| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056177 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Double Tree Post Acute Care Center | 7400 24th Street<br>Sacramento, CA 95822 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>50312<br><br>Based on observation, interview and record review, the facility failed to properly manage a resident's Type 2 Diabetes Mellitus (DM2-a disease that results in too much glucose, also called blood sugar in the blood) for one of 28 sampled residents (Resident 31) when the Licensed Nurses (LN) did not follow Physician Orders and the standards of care for diabetes.<br><br>These failures resulted in Resident 31 having dangerously high levels of glucose throughout the day and suffering from unwanted symptoms of hyperglycemia (high sugar level) which could have led to a diabetic coma, a life-threatening medical emergency requiring immediate medical care or death if left untreated.<br><br>Findings:<br><br>An Immediate Jeopardy (IJ) situation was declared at 7:25 p.m. on 9/30/24 with Facility leadership representatives including the Regional Administrator (ADM) and Director of Nursing (DON) due to Resident 31 having dangerously high glucose levels throughout the day and suffering from symptoms of hyperglycemia while the Licensed Nurses (LNs) failed to administer Resident 31's morning insulin (a medication that lowers the glucose level in body), notify the physician, follow up with the physician, follow the physician's new insulin order in the afternoon, and properly document the glucose levels for the physician to properly assess Resident 31's condition. The Immediate Jeopardy status was lifted onsite on 10/1/24 at 4 p. m. after the facility provided an acceptable action plan.<br><br>During a review of Resident 31's undated, Admission Record (AR), the AR indicated Resident 31 was admitted to the facility in August of 2018 with diagnoses that included type 2 Diabetes Mellitus (DM2) with hyperglycemia (a disease characterized by high blood sugar levels) and DM2 with diabetic neuropathy (nerve pain due to having diabetes), End Stage Renal Disease (kidney failure), Chronic Diastolic Heart Failure (condition that the heart cannot pump blood efficiently), and Hypertensive Chronic Kidney Disease (a condition where high blood pressure damages the kidneys). Resident 31 was insulin dependent (a condition that the body is unable to produce enough insulin and requires regular insulin injections).<br><br>Review of Resident 31's medical record document titled Order Summary Report dated 8/12/24, indicated the following orders for diabetes:<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Insulin Regular (Humulin R, a short acting insulin), 100 u/ml (units per milliliter, concentration of insulin in a measurement of fluid). Amount to inject as per sliding scale (insulin dosage based on pre-defined blood glucose ranges);<br><br>For Blood Sugar (BS) = 70-130 mg/dl (milligrams per deciliter, unit of measure): Give 0 units<br><br>If BS is < (less than) 70 mg/dl, Follow facility protocol.<br><br>For BS = 131-150: Give 1 unit<br><br>For BS = 151-180: Give 2 units<br><br>For BS = 181-210: Give 3 units<br><br>For BS = 211-240: Give 4 units<br><br>For BS = 241-270: Give 5 units<br><br>For BS = 271-300: Give 6 units<br><br>For BS = 301-330: Give 7 units<br><br>For BS = 331-360: Give 8 units<br><br>For BS = 361-400: Give 10 units<br><br>If BS greater than 400 mg/dl, Give 12 units and notify MD (Medical Doctor)<br><br>-Insulin glargine (a long-acting insulin) KwikPen subcutaneous solution pen-injector (disposable insulin delivery device) 100 unit/ml, inject 10 unit subcutaneously (under the skin) at bedtime for DM2.<br><br>- Glipizide (an oral medication used to lower blood glucose by stimulating the release of insulin), 5 mg (milligram, a unit of measure), give one table by mouth two times a day for DM2. Take 30 minutes before a meal.<br><br>During a medication administration observation in Resident 31's room, on 9/30/24 at 9:51 a.m., LN 1 administered 5 units of insulin glargine 100 u/ml and one tablet of glipizide 5 mg to Resident 31 after breakfast while LN 1 did not administer Resident 31's sliding scale Humulin R insulin.<br><br>During an interview on 9/30/24 at 9:55 am with LN 1, LN 1 stated Humulin R was not given since Resident 31's morning blood sugar level was at 466 mg/dl and the insulin sliding scale order only covered up to 400 mg/dl. LN 1 referred to the Medication Administration Record (MAR) insulin calculator tool showing that based on Resident 31's blood sugar level of 466 mg/dl, the sliding scale indicated that this order did not need to be administered.