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	255127	A. BUILDING _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO COMM LIVING CENTER	1410 WEST QUITMAN STREET IUKA, MS 38852

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F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted an annual recertification survey and complaint investigations for CI MS #21345, CI MS #21398, and CI MS #21656 from 5/15/23 through 5/18/23. The SA extended the survey and entered the facility again on 05/31/23 and exited on 06/01/23. The SA found the facility to not be in compliance regarding CI MS #21656 related to the death of a resident. The facility was not in compliance with the requirements of participation in Medicare and Medicaid.

During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F578, F583 F644, F656, F 695, F801, and F812. The SA investigated CI MS #21345 for Respect/Resident Rights and did not cite deficiencies related to this allegation. The SA investigated CI MS #21398 for Physical Environment and did not cite any deficiencies related to this allegation.

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, which revealed a blood sugar of 764 at 5:38 AM

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

Electronically Signed | 06/19/2023

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F 000	Continued From page 1	F 000		

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 and failure to develop and implement a comprehensive care plan regarding the care needed for the diagnosis of diabetes the facility placed Resident #1 and 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 State Agency (SA) called Immediate Jeopardy (IJ) on 05/31/23 at 5:00 PM and provided the facility with the IJ templates.
Immediate Jeopardy was cited at:
42 CFR 483.21 (a) Baseline Care Plan (F655) at a scope and severity (S/S) of J;
42 CFR 483.21 (b)(3) Professional Standards (F658) at a S/S of J;
42 CFR 483.70 (i)(1)(ii) Medical Record Accurately Documented (F842) at a S/S of J

Immediate Jeopardy and Substandard Quality of Care (SQC) was cited at:
42 CFR 483.25 Quality of Care (F684) at a S/S of J;
42 CFR 483.45(f)(2) Free of Significant Medication Error (F760) at a S/S of J

The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on

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F 000	Continued From page 2 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23, prior to exit. Therefore, the scope and severity for 42 CFR 483.21 (a) Baseline Care Plan (F655), 42 CFR 483.21 (b)(3) Professional Standards (F658), 42 CFR 483.25 Quality of Care (F684), 42 CFR 483.45(f)(2) Free of Significant Medication Error (F760), and 42 CFR 483.70 (i)(1)(ii) Medical Record Accurately Documented (F842), were lowered from a "J" to a "D", 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 was licensed for 73 beds and the census at the time of the survey was 67.	F 000		
F 655 SS=J	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		6/22/23

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F 655	Continued From page 3 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, facility and hospital record review, and facility policy review the facility failed to ensure a baseline careplan was developed for a resident with Diabetes resulting in death for one (1) of six (6) resident 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. Resident #1's	F 655	1. On 5/22/23, the Regional Nurse Consultant (RNC), in-serviced the MDS coordinator on ensuring all residents receive a baseline care plan upon admission to help develop the comprehensive care plan. 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. An audit of all current residents baseline care plan was completed on	

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F 655	Continued From page 4 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 and failure to develop and implement a baseline care plan for diabetes to safeguard against adverse events that are most likely to occur right after admission. This failure 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 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 "J" to a "D", 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.	F 655	5/22/23. DON to ensure all current residents have a completed baseline care plan. 2. This alleged deficient practice has the potential to affect all residents. All new admissions to be reviewed daily during clinical meetings for complete baseline care plans. 3. Director of Nursing (DON), 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 beginning on 05/22/23. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit beginning on 05/22/23. The admission audit will include ensuring a baseline care plan has been put in place for each new admission. An audit of all current residents□ baseline care plan was completed on 5/22/23. 4. Starting on 05/22/23, DON to ensure all current residents have a completed baseline care plan by monitoring new admissions daily x 4 weeks, bi-weekly x 2, then monthly x 4 months. Any issues will be corrected immediately. 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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Findings Include:

Review of the facility policy titled, "Care Plan Comprehensive", undated, revealed, "5. A baseline care plan is developed upon the residents' admission. The baseline care plan is used to help develop the comprehensive care plan."

