MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71IH	A. BUILDING: _____ B. WING _____	C 06/01/2023

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TISHOMINGO COMM LIVING CENTER	1410 WEST QUITMAN STREET IUKA, MS 38852

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M 460	45.16.3 Criminal History Record Checks Criminal History Record Checks. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be preformed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on: 1. Every new employee of a covered entity who provides direct patient care or services and who is employed on or after July 01, 2003, and 2. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer. 3. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted. 4. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be	M 460		6/22/23

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M 460	Continued From page 1 eligible to be employed at the licensed facility: a. possession or sale of drugs b. murder c. manslaughter d. armed robbery e. rape f. sexual battery g. sex offense listed in Section 45-33-23(g), Mississippi Code of 1972 h. child abuse i. arson j. grand larceny k. burglary l. gratification of lust m. aggravated assault n. felonious abuse and/or battery of vulnerable adult 5. Documentation of verification of the employee ' s disciplinary status, if any, with the employee ' s professional licensing agency as applicable, and evidence of submission of the employee ' s fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee ' s disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual ' s suitability for such employment. 6. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency shall require every employee of a covered entity employed prior to July 01, 2003, to sign an affidavit stating	M 460		

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that he or she does not have a criminal history as outlined in paragraph (3) above.

7. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed an affidavit as required by this section. The covered entity shall place the affidavit in the employee ' s personnel file as proof of compliance with this section.

8. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or pleas has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility ' s policies and procedures.

9. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (7) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity ' s hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at

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M 460	Continued From page 3 which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility. 10. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00). 11. Should results of an employee applicant ' s criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant ' s suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi State Department of Health without the necessity of an additional criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant ' s criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history check as required in this subsection. 12. For individuals contacted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check.	M 460		

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M 460	Continued From page 4 13. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officer, employees, attorneys, and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section. The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an allegation of discrimination is made regarding an employment decision authorized under this section. This Statute is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to perform a criminal background check for one (1) of five (5) employees reviewed. Findings include: A record review of the facility policy, "21-Criminal Background History Check (Mississippi Only)", with a revision date of November 13, 2017, revealed "Policy A. It is the policy of the facility to adhere to the regulations promulgated by the Mississippi State Department of Health. The facility shall require a criminal history record check on every new employee." Record review of Housekeeper #1's personnel file revealed that the facility did not perform a background check. Review of "Employee Timecards" revealed that Housekeeper #1 worked her first shift at the	M 460	1. Housekeeper #1□s last day of employment was 5/4/23. On 5/18/23, Administrator in-serviced Business Office Manager on facility policy on criminal history record checks being performed on all new employees. 2. All residents have the potential to be affected by the alleged deficient practice. On 6/12/23 audits of employee files were initiated by Administrator and Business Office Manager with issues being corrected as found with date of certain 6/22/23. 3. On 6/12/23, all employee records were audited by the Administrator and Business Office Manager (BOM) to ensure the facility conducted and received a criminal history record for all current employees. On 6/13/23, the Regional Director of Operations in-serviced the Administrator,	

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M 460	Continued From page 5 facility on 2/22/23 and has worked 36 days between 2/22/23 and 5/4/23. During an interview on 5/18/23 at 11:15 AM, the Business Office Manager stated that Housekeeper #1 was hired on 2/12/23 and her fingerprints were obtained on 2/13/23, but the background check came back rejected due to the fingerprints being smudged. She stated that she had made herself a note to go back and redo them, but due to human error she did not do it. During an interview on 5/18/23 at 11:22 AM, the Business Office Manager stated that it was important to do background checks to make sure no criminals are working for them and for the safety of the residents. During an interview on 5/18/23 at 11:24 AM, the Administrator verified that it was important to do background checks to make sure no criminals are working for them, for the safety of the residents and that they had failed to resubmit the fingerprints for Housekeeper #1.	M 460	Business Office Manager, Dietary Manager, Housekeeping Manager, Director of Nurses, Maintenance Director, and Assistant Director of Nursing on the following the company policy regarding criminal history record checks being performed on all new employees. On 6/12/23, The administrator will review all new hires weekly X 4 weeks and monthly x 2 months thereafter to ensure compliance with completing background checks on all new employees. 4. The administrator will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 6/22/23 and as needed for review/revision.	
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record	M 735		6/22/23

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M 735	Continued From page 6 service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years.	M 735		

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M 735	Continued From page 7 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure resident's medical records were accurately and completely documented on a newly admitted resident. Resident #1's admitting physician's orders were not transcribed correctly or implemented for one (1) of six (6) resident medication records reviewed. Resident #1 During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/15/23, when the facility failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order and develop a comprehensive care plan regarding the care needed for the diagnosis of diabetes for Resident #1. Resident #1's physician ordered long-acting insulin was not administered for five days following admission on 5/15/23 at approximately 4:49 PM and the resident had to be transferred to the Emergency Room on 5/20/23 at 5:10 AM.The resident had a blood sugar of 764 mg/dl (milligrams/deciliter) at 5:38 AM and resulted in death of the resident at 6:35 AM with a diagnosis of diabetic ketoacidosis (DKA). The facility's failure to accurately transcribe physicians orders, reconcile and verify physicians orders to prevent Diabetic Ketoacidosis as a result of the omission of an insulin order resulted in the death of Resident #1 and placed other residents with significant medication orders at risk of developing a situation that was likely to cause serious injury, harm, impairment, or death.	M 735	1. On 5/20/23 through 5/30/23, all resident physicians assessed all resident orders and revised with no negative outcomes. On 5/20/23, licensed nurses were in-serviced on medication management, medication reconciliation, observing and reporting to the doctor. 2. This alleged deficient practice has the potential to affect all residents. 3. On 5/20/23, DON In-serviced licensed nurses on ensuring physician orders are accurately transcribed, reconciled and verified for new and returning residents in order to meet professional standards of quality. On 5/20/23, DON in-serviced licensed nurses on medication administration of insulin injections, admission policy, diabetic resident review, fingerstick glucose procedure, and observing and reporting to the physician. On 5/22/23, the Regional Nurse Consultant (RNC), in-serviced DON and on 5/23/23 ADON on ensuring physician orders are accurately transcribed, reconciled and verified for new and returning residents in order to meet professional standards of quality. On 5/22/23, the RNC in-serviced the DON/IP on diabetic orders, MD notification, incident care plans, and new employee orientation. On 5/22/23, the RNC in-serviced Medical Records on care plans and diabetic orders. Director of Nursing (DON), Assistant Director of Nursing	