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a reconciliation (review of medications observed being administered against the physician orders) of the observation of medication administration with Resident 31's active Physician Orders indicated an order for glipizide 5mg, give one tablet by mouth two times a day for Diabetes Mellitus 2. Take 30 minutes before a meal. The Physician Order also included orders for the sliding scale Humulin R Insulin.<br><br>During an interview on 9/30/24 at 11:25 a.m. with LN 1, LN 1 acknowledged that Resident 31's insulin Humulin R order should have been administered in the morning. LN 1 further stated that she had not re-checked Resident 31's blood glucose and she had not notified the physician.<br><br>During an interview on 9/30/24 at 11:30 a.m. with LN 1, LN 1 acknowledged the order stated to administer Resident 31's glipizide 5 mg 30 minutes before a meal. LN 1 stated Resident 31's breakfast tray was delivered about thirty minutes before the glipizide 5 mg was given on 9/30/24.<br><br>A review of the meal schedule posted in the hallway for 9/30/24 indicated, the kitchen started serving breakfast at 7:05 a.m. 9/30/24.<br><br>During an interview on 9/30/24 at 11:31 a.m. with LN 1, LN 1 stated Resident 31 had a BS of 353 mg/dl before lunch and 15 units of Humulin R insulin were given to the resident.<br><br>A review of Resident 31's progress notes on 9/30/24 at 11:32 a.m., LN 1 had documented 10 units of Humulin R insulin, and 5 units of glargine were administered to Resident 31.<br><br>During an interview on 9/30/24 at 12:45 p.m. with LN 1, LN 1 stated the blood sugar was high per the glucometer (a device that measures blood sugar level) at 12:45 p.m. LN 1 did not know what a high level reading meant in regard to Resident 31's blood's glucose level.<br><br>A review of Resident 31's MAR printed on 9/30/24 at 6:04 p.m. stated Resident 31 had only received 8 units of Humulin R insulin by LN 1, not the 15 units LN 1 reported, or the 10 units LN 1 had documented on the progress notes.<br><br>A review of the glucometer's manual, dated 10/1/24, indicated, a high reading would be the amount of glucose greater than 600 mg/dl.<br><br>During a review of an online publication on the computer, obtained from the internet, on the importance of diabetes care by the Mayo Clinic, Mayo Foundation for Medical Education and Research (a nonprofit American academic medical center focused on integrated health care, education, and research), if blood sugar level goes above 600 mg/dL, the condition is called diabetic hyperosmolar syndrome (a life-threatening emergency when blood sugars get too high). When blood sugar is very high, the extra sugar passes from the blood into the urine. That triggers a process that draws a large amount of fluid from the body. If it isn't treated, this can lead to life-threatening dehydration (harmful reduction int the amount of water in the body) and a diabetic coma (unconsciousness).<br><br>During an interview on 9/30/24 at 2:30 p.m. with LN 1, LN 1 stated Resident 31's blood sugar was still high on the glucometer, however, LN 1 was unable to document high on the MAR.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 9/30/24 at 2:48 p.m. with LN 1, LN 1 stated, it had been difficult to reach the physician for the past two hours. LN 1 further stated, I was finally able to reach the physician [14:48 (2:48p.m.)] after the third call, a new order was placed [for Resident 31] to administer 10 units of Humulin R insulin and to recheck [Resident 31's] blood sugar level in 20 minutes.<br><br>During an interview on 9/30/24 at approximately 3:15 p.m. with LN 1, LN 1 stated Resident 31's blood sugar was 577 mg/dl, and 10 units of insulin were given to Resident 31 by LN 2. LN 1 was not able to provide the time of Resident 31's insulin administration and stated that the record had not been completed on the MAR as required. On 9/30/24 at approximately 3:30 p.m., LN 2 stated no insulin had been given to Resident 31 and LN 1 was dealing with Resident 31's insulin. LN 2 also stated Resident 31 was napping and had no issues with high sugar levels. On 9/30/24 at 3:34 p.m. with LN 1, LN 1 stated Resident 31 was doing ok and had no symptoms of hyperglycemia. LN 1 also stated that the ordered dose of insulin was still not administered to Resident 31 regardless of Resident 31's high glucose level.<br><br>During an interview on 9/30/24 at 3:36 p.m. with Resident 31, Resident 31 complained of headache, dizziness, being thirsty, and not feeling well. Resident 31 stated she did not receive her morning insulin and she had never felt this way before.<br><br>During an interview on 9/30/24 at 3:45 p.m. with LN 2, LN 2 stated that Resident 31's blood sugar was still high after using two different glucometers to double check the reading. LN 2 also stated, the 10 units of insulin had been administered.