical Nurse (LPN) #1 physically assessed and observed all Residents receiving enteral feedings with no significant findings identified. They also, physically assessed and observed all diabetic Residents with insulin with no significant findings identified. On March 25, 2021 and March 28, 2021, the Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records Clerk audited the electronic medical records, the enteral feeding orders, medication administration records, and intake records for any Resident on enteral feeding for omissions and discrepancies from February 5, 2021 to present. Omissions of enteral feedings and flushes were noted on the audit for four of eight Residents. The physician was notified of all four of eight Residents with omissions March 29, 2021 with no new orders received. The Director of Nurses (DON), Registered Nurse (RN) #2, Registered Nurse (RN) #3, Registered Nurse (RN) #4, Licensed Practical Nurse (LPN) #1 and Medical Records also audited the physician orders, electronic records, and medication administration of all insulin dependent diabetics for omissions and discrepancies from February 5, 2021 to present. Omissions were noted for fourteen of twenty-six Residents blood glucose results and two of seventeen insulin administrations. The physician was notified of all fourteen Residents with omissions March 29, 2021 with no new orders received. One of seventeen Residents audited was noted with a discrepancy in blood glucose results documentation. The physician was notified of the

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Resident discrepancy on March 29, 2021 with no new orders received. On March 25, 2021, Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2 and Registered Nurse (RN) #1 checked insulin supplies for all insulin dependent diabetics to ensure they had the proper amount in the facility per physician's orders. Licensed Practical Nurse (LPN) #1 contacted three local pharmacies to ensure that the facility will have an adequate backup supply.
-Validated through record review, observation, and interviews that the audits were completed for residents receiving accuchecks and insulin, eternal feedings and eternal flushes and verified through interview with the DON that she is responsible for checking the MAR/TAR daily for documentation going forward. Interview with the MD stated that he was notified regarding any discrepancies and omissions in the medical record.

5. Licensed Practical Nurse (LPN) #3 was disciplined for improper documentation on March 25, 2021. LPN # 4, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, LPN #10, RN # 5, RN #6, and RN # 7 received an employee written warning discipline on March 29, 2021. The Mississippi State Board of Nursing was called regarding LPN #3 at 5:42PM unable to leave a message. Return call made on March 26, 2021 at 9:12Am. The Mississippi State Board of Nursing was called regarding Licensed Nurses #4-10 and Registered Nurses #5-7 on March 29, 2021. The following agencies were notified on March 25, 2021. Mississippi State Department of Health Abuse Hotline was called at 5:39PM. Mississippi State Board of Nursing Home Administrators was called at 5:43PM. The Office of the Attorney General was called at 6:05PM. The local Police

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F 760	Continued From page 97 Department was called on March 26, 2021 at 9:19am. -Validated through record review and interview with the DON, RN#7, LPN #4 that the employees LPN 4-10 and RN 5-7 had received written warnings for disciplines and were reported to the Board of Nursing for failure to document in the medical record. Record review validated that the MSDH hotline, The AG office, and the local police dept were all notified. The facility alleges removal of the immediacy as of March 30, 2021 8:00am. The SA validated all actions were completed to remove the IJ on March 31, 2021.	F 760		