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M 735	Continued From page 8 The SA notified the facility's Administrator of the IJ and SQC on 5/31/23 at 5:00 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23. Findings include: Review of the facility policy titled, "Medication on Admission, Reconciliation of" with a revision date of 8/25/14 revealed "Purpose ...The purpose of this procedure is to ensure medication safety by accurately accounting for the resident ' s medications, routes and dosages upon admission or readmission to the facility... "General Guidelines ...#2. Medication reconciliation reduces medication errors and enhance resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process...". Review of the facility policy titled "Medical Record Audits" with a revision date of 6/20/12 revealed "Policy Statement ...It is the policy of this facility to conduct on going audits and monitoring for completion, timeliness and accuracy of the resident ' s medical record", This review revealed under "Procedure ...#1 Audits will be conducted on the resident ' s medical record according to the following schedule: a. Upon Admission/Readmission ...". An interview on 5/31/23 at 10:30 AM, with the Administrator revealed that Resident #1 was	M 735	(ADON), Medical Records (MR) and Minimum Data Set Nurse (MDS) as a team will perform an admission audit and review all orders the day after admission and any orders received within 24 hours of admitting to the facility starting 5/23/23 and on the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit starting 5/23/23. Any issues will be immediately corrected. 4. Starting on 05/23/23, the Medical Records, DON, ADON, or MDS nurse will audit new admissions daily x 4 weeks, weekly x 4 weeks, then monthly x 4 months. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit starting 5/23/23. Any issues will be immediately corrected. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 6 months starting 06/22/2023 and as needed for review/revision.	

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admitted on 5/15/23 with diagnoses that included diabetes, fell and hit her head on 5/20/23 and was sent to the Emergency Room (ER) where she passed away. She revealed that during the investigation of the incident the staff discovered that the residents order of Lantus had been omitted.

An interview on 5/31/23 at 11:45 AM, with the Director of Nurses (DON) confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes Mellitus. She confirmed that the resident's Lantus order had been omitted when the Assistant Director of Nurses (ADON) entered the orders, and that omission was found after the resident fell and went to the hospital on 5/20/23. She revealed that the orders should have been verified by someone, but that did not happen, and she is not sure why. She revealed that the facility has a policy and procedure in place to prevent this from happening, but this was a system breakdown.

An interview on 5/31/23 at 1:00 PM, with the ADON confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes. She confirmed that she entered the resident's orders into her facility medical record, but did not realize that the order for Lantus had been left off until the DON and the Administrator informed her on 5/20/23. She stated, "I do recall taking verbal report from the nurse at the hospital before the resident was admitted and she told me that the resident was a brittle diabetic that tends to drop quickly." She revealed that she or the DON enters the admission orders for the residents and then when we they are finished, they give it to Medical Records Department for Verification. She stated that she gave the record to someone to verify but does not recall who and stated she recalled that

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survey was going on that week, so we were busy getting information for them, but that is no excuse. She confirmed that she was suspended from work on 5/20/23 while they completed their investigation and returned to work on 5/25/23 and was also in-serviced about medication entry, medication errors, the admission process and care plans.

A telephone interview on 5/31/23 at 6:57 PM, with Registered Nurse (RN) #1 revealed she was the nurse on duty the night that Resident #1 had to go to the ER. She revealed she was not aware that the resident was supposed to be taking Lantus until the DON notified her during the investigation, because there was no order.

An interview on 6/1/23 at 11:02 AM, with the Medical Records Nurse revealed that she was given Resident #1's record to review her admission orders, but there was so much going on that week with Case Mix and Survey that it got pushed back on her end and that is how the system failed for her personally. She stated, "I realized she was on my list to review. Survey left on Thursday and I was going to look at her record on Monday 5/22/23." She revealed that orders need follow-up verification and that is what she is supposed to do to make sure there are no errors. She stated, "I knew that was my responsibility to verify orders. I didn't realize that not doing that would have resulted in in this." She revealed she did receive an in-service after the incident occurred regarding the admission process, verifying orders and care plans. She stated that the Administrator told her that even when we have other things going on that I have to put admissions first.

An interview on 6/1/23 at 11:15 AM, with the

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DON, confirmed the facility had policies in place to prevent this from happening, but the process broke down. She revealed she could not say why the process broke down except it was a high stress week with both survey and case mix present, although that is no excuse. She revealed that the process for entering admission orders was that the DON or ADON received the orders from social services who gets them from the doctor or hospital, enters them and then one of us or medical records verifies the orders.

An interview on 6/1/23 at 4:55 PM, with the Administrator revealed she felt like the week this happened with Resident #1 was the "perfect storm," with case mix and survey both going on, but that is no excuse. She revealed that medical records were helping with case mix due to MDS being off and it just fell through and stated that she and the team have learned a lot from this and hates that it happened.

Record review of Resident #1's admitting orders from the hospital revealed the following orders regarding her diagnosis of diabetes; Lantus 20 units subcutaneous daily, Humalog 300 units/3ml solution per sliding scale protocol-corrective low-dose regimens; fingerstick blood glucose of 141-180 -2 units sub-Q, 181-220-4 units sub-Q, 221-260-6 units sub-Q, 261-300-8 units sub-Q, 301-350-10 units sub-Q, 351-400 12 units sub-Q, greater than 400 mg/dl-14 units sub-Q. Documentation revealed that Lantus 20 units was last administered to Resident #1 on 5/15/23 at 8:57 AM prior to admission to the facility.

Record review of Resident #1 ' s facility physicians orders revealed there was no order for Lantus 20 units subcutaneous daily.

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Record review of the written statement given by the ADON revealed "(Resident #1's proper name) was admitted on Monday and in report I was told she was a brittle diabetic with a history of DKA and her blood sugars dropped at night. While putting in her orders I was notified of another admission coming while also trying to secure staffing. I remember I needed clarification for her Lantus but do not recall what pulled me away from finishing her admission." This statement was signed by the DON.