<br><br>A review of Resident 31's MAR dated, 9/30/24, at 3:48 p.m., had no documentation for the dose of insulin that was administered per LN 2 in the 3:45 p.m. interview. The MAR documentation did not include the blood glucose levels including the high readings that were taken at:<br><br>12:45 p.m. High (per glucometer manual: High would be greater than 600 mg/dl),<br><br>2:30 p.m. High,<br><br>3:14 p.m. 577 mg/dl, and,<br><br>3:45 p.m. High & High (two different glucometers were used).<br><br>The MAR indicated for 9/30/24 the 6:30 a.m. BS of 466, 11:30 a.m. BS of 353, and the 4:30 p.m. BS of 517.<br><br>During an interview on 9/30/24 at 4 p.m. with LN 1, LN 1 stated, the physician was just called around 3:55 p. m. and wanted Resident 31 to be sent to the hospital.<br><br>During an observation and interview on 9/30/24 at 4:17 p.m. with Resident 31 in Resident 31's room and stated, she still did not feel good. Resident 31 reported being dizzy, had a headache, and was thirsty while holding a cup of ice in hand.<br><br>During an interview on 9/30/24 at 5:11 p.m. with LN 2, LN 2 stated Resident 31's blood sugar was still elevated at 517 mg/dl and Resident 31 was being sent out to the emergency room .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 9/30/24 at 5:23 p.m. with the DON, the DON stated, that the computer program for documenting the blood sugar levels would only accept numerical values. It would not accept the words high. The DON further stated, the LNs should have followed the Physician Orders to administer the insulin dose on time, reached out to the provider if the blood glucose level was high, or if insulin was not administered, rechecked the levels, and followed the standards of practice. The DON acknowledged that untreated hyperglycemia could cause serious harm.<br><br>During an interview on 10/1/24 at approximately 10 a.m. with the Information Technologist (IT), the IT confirmed that the computer program for documenting the blood sugar levels would only accept numerical value and it was impossible for the nurses to enter high to document the high blood sugar levels.<br><br>During a review of another online publication on the computer, obtained from the internet, on the importance of diabetes care by the Mayo Clinic, it's important to treat hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart.<br><br>During an interview on 10/1/24 at approximately 10 a.m. with the ADM, the ADM stated, it (the missed medications and not calling the doctor) was a hundred percent the nurse's fault [LN 1], and the nurse [LN 1] would not be coming back [to the facility].<br><br>During an interview on 10/1/24 at 11:52 a.m. with the DON, the DON stated, Resident 31 was still at the hospital while now dealing with kidney issues as well.<br><br>During an interview on 10/3/24 at 12:20 p.m. with the DON and the facility's Consultant Nurse (CN), the DON and CN were unable to provide standards of care used within the facility to treat the diabetic residents.<br><br>During an interview on 10/3/24 at 9:26 a.m. with the Consultant Pharmacist (CP), the CP stated that both the morning nurse [LN1] and the afternoon nurse [LN 2] should have called the pharmacy or the physician right away to ask for a recommendation. He acknowledged; the provided diabetes care was inappropriate for Resident 31.<br><br>During an attempt to discuss the details of Resident 31's case with the physician, a message was left on 10/2/24 at 12 p.m. for the physician at the facility provided number. The physician did not call back.<br><br>During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, dated September 2014, the P&P indicated, The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure the correspondence with the order on the medication sheet and the Physician's Order. The nurse shall notify the director of nursing services and attending physician of any discrepancies before giving the insulin.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a review of the facility's P&P titled, Change in a Resident's Condition or Status dated May 2017, the P&P indicated The nurse will notify the Resident's Attending Physician or physician on call when there has been a .significant change in the resident's physical/emotional/mental condition; .A significant change of condition is a major decline or improvement in the Resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41600<br><br>Based on observation, interview, and record review, the facility failed to verify, document, seal, and replace an opened E-Kit (emergency kit, a limited supply of medications in the facility to use during an emergency or after-hours) for a census of 116 residents.<br><br>This failure had the potential to have expired pharmaceutical products, contribute to decreased availability of medications in an emergency or increase the risk of drug diversion.