An interview on 6/1/23 at 11:02 AM with the Medical Records Nurse revealed that she confirmed that Minimum Data Set (MDS) nurse is responsible for care plans being put in the resident's record, but each department also does some of their own and if a resident is admitted on the weekend or at night then the nurse supervisor or admitting nurse is responsible for all the resident's care plans. And that a resident's care plans should match the physician orders and diagnoses. She confirmed that by not checking the admission orders and verifying the medical record was accurate that they also failed to develop a base line care plan for diabetes which might would have caught that the Lantus had been omitted.

An interview on 6/1/23 at 11:15 AM with the DON confirmed that the baseline care plan had a yes or no question regarding if the resident was a diabetic and Resident #1's was marked yes, but there were no care instructions regarding diabetes. She revealed that the resident did not have a comprehensive care plan regarding the diagnosis of diabetes, but she should have and confirmed that 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 but that is no excuse.

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An interview on 6/1/23 at 1:06 PM with the MDS nurse revealed that she is part of the interdisciplinary team and receives an email from social services regarding new admissions. She revealed she is responsible for getting the baseline care plan in the resident's record after admission within 48 hours, but the facility does it in 24 hours. She revealed that if a resident is admitted at night or on the weekend then the nurse supervisor would be responsible for putting the care plans in. She revealed the resident's care plan needed to match the orders and the diagnosis and the purpose of the care plan is to know what kind of care the resident needs. She revealed that if she was in the building when a resident was admitted and saw a diagnosis of diabetes then she would try to get the care plan opened as soon as possible (ASAP). She stated, "You need to know if someone is a diabetic." She revealed that she was not at work when Resident #1 was admitted on 5/15/23 and did not return to work until 5/18/23. She stated that in her absence the DON and ADON would have been responsible for the care plans, and she felt like within 5 days the resident's diabetic care plan should have been done.

An interview on 6/1/23 at 1:20 PM with the DON revealed that she did not do a care plan for Resident #1 while the MDS nurse was out during the week of 5/15/23. She revealed she thought the Corporate MDS person was the backup to the MDS nurse when she was out and thought that person was going to do the care plans, but confirmed a care plan should have been completed and confirmed that a lot of breakdowns of their system occurred.

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Record review of Resident #1's admitting orders from the hospital dated 05/15/23 revealed the following orders regarding her diagnosis of diabetes; Lantus 20 units subcutaneous (sub-Q) daily, Humalog 300 units/3 milliliter (ml) 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, This review revealed that Lantus 20 unit subcutaneous was last given on 5/15/23 at 8:57 AM.

Record review of Resident #1's facility physicians orders revealed there was no order for Lantus 20 units subcutaneous daily on her Medication Administration Record (MAR).

Record review of Resident #1's preliminary certificate of death revealed the "Cause of death to be cardiac arrest due to or as a consequence of ketoacidosis, due to or because of diabetes mellitus," received by the facility via fax on 5/22/23 at 12:04 PM.

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

Review of the Removal Plan revealed the facility

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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 5:10 am 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 Subcutaneous 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

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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.

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

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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.

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

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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.

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

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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 actions to remove the IJ had been completed and the IJ removed on 05/31/23.

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F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, facility and hospital record review, and facility policy review, the facility failed to provide services to meet professional standards by failing to ensure the accuracy and reconciliation of a resident's physician orders for medications for a resident with Diabetes resulting in death for one (1) of six (6) resident 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. 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 adhere to professional standards and accurately transcribe physician's orders, reconcile and verify physician's orders, and prevent Diabetic Ketoacidosis from the	F 658	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. Starting on 05/20/23 and completed on 5/22/23, Regional Nurse Consultant (RNC) and Director of Nursing (DON) conducted audits of new admission medication orders to ensure accuracy for current residents who were admitted since March 2023, with issues corrected immediately. 2. This alleged deficient practice has the potential to affect all residents. 3. On 05/20/23, 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 05/20/23, DON in-serviced licensed	6/22/23

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omission of an insulin order, lead to the death of Resident #1 and placed other residents with significant medication orders at risk of 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 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 "J" to a "D", 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 policy titled, "Conformity with Laws and Professional Standards" with a revision date of 01/2023, revealed under, "Policy Statement ...Our facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided".