Review of the typed statement signed by the Medical Records Nurse read as follows: "I was unable to review admissions during the week beginning 5/15/23 due to assisting with State mix review and state survey. Afterwards, Information Technology (IT) was working on my computer due to problems with my email. Friday, I reviewed the admission for 5/12/23; assisted with advance directive clarifications, cleared/audited forms, and worked on filing and putting documents on charts.

Record review of Resident #1's documented blood sugars since admission revealed Resident #1's blood sugar had been checked 18 times and 14 of those were above 141 requiring insulin per physician's ordered sliding scale.The documented blood sugars were as follows:

5/15/23 @ 5:13 PM = 159

5/15/23 @ 8:47 PM = 141

5/16/23 @ 7:20 AM = 129

5/16/23 @ 11:50 AM =116

5/16/23 @ 4:21 PM = 128

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M 735	Continued From page 13 5/16/23 @ 9:04 PM = 270 5/17/23 @ 7:23 AM = 308 5/17/23 @ 12:06 PM = 329 5/17/23 @ 4:56 PM = 253 5/17/23 @ 8:13 PM = 217 5/18/23 @ 7:57 AM = 398 5/18/23 @ 1:25 PM = 284 5/18/23 @ 6:36 PM = 393 5/18/23 @ 9:46 PM = 377 5/19/23 @ 7:47 AM = 399 5/19/23 @ 12:50 PM = 188 5/19/23 @ 4:38 PM = 374 5/19/23 @ 9:37 PM = 388 Record review of Resident #1's ER visit on 5/20/23 revealed a bedside glucose of "High Critical-Very abnormal high" collected at 5:34 AM and a comprehensive Metabolic Panel glucose result of 764mg/dl collected at 5:38 AM. Record review of Resident #1's preliminary certificate of death received by the facility fax on 5/22/23 at 12:04 PM, revealed the cause of death to be cardiac arrest due to or as a consequence of ketoacidosis, due to or as a consequence of diabetes mellitus. Record review of Resident #1's Admission	M 735		

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Record revealed the resident was admitted to the facility on 5/15/23 with medical diagnoses that included Alzheimer's and Type 2 Diabetes.

Record review of Resident #1's Minimum Data Set with an Assessment Reference Date of 5/20/23 revealed in Section I, a diagnosis of Diabetes and in Section C a Brief Interview for Mental Status (BIMS) of 11 which indicated the resident was moderately cognitively impaired.

Review of the facilities Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan:

1. On May 20,2023, at 4:50 am, the Night Shift Registered Nurse (RN) #1 was in a resident ' s room providing care in the room next door when she heard a loud "thump x 2." She immediately went to the adjoining room which was resident #1 ' s and upon entering the room, RN #1 observed that Resident #1 was lying on the floor and then attempted to stand up from the floor, when she fell backwards hitting her head prior to RN #1 being able to intervene. Resident # 1 was transferred to the Emergency Room (ER), (proper name of hospital) per resident ' s Medical Doctor, at 5:10am on May 20.2023. Resident # 1 blood sugar was last checked on 5/19/23 per Evening Shift Licensed Practical Nurse (LPN), resulting in blood sugar of 388 mg/dl with Humalog 12 units administered Subcutaneously to Right Upper Quadrant of Abdomen per LPN. Blood Sugar at (Proper name of hospital) ER was 764. Resident expired at (Proper name of hospital) ER on 5/20/23 at 0635 am. Upon investigation on May 20, 2023, of the incident, a chart review was performed, and it was observed that an insulin

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M 735	Continued From page 15 order, Lantus insulin 20 units every night, was omitted. 2. An Emergency QA meeting was held on May 20, 2023, at 16:12 pm with Regional Director of Operations (DO), Regional Nurse Consultant (RNC), Director of Nursing/Infection Preventionist (DON/IP), Nursing Home Administrator (NHA), and Facility Medical Director (FMD). To prevent this from happening in the future and going forward the DON/IP, Assistant Director of Nursing (ADON), Medical Records (MR), and Minimum Data Set Nurse (MDS) as a team will perform an admission audit and review all orders the day after admission and any orders received within 24 hours of admitting to the facility. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit. 3. Starting on May 20, 2023, and ending on May 30, 2023, the RNC and all resident physicians assessed all resident orders and revised with no negative outcomes. 4. Starting on 5/20/23 at 1700 the DON/IP started the following processes in which nurses were not allowed to work until in serviced on: Glucometer check offs, Inservice on Policy for Medication Administration of Insulin Injections, Inservice on Admission Policy, Inservice on Diabetic Resident Review, Inservice on Medication Management, Inservice on Abuse and Neglect, Inservice on Fingerstick Glucose Procedure, Inservice on Observing and Reporting to MD, Inservice on Charting Errors, Inservice on Medication Reconciliation, and Inservice on Diabetes Policies and Procedures. These in services and check offs concluded on 5/25/23 at 1900.	M 735		

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M 735	Continued From page 16 5. ADON was suspended on 5/20/23 pending investigation per NHA. 1 on 1 In-service with ADON for admission processes, medication errors, and order entry was performed by NHA, RDO, and RNC on 5/23/23. The ADON returned to work on 5/24/23. 6. Monitoring Procedures started on 5/20/23 and included the IDT Clinical team (DON/IP, ADON, MR, and MDS) implementing admission checklist sheets that includes all medications, parameters orders, Code Status documentation, Immunization History and needs, and ancillary orders on new admissions that are reviewed and left in a binder during morning clinical meetings held daily at 9 am. Monitoring procedures for diabetic residents started on 5/20/23 and the first Weekly review of diabetic residents was performed by DON/IP on 5/29/23 with no new findings noted. In the event that findings need correction, the DON/IP will report directly to the FMD Immediately. 7. On 5/22/23, the RNC performed 1 on 1 in-service with MDS on care plans. On 5/22/23, the RNC performed 1 on 1 in-service on diabetic orders, Medical Director (MD) notification, incident care plans, and new employee orientation with DON/IP. On 5/22/23, the RNC performed 1 on 1 in service on care plans and diabetic orders with Medical Records. On 6/1/23, the SA validated the facilities Removal Plan by staff interviews, record reviews, review of the Quality Assurance sign in sheet and review of in-service sign in sheets. The SA verified the facility had implemented the following measures to remove the IJ on 05/31/23. The SA validated through interview on 06/01/23	M 735		

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with the Administrator and DON and record review that the initial investigation was started the morning of 5/20/23 by the Administrator and the DON including interview of team members that were in the facility at that time.