The Administrator revealed during an interview on 5/31/23 at 10:30 AM, that Resident #1 was admitted on 5/15/23 with a diagnosis of diabetes. On 5/20/23, the resident fell and hit her head and was sent to the Emergency Room (ER) where she passed away. She revealed that during the investigation of the incident the staff discovered

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 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(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.

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 to ensure that orders are accurate, documentation is completed, and admission is completed.

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F 658	Continued From page 15 that the resident's order for Lantus daily had been omitted from her admission orders. The Director of Nurses (DON) confirmed during an interview on 5/31/23 at 11:45 AM, that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes. She confirmed that the order for Lantus had been omitted when the Assistant Director of Nursing (ADON) entered the physician orders, and that omission was found after the resident fell and went to the hospital and died 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 and this was a system breakdown. The Assistant Director of Nurses (ADON) confirmed in an interview on 5/31/23 at 1:00 PM, 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 and 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 residents and then when we they are finished, they give it to Medical Records for her to verify. She revealed she gave the record to someone to verify but does not recall who. 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 in-serviced about medication entry,	F 658	On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/Infection preventionist, 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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medication errors, the admission process and care plans.

Registered Nurse (RN) #1 revealed during a phone interview on 5/31/23 at 6:57 PM, she was the nurse on duty the night that Resident #1 had to go to the ER. She revealed that the resident had been able to walk without assistance since admission and had not showed any signs of problems with her blood sugar since she had come on shift at 10:00 PM. She confirmed the resident fell and had to go to the ER. She confirmed that the Resident Representative (RR) had called the facility and notified her that the resident had passed away at the ER and then she received a call from the ER verifying that the resident had passed away. She stated that she was not aware that the resident was supposed to be taking Lantus every day because there was no order in the medical record until the facility notified her during the investigation.

Interview on 6/1/23 at 11:02 AM with the Medical Records Nurse revealed that she was given Resident #1's medical record to review her admission orders, but there was so much going on that week 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, and I was going to look at her record on Monday 5/22/23." She revealed that orders needed 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 (death)." She stated she was in-service after the incident occurred regarding the admission process, verifying orders and care plans. She

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stated that the Administrator told her that even when we have other things going on that I must put admissions first.

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", 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.

Record review of Resident #1's admitting orders from the hospital dated 05/15/23 revealed the following orders regarding her diagnosis of diabetes; Lantus 20 units subcutaneous (sub-Q) daily, Humalog 300 units/3 ml 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, This review revealed that Lantus 20 unit subcutaneous was last given on 5/15/23 at 8:57 AM.

Record review of Resident #1's facility physicians orders revealed there was no order for Lantus 20 units subcutaneous daily on her Medication Administration Record (MAR).

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 Diabetic Ketoacidosis (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

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pulled me away from finishing her admission." and 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 admissions 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 the resident'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:

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 764 collected at 5:38 AM.

Record review of Resident #1's preliminary certificate of death revealed the "Cause of death to be cardiac arrest due to or as a consequence of ketoacidosis, due to or because of diabetes mellitus," received by the facility via fax on 5/22/23 at 12:04 PM.

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.

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Record review of Resident #1's MDS with an Assessment Reference Date (ARD) of 5/20/23 revealed in Section I, a diagnosis of Diabetes and in Section C a Brief Interview for Mental Status score (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 5:10 am 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 Subcutaneous 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.

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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.