The SA validated through interview on 06/01/23 with the Administrator, DON, medical director, and record review of the sign in sheets that a Quality Assurance meeting was completed on 5/20/23 at 4:12 PM. Discussion and an immediate plan including initiation of the DON/IP, Assistant Director of Nursing (ADON), Medical Records (MR), and Minimum Data Set Nurse (MDS) as a team will perform an admission audit and review all orders the day after admission and any orders received within 24 hours of admitting to the facility. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit.

The SA validated through interviews on 06/01/23 with the DON and Administrator and record reviews that the RNC and all resident physicians assessed all resident orders and blood sugars and revised with no negative outcomes.

The SA validated through interviews and record reviews on 06/01/23 with the DON, RNC, ADON, Medical Records Nurse, RN #1 and MDS nurse and review of in-service sign in sheets that nurses were not allowed to work until in serviced on: Glucometer check offs, Inservice on Policy for Medication Administration of Insulin Injections, Inservice on Admission Policy, Inservice on Diabetic Resident Review, Inservice on Medication Management, Inservice on Abuse and Neglect, Inservice on Fingerstick Glucose Procedure, Inservice on Observing and

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M 735	Continued From page 18 Reporting to MD, Inservice on Charting Errors, Inservice on Medication Reconciliation, and Inservice on Diabetes Policies and Procedures. These in services and check offs concluded on 5/25/23 at 1900. The SA validated through interviews and record reviews on 06/01/23 with the DON and ADON that the ADON was suspended following the investigation on 5/20/23 and returned to work on 5/24/23 after being in-serviced on the admission process, medication errors and order entry. The SA validated through interviews and record reviews on 06/01/23 with the DON, Administrator, ADON, Medical Records Nurse and the MDS Nurse that monitoring procedures started on 5/20/23 and included the Interdisciplinary (IDT) Clinical team (DON/Infection Preventionist (IP), ADON, Medical Records (MR), and MDS) implementing admission checklist sheets that includes all medications, parameters orders, Code Status documentation, Immunization History and needs, and ancillary orders on new admissions that are reviewed and left in a binder during morning clinical meetings held daily at 9 am. Monitoring procedures for diabetic residents started on 5/20/23 and the first Weekly review of diabetic residents was performed by DON/IP on 5/29/23 with no new findings noted. In the event that findings need correction, the DON/IP will report directly to the FMD Immediately. The SA validated through interviews and record reviews on 06/01/23 with the RNC and DON and review of in-service sign in sheets that on 5/22/23 the RNC performed 1 on 1 in service with MDS on care plans. On 5/22/23, the RNC performed 1 on 1 in service on diabetic orders, MD notification, incident care plans, and new	M 735		

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M 735	Continued From page 19 employee orientation with the DON/IP and on 5/22/23, the RNC performed 1 on 1 in service on care plans and diabetic orders with Medical Records. The SA validated on 06/01/23 that all corrective actions to remove the IJ had been completed and the IJ removed on 05/31/23. Based on staff interview, record review and facility policy review the facility failed to ensure resident's medical records were accurately and completely documented on a newly admitted resident. Resident #1's admitting physician's orders were not transcribed correctly or implemented for one (1) of six (6) resident medication records reviewed. Resident #1 During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/15/23, when the facility failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order and develop a comprehensive care plan regarding the care needed for the diagnosis of diabetes for Resident #1. Resident #1's physician ordered long-acting insulin was not administered for five days following admission on 5/15/23 at approximately 4:49 PM and the resident had to be transferred to	M 735		

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the Emergency Room on 5/20/23 at 5:10 AM.The resident had a blood sugar of 764 mg/dl (milligrams/deciliter) at 5:38 AM and resulted in death of the resident at 6:35 AM with a diagnosis of diabetic ketoacidosis (DKA).

The facility's failure to accurately transcribe physicians orders, reconcile and verify physicians orders to prevent Diabetic Ketoacidosis as a result of the omission of an insulin order resulted in the death of Resident #1 and placed other residents with significant medication orders at risk of developing a situation that was likely to cause serious injury, harm, impairment, or death.

The SA notified the facility's Administrator of the IJ and SQC on 5/31/23 at 5:00 PM and provided the Administrator with the IJ templates.

The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23.

Findings include:

Review of the facility policy titled, "Medication on Admission, Reconciliation of" with a revision date of 8/25/14 revealed "Purpose ...The purpose of this procedure is to ensure medication safety by accurately accounting for the resident ' s medications, routes and dosages upon admission or readmission to the facility... "General Guidelines ...#2. Medication reconciliation reduces medication errors and enhance resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the

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M 735	Continued From page 21 admission/transfer process...". Review of the facility policy titled "Medical Record Audits" with a revision date of 6/20/12 revealed "Policy Statement ...It is the policy of this facility to conduct on going audits and monitoring for completion, timeliness and accuracy of the resident ' s medical record", This review revealed under "Procedure ...#1 Audits will be conducted on the resident ' s medical record according to the following schedule: a. Upon Admission/Readmission ...". An interview on 5/31/23 at 10:30 AM, with the Administrator revealed that Resident #1 was admitted on 5/15/23 with diagnoses that included diabetes, fell and hit her head on 5/20/23 and was sent to the Emergency Room (ER) where she passed away. She revealed that during the investigation of the incident the staff discovered that the residents order of Lantus had been omitted. An interview on 5/31/23 at 11:45 AM, with the Director of Nurses (DON) confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes Mellitus. She confirmed that the resident's Lantus order had been omitted when the Assistant Director of Nurses (ADON) entered the orders, and that omission was found after the resident fell and went to the hospital on 5/20/23. She revealed that the orders should have been verified by someone, but that did not happen, and she is not sure why. She revealed that the facility has a policy and procedure in place to prevent this from happening, but this was a system breakdown. An interview on 5/31/23 at 1:00 PM, with the ADON confirmed that Resident #1 was admitted	M 735		

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on 5/15/23 with a diagnosis of Diabetes. She confirmed that she entered the resident's orders into her facility medical record, but did not realize that the order for Lantus had been left off until the DON and the Administrator informed her on 5/20/23. She stated, "I do recall taking verbal report from the nurse at the hospital before the resident was admitted and she told me that the resident was a brittle diabetic that tends to drop quickly." She revealed that she or the DON enters the admission orders for the residents and then when we they are finished, they give it to Medical Records Department for Verification. She stated that she gave the record to someone to verify but does not recall who and stated she recalled that survey was going on that week, so we were busy getting information for them, but that is no excuse. She confirmed that she was suspended from work on 5/20/23 while they completed their investigation and returned to work on 5/25/23 and was also in-serviced about medication entry, medication errors, the admission process and care plans.

A telephone interview on 5/31/23 at 6:57 PM, with Registered Nurse (RN) #1 revealed she was the nurse on duty the night that Resident #1 had to go to the ER. She revealed she was not aware that the resident was supposed to be taking Lantus until the DON notified her during the investigation, because there was no order.

An interview on 6/1/23 at 11:02 AM, with the Medical Records Nurse revealed that she was given Resident #1's record to review her admission orders, but there was so much going on that week with Case Mix and Survey that it got pushed back on her end and that is how the system failed for her personally. She stated, "I realized she was on my list to review. Survey left

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on Thursday and I was going to look at her record on Monday 5/22/23." She revealed that orders need follow-up verification and that is what she is supposed to do to make sure there are no errors. She stated, "I knew that was my responsibility to verify orders. I didn't realize that not doing that would have resulted in in this." She revealed she did receive an in-service after the incident occurred regarding the admission process, verifying orders and care plans. She stated that the Administrator told her that even when we have other things going on that I have to put admissions first.

An interview on 6/1/23 at 11:15 AM, with the DON, confirmed the facility had policies in place to prevent this from happening, but the process broke down. She revealed she could not say why the process broke down except it was a high stress week with both survey and case mix present, although that is no excuse. She revealed that the process for entering admission orders was that the DON or ADON received the orders from social services who gets them from the doctor or hospital, enters them and then one of us or medical records verifies the orders.

An interview on 6/1/23 at 4:55 PM, with the Administrator revealed she felt like the week this happened with Resident #1 was the "perfect storm," with case mix and survey both going on, but that is no excuse. She revealed that medical records were helping with case mix due to MDS being off and it just fell through and stated that she and the team have learned a lot from this and hates that it happened.

Record review of Resident #1's admitting orders from the hospital revealed the following orders regarding her diagnosis of diabetes; Lantus 20

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units subcutaneous daily, Humalog 300 units/3ml solution per sliding scale protocol-corrective low-dose regimens; fingerstick blood glucose of 141-180 -2 units sub-Q, 181-220-4 units sub-Q, 221-260-6 units sub-Q, 261-300-8 units sub-Q, 301-350-10 units sub-Q, 351-400 12 units sub-Q, greater than 400 mg/dl-14 units sub-Q. Documentation revealed that Lantus 20 units was last administered to Resident #1 on 5/15/23 at 8:57 AM prior to admission to the facility.

Record review of Resident #1 ' s facility physicians orders revealed there was no order for Lantus 20 units subcutaneous daily.

Record review of the written statement given by the ADON revealed "(Resident #1's proper name) was admitted on Monday and in report I was told she was a brittle diabetic with a history of DKA and her blood sugars dropped at night. While putting in her orders I was notified of another admission coming while also trying to secure staffing. I remember I needed clarification for her Lantus but do not recall what pulled me away from finishing her admission." This statement was signed by the DON.

Review of the typed statement signed by the Medical Records Nurse read as follows: "I was unable to review admissions during the week beginning 5/15/23 due to assisting with State mix review and state survey. Afterwards, Information Technology (IT) was working on my computer due to problems with my email. Friday, I reviewed the admission for 5/12/23; assisted with advance directive clarifications, cleared/audited forms, and worked on filing and putting documents on charts.

Record review of Resident #1's documented blood sugars since admission revealed Resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 735	Continued From page 25 #1's blood sugar had been checked 18 times and 14 of those were above 141 requiring insulin per physician's ordered sliding scale.The documented blood sugars were as follows: 5/15/23 @ 5:13 PM = 159 5/15/23 @ 8:47 PM = 141 5/16/23 @ 7:20 AM = 129 5/16/23 @ 11:50 AM =116 5/16/23 @ 4:21 PM = 128 5/16/23 @ 9:04 PM = 270 5/17/23 @ 7:23 AM = 308 5/17/23 @ 12:06 PM = 329 5/17/23 @ 4:56 PM = 253 5/17/23 @ 8:13 PM = 217 5/18/23 @ 7:57 AM = 398 5/18/23 @ 1:25 PM = 284 5/18/23 @ 6:36 PM = 393 5/18/23 @ 9:46 PM = 377 5/19/23 @ 7:47 AM = 399 5/19/23 @ 12:50 PM = 188 5/19/23 @ 4:38 PM = 374 5/19/23 @ 9:37 PM = 388	M 735		

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M 735	Continued From page 26 Record review of Resident #1's ER visit on 5/20/23 revealed a bedside glucose of "High Critical-Very abnormal high" collected at 5:34 AM and a comprehensive Metabolic Panel glucose result of 764mg/dl collected at 5:38 AM. Record review of Resident #1's preliminary certificate of death received by the facility fax on 5/22/23 at 12:04 PM, revealed the cause of death to be cardiac arrest due to or as a consequence of ketoacidosis, due to or as a consequence of diabetes mellitus. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 5/15/23 with medical diagnoses that included Alzheimer's and Type 2 Diabetes. Record review of Resident #1's Minimum Data Set with an Assessment Reference Date of 5/20/23 revealed in Section I, a diagnosis of Diabetes and in Section C a Brief Interview for Mental Status (BIMS) of 11 which indicated the resident was moderately cognitively impaired. Review of the facilities Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan: 1. On May 20,2023, at 4:50 am, the Night Shift Registered Nurse (RN) #1 was in a resident ' s room providing care in the room next door when she heard a loud "thump x 2." She immediately went to the adjoining room which was resident #1 ' s and upon entering the room, RN #1 observed that Resident #1 was lying on the floor and then attempted to stand up from the floor, when she	M 735		