5. ADON was suspended on 5/20/23 pending

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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.

State Agency (SA) Validation:

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

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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.

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

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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.

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

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F 658	Continued From page 24 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 actions to remove the IJ had been completed and the IJ removed on 05/31/23.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review the facility failed to ensure each resident received the necessary care and services in accordance with professional standards of practice to meet each resident's physical needs for one (1) of 10 residents reviewed (six (6) sampled residents and four (4) unsampled residents). 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	F 684	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. Starting on 05/20/23 and completed on 5/22/23, Regional Nurse Consultant (RNC) and Director of Nursing (DON) conducted audits of new admission medication orders to ensure accuracy for	6/22/23

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F 684	Continued From page 25 failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order. 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 and failure to develop and implement a comprehensive care plan regarding the care needed for the diagnosis of diabetes 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 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 "J" to a "D", 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.	F 684	current residents who were admitted since March 2023, with issues corrected immediately. 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 and 5/23/23, the Regional Nurse Consultant (RNC), in-serviced DON and 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/Infection Preventionist on diabetic orders, Doctor 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 (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.	

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F 684	Continued From page 26 Findings Include: Review of the facility policy titled, "Conformity with Laws and Professional Standards" with a revision date of 01/20/23, revealed, "Policy Statement ...Our facility operates and provides services in compliance with current federal, state and local laws and regulations, codes and professional standards of practice that apply to our facility and types of services provided..." Review of the facility policy titled, "Medications 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". During an interview with the Administrator on 5/31/23 at 10:30 AM, revealed that Resident #1 was admitted to the facility on 5/15/23 with a diagnosis of 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 for Lantus daily had been omitted from her admission orders. During an interview with the Director of Nurses (DON) on 5/31/23 at 11:45 AM, she confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes. She confirmed that the resident's order for Lantus had been omitted when the Assistant Director of Nursing (ADON) entered the physician orders, and that omission was found after the resident fell and went to the	F 684	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 to ensure that orders are accurate, documentation is completed, and admission is completed. 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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hospital and died 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 and this was a system breakdown.

In an interview with the ADON on 5/31/23 at 1:00 PM, confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes. She confirmed that she entered the resident's orders in the facility medical record and 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 enter the admission orders for residents and then when we they are finished, they give it to Medical Records for her to verify. She revealed she gave the record to someone to verify but does not recall who. 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.

During a phone interview on 5/31/23 at 6:57 PM, Registered Nurse (RN) #1 revealed she was Resident #1's nurse the night she had to go to the ER. She stated that she was in the resident's room next door to Resident #1's room providing care to another resident and heard two loud thumps coming from Resident #1's room. She went to Resident #1's room and found her lying on the floor between the wall and the dresser and

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she told the resident to hang on and she would get some help, then she called for assistance from another staff member. She stated that the resident attempted to get up before she could get to her and almost made it to her knees then fell back again and hit her head on the dresser. She revealed that after the resident fell the second time and hit her head, she started scooting across the floor and was shaking. She stated that the resident said something that was not understandable and made eye contact with her, but it did not seem like she was understanding simple commands. She revealed that she immediately notified Doctor #1 who gave her the order to send her out to the ER. She then called 911, the DON and attempted to reach the resident's Resident Representative (RR) but did not get an answer. She revealed that the resident had been able to walk without assistance since admission and had not showed any signs of problems with her blood sugar since she had come on shift at 10:00 PM. She confirmed that the RR had called the facility and notified her that the resident had passed away at the ER and then she received a call from the ER verifying that the resident had passed away. She stated that she was not aware that the resident was supposed to be taking Lantus every day because there was no order in the medical record until the facility notified her during the investigation.