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M 735	Continued From page 27 fell backwards hitting her head prior to RN #1 being able to intervene. Resident # 1 was transferred to the Emergency Room (ER), (proper name of hospital) per resident ' s Medical Doctor, at 5:10am on May 20.2023. Resident # 1 blood sugar was last checked on 5/19/23 per Evening Shift Licensed Practical Nurse (LPN), resulting in blood sugar of 388 mg/dl with Humalog 12 units administered Subcutaneously to Right Upper Quadrant of Abdomen per LPN. Blood Sugar at (Proper name of hospital) ER was 764. Resident expired at (Proper name of hospital) ER on 5/20/23 at 0635 am. Upon investigation on May 20, 2023, of the incident, a chart review was performed, and it was observed that an insulin order, Lantus insulin 20 units every night, was omitted. 2. An Emergency QA meeting was held on May 20, 2023, at 16:12 pm with Regional Director of Operations (DO), Regional Nurse Consultant (RNC), Director of Nursing/Infection Preventionist (DON/IP), Nursing Home Administrator (NHA), and Facility Medical Director (FMD). To prevent this from happening in the future and going forward the DON/IP, Assistant Director of Nursing (ADON), Medical Records (MR), and Minimum Data Set Nurse (MDS) as a team will perform an admission audit and review all orders the day after admission and any orders received within 24 hours of admitting to the facility. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit. 3. Starting on May 20, 2023, and ending on May 30, 2023, the RNC and all resident physicians assessed all resident orders and revised with no negative outcomes.	M 735		

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M 735	Continued From page 28 4. Starting on 5/20/23 at 1700 the DON/IP started the following processes in which nurses were not allowed to work until in serviced on: Glucometer check offs, Inservice on Policy for Medication Administration of Insulin Injections, Inservice on Admission Policy, Inservice on Diabetic Resident Review, Inservice on Medication Management, Inservice on Abuse and Neglect, Inservice on Fingerstick Glucose Procedure, Inservice on Observing and Reporting to MD, Inservice on Charting Errors, Inservice on Medication Reconciliation, and Inservice on Diabetes Policies and Procedures. These in services and check offs concluded on 5/25/23 at 1900. 5. ADON was suspended on 5/20/23 pending investigation per NHA. 1 on 1 In-service with ADON for admission processes, medication errors, and order entry was performed by NHA, RDO, and RNC on 5/23/23. The ADON returned to work on 5/24/23. 6. Monitoring Procedures started on 5/20/23 and included the IDT Clinical team (DON/IP, ADON, MR, and MDS) implementing admission checklist sheets that includes all medications, parameters orders, Code Status documentation, Immunization History and needs, and ancillary orders on new admissions that are reviewed and left Level IV Based on staff interview, record review and facility policy review the facility failed to ensure resident's medical records were accurately and completely documented on a newly admitted resident. Resident #1's admitting physician's orders were not transcribed correctly or implemented for one (1) of six (6) resident	M 735		

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medication records reviewed. Resident #1

During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/15/23, when the facility failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order and develop a comprehensive care plan regarding the care needed for the diagnosis of diabetes for Resident #1. Resident #1's physician ordered long-acting insulin was not administered for five days following admission on 5/15/23 at approximately 4:49 PM and the resident had to be transferred to the Emergency Room on 5/20/23 at 5:10 AM.The resident had a blood sugar of 764 mg/dl (milligrams/deciliter) at 5:38 AM and resulted in death of the resident at 6:35 AM with a diagnosis of diabetic ketoacidosis (DKA).

The facility's failure to accurately transcribe physicians orders, reconcile and verify physicians orders to prevent Diabetic Ketoacidosis as a result of the omission of an insulin order resulted in the death of Resident #1 and placed other residents with significant medication orders at risk of developing a situation that was likely to cause serious injury, harm, impairment, or death.

The SA notified the facility's Administrator of the IJ and SQC on 5/31/23 at 5:00 PM and provided the Administrator with the IJ templates.

The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23. Therefore, the scope and severity was lowered from a Level IV to a Level II, while the facility develops a plan of correction to monitor

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the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility policy titled, "Medication on Admission, Reconciliation of" with a revision date of 8/25/14 revealed "Purpose ...The purpose of this procedure is to ensure medication safety by accurately accounting for the resident ' s medications, routes and dosages upon admission or readmission to the facility... "General Guidelines ...#2. Medication reconciliation reduces medication errors and enhance resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process...".

Review of the facility policy titled "Medical Record Audits" with a revision date of 6/20/12 revealed "Policy Statement ...It is the policy of this facility to conduct on going audits and monitoring for completion, timeliness and accuracy of the resident ' s medical record", This review revealed under "Procedure ...#1 Audits will be conducted on the resident ' s medical record according to the following schedule: a. Upon Admission/Readmission ...".

An interview on 5/31/23 at 10:30 AM, with the Administrator revealed that Resident #1 was admitted on 5/15/23 with diagnoses that included diabetes, fell and hit her head on 5/20/23 and was sent to the Emergency Room (ER) where she passed away. She revealed that during the investigation of the incident the staff discovered that the residents order of Lantus had been

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M 735	Continued From page 31 omitted. An interview on 5/31/23 at 11:45 AM, with the Director of Nurses (DON) confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes Mellitus. She confirmed that the resident's Lantus order had been omitted when the Assistant Director of Nurses (ADON) entered the orders, and that omission was found after the resident fell and went to the hospital on 5/20/23. She revealed that the orders should have been verified by someone, but that did not happen, and she is not sure why. She revealed that the facility has a policy and procedure in place to prevent this from happening, but this was a system breakdown. An interview on 5/31/23 at 1:00 PM, with the ADON confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes. She confirmed that she entered the resident's orders into her facility medical record, but did not realize that the order for Lantus had been left off until the DON and the Administrator informed her on 5/20/23. She stated, "I do recall taking verbal report from the nurse at the hospital before the resident was admitted and she told me that the resident was a brittle diabetic that tends to drop quickly." She revealed that she or the DON enters the admission orders for the residents and then when we they are finished, they give it to Medical Records Department for Verification. She stated that she gave the record to someone to verify but does not recall who and stated she recalled that survey was going on that week, so we were busy getting information for them, but that is no excuse. She confirmed that she was suspended from work on 5/20/23 while they completed their investigation and returned to work on 5/25/23 and was also in-serviced about medication entry,	M 735		

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medication errors, the admission process and care plans.

A telephone interview on 5/31/23 at 6:57 PM, with Registered Nurse (RN) #1 revealed she was the nurse on duty the night that Resident #1 had to go to the ER. She revealed she was not aware that the resident was supposed to be taking Lantus until the DON notified her during the investigation, because there was no order.

An interview on 6/1/23 at 11:02 AM, with the Medical Records Nurse revealed that she was given Resident #1's record to review her admission orders, but there was so much going on that week with Case Mix and Survey that it got pushed back on her end and that is how the system failed for her personally. She stated, "I realized she was on my list to review. Survey left on Thursday and I was going to look at her record on Monday 5/22/23." She revealed that orders need follow-up verification and that is what she is supposed to do to make sure there are no errors. She stated, "I knew that was my responsibility to verify orders. I didn't realize that not doing that would have resulted in in this." She revealed she did receive an in-service after the incident occurred regarding the admission process, verifying orders and care plans. She stated that the Administrator told her that even when we have other things going on that I have to put admissions first.

An interview on 6/1/23 at 11:15 AM, with the DON, confirmed the facility had policies in place to prevent this from happening, but the process broke down. She revealed she could not say why the process broke down except it was a high stress week with both survey and case mix present, although that is no excuse. She revealed

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that the process for entering admission orders was that the DON or ADON received the orders from social services who gets them from the doctor or hospital, enters them and then one of us or medical records verifies the orders.

An interview on 6/1/23 at 4:55 PM, with the Administrator revealed she felt like the week this happened with Resident #1 was the "perfect storm," with case mix and survey both going on, but that is no excuse. She revealed that medical records were helping with case mix due to MDS being off and it just fell through and stated that she and the team have learned a lot from this and hates that it happened.

Record review of Resident #1's admitting orders from the hospital revealed the following orders regarding her diagnosis of diabetes; Lantus 20 units subcutaneous daily, Humalog 300 units/3ml solution per sliding scale protocol-corrective low-dose regimens; fingerstick blood glucose of 141-180 -2 units sub-Q, 181-220-4 units sub-Q, 221-260-6 units sub-Q, 261-300-8 units sub-Q, 301-350-10 units sub-Q, 351-400 12 units sub-Q, greater than 400 mg/dl-14 units sub-Q. Documentation revealed that Lantus 20 units was last administered to Resident #1 on 5/15/23 at 8:57 AM prior to admission to the facility.

Record review of Resident #1 ' s facility physicians orders revealed there was no order for Lantus 20 units subcutaneous daily.

Record review of the written statement given by the ADON revealed "(Resident #1's proper name) was admitted on Monday and in report I was told she was a brittle diabetic with a history of DKA and her blood sugars dropped at night. While putting in her orders I was notified of another

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admission coming while also trying to secure staffing. I remember I needed clarification for her Lantus but do not recall what pulled me away from finishing her admission." This statement was signed by the DON.

Review of the typed statement signed by the Medical Records Nurse read as follows: "I was unable to review admissions during the week beginning 5/15/23 due to assisting with State mix review and state survey. Afterwards, Information Technology (IT) was working on my computer due to problems with my email. Friday, I reviewed the admission for 5/12/23; assisted with advance directive clarifications, cleared/audited forms, and worked on filing and putting documents on charts.

Record review of Resident #1's documented blood sugars since admission revealed Resident #1's blood sugar had been checked 18 times and 14 of those were above 141 requiring insulin per physician's ordered sliding scale.The documented blood sugars were as follows:

5/15/23 @ 5:13 PM = 159

5/15/23 @ 8:47 PM = 141

5/16/23 @ 7:20 AM = 129

5/16/23 @ 11:50 AM =116

5/16/23 @ 4:21 PM = 128

5/16/23 @ 9:04 PM = 270

5/17/23 @ 7:23 AM = 308

5/17/23 @ 12:06 PM = 329

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M 735	Continued From page 35 5/17/23 @ 4:56 PM = 253 5/17/23 @ 8:13 PM = 217 5/18/23 @ 7:57 AM = 398 5/18/23 @ 1:25 PM = 284 5/18/23 @ 6:36 PM = 393 5/18/23 @ 9:46 PM = 377 5/19/23 @ 7:47 AM = 399 5/19/23 @ 12:50 PM = 188 5/19/23 @ 4:38 PM = 374 5/19/23 @ 9:37 PM = 388 Record review of Resident #1's ER visit on 5/20/23 revealed a bedside glucose of "High Critical-Very abnormal high" collected at 5:34 AM and a comprehensive Metabolic Panel glucose result of 764mg/dl collected at 5:38 AM. Record review of Resident #1's preliminary certificate of death received by the facility fax on 5/22/23 at 12:04 PM, revealed the cause of death to be cardiac arrest due to or as a consequence of ketoacidosis, due to or as a consequence of diabetes mellitus. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 5/15/23 with medical diagnoses that included Alzheimer's and Type 2 Diabetes. Record review of Resident #1's Minimum Data Set with an Assessment Reference Date of	M 735		

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5/20/23 revealed in Section I, a diagnosis of Diabetes and in Section C a Brief Interview for Mental Status (BIMS) of 11 which indicated the resident was moderately cognitively impaired.

Review of the facilities Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan:

1. On May 20,2023, at 4:50 am, the Night Shift Registered Nurse (RN) #1 was in a resident ' s room providing care in the room next door when she heard a loud "thump x 2." She immediately went to the adjoining room which was resident #1 ' s and upon entering the room, RN #1 observed that Resident #1 was lying on the floor and then attempted to stand up from the floor, when she fell backwards hitting her head prior to RN #1 being able to intervene. Resident # 1 was transferred to the Emergency Room (ER), (proper name of hospital) per resident ' s Medical Doctor, at 5:10am on May 20.2023. Resident # 1 blood sugar was last checked on 5/19/23 per Evening Shift Licensed Practical Nurse (LPN), resulting in blood sugar of 388 mg/dl with Humalog 12 units administered Subcutaneously to Right Upper Quadrant of Abdomen per LPN. Blood Sugar at (Proper name of hospital) ER was 764. Resident expired at (Proper name of hospital) ER on 5/20/23 at 0635 am. Upon investigation on May 20, 2023, of the incident, a chart review was performed, and it was observed that an insulin order, Lantus insulin 20 units every night, was omitted.