During an interview on 6/1/23 at 11:02 AM, with the Medical Records Nurse revealed that she was given Resident #1's medical record to review her admission orders, but there was she was so busy that week 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, and I was going to look at her record on

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Monday 5/22/23." She revealed that orders needed 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 (death)." She stated she was in-serviced 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 must put admissions first. She confirmed that Minimum Data Set (MDS) is responsible for care plans being put in resident's record, but each department also does some of their own and if a resident is admitted on the weekend or at night then the nurse supervisor or admitting nurse is responsible for all the resident's care plans. And that a resident's care plans should match the physician orders and diagnoses. She confirmed that by not checking the admission orders and verifying the medical record was accurate that they also failed to develop a base line care plan for diabetes which might would have caught that the Lantus had been omitted.

In interview with the DON on 6/1/23 at 11:15 AM, she stated she was in serviced by the Registered Nurse Consultant (RNC) following the death of Resident #1 regarding medication errors, doctor notification and care plans. She confirmed that the baseline care plan had a yes or no question regarding if the resident was a diabetic and Resident #1's was marked yes, but there were no care instructions regarding diabetes. She revealed that the resident did not have a comprehensive care plan regarding the diagnosis of diabetes, but she should have and confirmed that the facility had policies in place to prevent

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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 but that is no excuse.

During an interview on 6/1/23 at 12:32 PM, with the DON revealed that medications are ordered from the pharmacy based on the orders that are entered in the computer system. She stated that since Resident #1 did not have an order in the computer system for Lantus, it was not ordered from the pharmacy.

On 6/1/23 at 1:06 PM, during an interview with the MDS nurse revealed that she is a member of the interdisciplinary team and receives an email from social services regarding new admissions. She revealed she is responsible for getting the baseline care plan in the resident's record after admission within 48 hours, but the facility does it in 24 hours. She revealed that if a resident is admitted at night or on the weekend then the nurse supervisor would be responsible for putting the care plans in. She revealed the resident's care plan needed to match the orders and the diagnosis and the purpose of the care plan is to know what kind of care the resident needs. She revealed that if she was in the building when a resident was admitted and saw a diagnosis of diabetes then she would try to get the care plan opened as soon as possible (ASAP). She stated, "You need to know if someone is a diabetic." She revealed that she was not at work when Resident #1 was admitted on 5/15/23 and did not return to work until 5/18/23. She stated that in her absence the DON and ADON would have been responsible for the care plans, and she felt like within 5 days the resident's diabetic care plan should have been done.

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In interview on with the DON 6/1/23 at 1:20 PM, she confirmed that Resident #1 did not have a care plan regarding her diagnosis of Diabetes. She revealed that she did not do a care plan for Resident #1 while the MDS nurse was out during the week of 5/15/23. She revealed she thought the Corporate MDS person was the backup to the MDS nurse when she was out and thought that person was going to do the care plans, but confirmed a care plan should have been completed and confirmed that a lot of breakdowns of their system occurred.

During an interview on 6/1/23 at 1:42 PM, with the Registered Nurse Consultant (RNC) revealed that the facility has 21 days to get the comprehensive care plans in the resident's record. When the State Agent asked if she felt like a resident with a diagnosis of diabetes and receiving insulin should have a care plan regarding that diagnosis sooner than 21 days, she smiled but did not respond.

An interview on 6/1/23 at 1:47 PM with RN #2 revealed she was the previous DON at the facility. She revealed that if she sees that a resident is getting blood glucose checks then she checks to make sure they have a care plan.

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. She revealed that she and the team have learned a lot from this and hates that it happened.

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Record review of the incident investigation revealed that RN #1 was in the neighboring resident room providing care to another resident and heard a loud thump followed by another softer thump in Resident #1's room. RN #1 then went to Resident #1 ' s room and observed the resident on the floor against the wall leaning against the dresser and before the nurse could get to the resident the resident attempted to get up and fell backwards hitting her head on the dresser and wall. RN #1 observed that the resident' eyes were open, and she was scooting across the floor but unable to follow simple instructions, track objects or respond verbally. RN #1 called Doctor #1 and received an order to send the resident to the ER for evaluation and treatment and 911 was notified. RN #1 then notified the DON and attempted to notify the Resident Representative (RR) with a phone message being left. This review revealed the resident left the facility around 5:10 AM via ambulance and at approximately 6:50 AM RN #1 was notified by the RR that the resident had passed away at the ER and then received a follow-up call from the ER confirming that the resident had passed away.