2. An Emergency QA meeting was held on May 20, 2023, at 16:12 pm with Regional Director of Operations (DO), Regional Nurse Consultant

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M 735	Continued From page 37 (RNC), Director of Nursing/Infection Preventionist (DON/IP), Nursing Home Administrator (NHA), and Facility Medical Director (FMD). To prevent this from happening in the future and going forward the DON/IP, Assistant Director of Nursing (ADON), Medical Records (MR), and Minimum Data Set Nurse (MDS) as a team will perform an admission audit and review all orders the day after admission and any orders received within 24 hours of admitting to the facility. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit. 3. Starting on May 20, 2023, and ending on May 30, 2023, the RNC and all resident physicians assessed all resident orders and revised with no negative outcomes. 4. Starting on 5/20/23 at 1700 the DON/IP started the following processes in which nurses were not allowed to work until in serviced on: Glucometer check offs, Inservice on Policy for Medication Administration of Insulin Injections, Inservice on Admission Policy, Inservice on Diabetic Resident Review, Inservice on Medication Management, Inservice on Abuse and Neglect, Inservice on Fingerstick Glucose Procedure, Inservice on Observing and Reporting to MD, Inservice on Charting Errors, Inservice on Medication Reconciliation, and Inservice on Diabetes Policies and Procedures. These in services and check offs concluded on 5/25/23 at 1900. 5. ADON was suspended on 5/20/23 pending investigation per NHA. 1 on 1 In-service with ADON for admission processes, medication errors, and order entry was performed by NHA, RDO, and RNC on 5/23/23. The ADON returned to work on 5/24/23.	M 735		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 735	Continued From page 38 6. Monitoring Procedures started on 5/20/23 and included the IDT Clinical team (DON/IP, ADON, MR, and MDS) implementing admission checklist sheets that includes all medications, parameters orders, Code Status documentation, Immunization History and needs, and ancillary orders on new admissions that are reviewed and left in a binder during morning clinical meetings held daily at 9 am. Monitoring procedures for diabetic residents started on 5/20/23 and the first Weekly review of diabetic residents was performed by DON/IP on 5/29/23 with no new findings noted. In the event that findings need correction, the DON/IP will report directly to the FMD Immediately. 7. On 5/22/23, the RNC performed 1 on 1 in-service with MDS on care plans. On 5/22/23, the RNC performed 1 on 1 in-service on diabetic orders, Medical Director (MD) notification, incident care plans, and new employee orientation with DON/IP. On 5/22/23, the RNC performed 1 on 1 in service on care plans and diabetic orders with Medical Records. On 6/1/23, the SA validated the facilities Removal Plan by staff interviews, record reviews, review of the Quality Assurance sign in sheet and review of in-service sign in sheets. The SA verified the facility had implemented the following measures to remove the IJ on 05/31/23. The SA validated through interview on 06/01/23 with the Administrator and DON and record review that the initial investigation was started the morning of 5/20/23 by the Administrator and the DON including interview of team members that were in the facility at that time.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71IH	A. BUILDING: _____ B. WING _____	C 06/01/2023

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M 735	Continued From page 39 The SA validated through interview on 06/01/23 with the Administrator, DON, medical director, and record review of the sign in sheets that a Quality Assurance meeting was completed on 5/20/23 at 4:12 PM. Discussion and an immediate plan including initiation of the DON/IP, Assistant Director of Nursing (ADON), Medical Records (MR), and Minimum Data Set Nurse (MDS) as a team will perform an admission audit and review all orders the day after admission and any orders received within 24 hours of admitting to the facility. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit. The SA validated through interviews on 06/01/23 with the DON and Administrator and record reviews that the RNC and all resident physicians assessed all resident orders and blood sugars and revised with no negative outcomes. The SA validated through interviews and record reviews on 06/01/23 with the DON, RNC, ADON, Medical Records Nurse, RN #1 and MDS nurse and review of in-service sign in sheets that nurses were not allowed to work until in serviced on: Glucometer check offs, Inservice on Policy for Medication Administration of Insulin Injections, Inservice on Admission Policy, Inservice on Diabetic Resident Review, Inservice on Medication Management, Inservice on Abuse and Neglect, Inservice on Fingerstick Glucose Procedure, Inservice on Observing and Reporting to MD, Inservice on Charting Errors, Inservice on Medication Reconciliation, and Inservice on Diabetes Policies and Procedures. These in services and check offs concluded on 5/25/23 at 1900.	M 735		

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M 735	Continued From page 40 The SA validated through interviews and record reviews on 06/01/23 with the DON and ADON that the ADON was suspended following the investigation on 5/20/23 and returned to work on 5/24/23 after being in-serviced on the admission process, medication errors and order entry. The SA validated through interviews and record reviews on 06/01/23 with the DON, Administrator, ADON, Medical Records Nurse and the MDS Nurse that monitoring procedures started on 5/20/23 and included the Interdisciplinary (IDT) Clinical team (DON/Infection Preventionist (IP), ADON, Medical Records (MR), and MDS) implementing admission checklist sheets that includes all medications, parameters orders, Code Status documentation, Immunization History and needs, and ancillary orders on new admissions that are reviewed and left in a binder during morning clinical meetings held daily at 9 am. Monitoring procedures for diabetic residents started on 5/20/23 and the first Weekly review of diabetic residents was performed by DON/IP on 5/29/23 with no new findings noted. In the event that findings need correction, the DON/IP will report directly to the FMD Immediately. The SA validated through interviews and record reviews on 06/01/23 with the RNC and DON and review of in-service sign in sheets that on 5/22/23 the RNC performed 1 on 1 in service with MDS on care plans. On 5/22/23, the RNC performed 1 on 1 in service on diabetic orders, MD notification, incident care plans, and new employee orientation with the DON/IP and on 5/22/23, the RNC performed 1 on 1 in service on care plans and diabetic orders with Medical Records. The SA validated on 06/01/23 that all corrective	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 735	Continued From page 41 actions to remove the IJ had been completed and the IJ removed on 05/31/23.	M 735		