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, This review revealed that the last time that Resident #1 received Lantus 20 units subcutaneously was

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on 5/15/23 at 8:57 AM.

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" and 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 care plans revealed the resident was indicated to have diabetes on the baseline care plan with no care instructions and there was no comprehensive care plan related to the resident's diagnosis of diabetes.

Record review of Resident #1's documented blood sugars since admission revealed the resident's blood sugar had been checked 18

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times and 14 of those were above 141 mg/dl 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

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F 684	Continued From page 35 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 764 collected at 5:38 AM. Record review of Resident #1's preliminary certificate of death 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 received by the facility via fax on 5/22/23 at 12:04 PM. 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	F 684		

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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 (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

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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.

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

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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.

1. 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.

2. 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.

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3/ 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.

4. 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.

5. 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.

6. 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)

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F 684	Continued From page 40 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. 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 actions to remove the IJ had been completed and the IJ removed on 05/31/23.	F 684		
F 760 SS=J	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 staff interview, record review and facility policy review the facility failed to ensure a	F 760	1. On 5/20/23 through 5/30/23, all resident physicians assessed all resident	6/22/23

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F 760	Continued From page 41 resident was free from significant medication errors as evidenced by insulin being omitted from a resident's record for one (1) of six (6) medication orders 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. 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 and failure to develop and implement a comprehensive care plan regarding the care needed for the diagnosis of diabetes 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	F 760	orders and revised with no negative outcomes. On 5/20/23, licensed nurses were in-serviced on medication management, medication reconciliation, and observing and reporting to the doctor. 2. This alleged deficient practice has the potential to affect all residents. Starting on 05/20/23 and completed on 5/22/23, Regional Nurse Consultant (RNC) and Director of Nursing (DON) conducted audits of new admission medication orders to ensure accuracy for current residents who were admitted since March 2023, with no issues identified. 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 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 05/23/23 ADON on ensuring physician orders are accurately transcribed, reconciled and verified for new and returning residents in order to	

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F 760	Continued From page 42 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 "J" to a "D", 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 policy titled, "Preventing and Detecting Adverse Consequences" with a revision date of 11/01/08 revealed under "Policy ...The facility employs a system to assure that medication usage is evaluated on an ongoing basis. When a resident has a change in condition, medication-related problems are considered, Significant medication-related problems are assess, document and reported as appropriate to the resident ' attending physician, the pharmacy, the consultant pharmacist and the Food and Drug Administration Med/Watch Program or USP/ISMP Medication Error Reporting Program (when applicable)".This review revealed under "Procedures, F ...In the event of a significant medication related error or adverse consequence, immediate actions is taken, as necessary, to protect the resident's safety and welfare, Significant is defined as ...2.) Requiring hospitalization ...6.) Life threatening ...7.) Resulting in death ...G. The attending physician is notified promptly of any significant error or adverse consequence..." Review of the facility policy titled, "Medications 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	F 760	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 (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. 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 to ensure that orders are accurate, documentation is completed, and admission is completed. On the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit starting 5/23/23. Any order entry errors and incomplete documentation 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	

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accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility..."

During an interview on 5/31/23 at 10:30 AM, the Administrator revealed that Resident #1 was admitted on 5/15/23 with a diagnosis of 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.

The Director of Nurses (DON) stated in an interview on 5/31/23 at 11:45 AM, that Resident #1 was admitted to the facility on 5/15/23 with a diagnosis of Diabetes. She confirmed the resident was on a sliding scale of insulin and had been receiving that when needed. She confirmed that the order for Lantus had been omitted when the 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. She revealed that the facility has a policy and procedure in place to prevent this from happening, but the system broke down.

On 5/31/23 at 1:00 PM, with the Assistant Director of Nurses (ADON), during an interview confirmed that Resident #1 was admitted on 5/15/23 with a diagnosis of Diabetes. She confirmed that she entered the Resident #1's orders into her facility medical record and 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

needed for review/revision.

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resident was a brittle diabetic that tends to drop quickly."

An interview on 5/31/23 at 6:57 PM via telephone, 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 because there was no order until the DON notified her.

The Medical Records nurse revealed during an interview on 6/1/23 at 11:02 AM that she was given Resident #1's record to review her admission orders, but there was a lot 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 that the Administrator told her that even when they have other things going on that I have to put admissions first.

On 6/1/23 at 12:32 PM, in an interview with the DON she revealed that medications are ordered from the pharmacy based on the orders that are entered in the resident's electronic record. She revealed that since Resident #1 did not have an order in the computer system for Lantus, it was not ordered.

The Administrator reported during an interview on

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6/1/23 at 4:55 PM, that 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 was helping with case mix due to MDS being off and it just fell through. She revealed that she and the team have learned a lot from this and hates that it happened.

Record review of the incident investigation revealed that RN #1 was in the neighboring resident room providing care to another resident and heard a loud thump followed by another softer thump in Resident #1's room. RN #1 then went to Resident #1's room and observed the resident on the floor against the wall leaning against the dresser and before the nurse could get to the resident the resident attempted to get up and fell backwards hitting her head on the dresser and wall. RN #1 observed that the resident ' s eyes were open, and she was scooting across the floor but unable to follow simple instructions, track objects or respond verbally. RN #1 called Doctor #1 and received an order to send the resident to the ER for evaluation and treatment and 911 was notified. RN #1 then notified the DON and attempted to notify the Resident Representative (RR) with a phone message being left. This review revealed the resident left the facility around 5:10 AM via ambulance and at approximately 6:50 AM RN #1 was notified by the RR that the resident had passed away at the ER. The facility then received a follow-up call from the ER confirming that the resident had passed away.

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 (sub-Q) 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 the last time Lantus 20 units subcutaneously was administer to Resident #1 was on 5/15/23 at 8:57 AM.

Record review of Resident #1's electronic record revealed Lantus 20 units subcutaneous daily was omitted from the physician orders.

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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F 760	Continued From page 47 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 764 mg/dl collected at 5:38 AM. 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" and this statement was signed by the DON. Review of the typed statement signed by the	F 760		

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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 preliminary certificate of death received by the facility via 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) score of 11 which indicated the resident was moderately cognitively impaired,

Review of the 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

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' 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 5:10 am 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

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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.

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

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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.

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

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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.

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

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F 760	Continued From page 53 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 actions to remove the IJ had been completed and the IJ removed on 05/31/23.	F 760		
F 842 SS=J	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		6/22/23

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resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 55 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT 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	F 842	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	

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F 842	Continued From page 56 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 "J" to a "D", 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 policy titled, "Medication on Admission, Reconciliation of" with a revision date	F 842	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 (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 and on the weekend, the Weekend RN Supervisor/Charge Nurse, DON/IP, or ADON will perform the admission audit. 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	

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F 842	Continued From page 57 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 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	F 842	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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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, 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

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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 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.

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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 (sub-Q) 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

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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

5/17/23 @ 4:56 PM = 253

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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 5/20/23 revealed in Section I, a diagnosis of

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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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(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

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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 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

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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

Reporting to MD, Inservice on Charting Errors, Inservice on Medication Reconciliation, and Inservice on Diabetes Policies and Procedures.

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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 employee orientation with the DON/IP and on 5/22/23, the RNC performed 1 on 1 in service on

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F 842	Continued From page 68 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.	F 842		