<br><br>Findings:<br><br>During a concurrent observation and interview on [DATE] at approximately 9:15 a.m. with Licensed Nurse (LN) 3 e-kit # 731 was observed to be kept unsealed in the north station medication storage room. LN 3 stated she did not know when the e-kit # 731 was opened and when the e-kit should have been replaced. LN 3 confirmed the opening of the e-kit # 731 was not logged in the e-kit logbook and the contracted facility pharmacy was never contacted for replacement and both pharmacy white labels were not signed by any pharmacists.<br><br>During an interview with the Director of Nursing (DON) on [DATE] at approximately 11:52 am, the DON acknowledged that e-kit # 731 should have been properly labeled with the pharmacist signatures, kept sealed all the time, properly documented the use, and replaced by another sealed e-kit box.<br><br>During an interview with a facility's registered pharmacist (RPh) on [DATE] at approximately 11 a.m., the RPh stated that the e-kit boxes go through a double check process in the pharmacy. Both the top and the bottom white labels on the e-kits need to be signed by two different pharmacists and then the e-kit boxes get sealed and sent to the facility. The RPh was unable to explain why e-kit # 731 did not have any pharmacist signatures on it.<br><br>During a review of the facility's policy and procedure (P&P) titled, Emergency Pharmacy Service and Emergency Kits, dated 2007, the P&P indicated, Emergency medications and supplies are provided by the pharmacy in compliance with applicable state regulations .Upon removal of any medication or supply item from the kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. The hard copy will be retained in the nursing care center .Before reporting off duty, the charge nurse indicates the opened or sealed status of the emergency kit at the shift change report . |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>41600<br><br>Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed 5% for two of 28 sampled residents (Resident 31 and 103).<br><br>1. For Resident 31, Licensed Nurse (LN) 1 did not administer Resident's Humulin Insulin medication used to lower blood sugar level, in accordance with the Physician Order.<br><br>2. For Resident 31, LN 1 did not administer Resident's glipizide, a medication given 30 minutes before breakfast to lower blood sugar level, 5 mg (milligram, unit of measure) in accordance with the Physician Order.<br><br>3. For Resident 103, LN 1 administered lactobacillus, a probiotic to aid in digestion, without clarifying the Physician Order.<br><br>These failures exposed the residents to possible adverse reactions and health complications.<br><br>Findings:<br><br>1. During an observation of medication administration on 9/30/24 at 9:37 a.m., LN 1 was observed to prepare and administer Resident 31's morning medications which did not include Humulin R insulin.<br><br>During a reconciliation (review of medications observed being administered against the physician orders) of the observation of the medication administration with Resident's current Physician Orders indicated an order for Humulin R insulin 100 u/ml (units/milliliter, unit of measure) for Diabetes Mellitus 2, a condition whereby the body ineffectively metabolizes sugar. Furthermore, the order indicated administer insulin based on the resident's blood sugar level before meals according to the following blood sugar levels: 70 - 130 mg/dl (milligram/deciliter, unit of measure) give 0 units; 131 - 150 mg/dl give 1 unit; 151 - 180 mg/dl give 2 units; 181 - 210 mg/dl give 3 units; 211 - 240 mg/dl give 4 units; 241- 270 mg/dl give 5 units; 271 - 300 mg/dl give 6 units; 301 - 330 mg/dl give 7 units; 331 - 360 mg/dl give 8 units; 361- 400 mg/dl give 10 units; If blood sugar is greater than 400 mg/dl, give 12 units and notify MD (Medical Doctor).<br><br>During an interview on 9/30/24 at 11:25 a.m. with LN 1, LN 1 stated Resident 31 did not receive any insulin per sliding scale (various units of insulin based on blood sugar levels) since the blood sugar level was 466 mg/dl at 6 a.m. LN 1 demonstrated the Medication Administration Record (MAR) insulin dose calculator tool and stated, based on the Blood Sugar Value entered, the sliding scale indicated that the Resident's insulin order did not need to be administered. LN 1 further stated she had not checked the blood sugar level since it was checked at 6 a.m.<br><br>During continued interview with LN 1 when asked how the dose of insulin for the administration was calculated, LN 1 responded based on Resident 31's blood sugar level of 466 mg/dl, the sliding scale insulin order (various units of insulin based on blood sugar levels) was used to calculate the dose that was not administered.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the Director of Nurses (DON) on 9/30/24 at 5:23 p.m., the DON admitted LN 1 failed to give the medication as ordered and notify the MD.<br><br>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber order, including any required time frame.<br><br>2. During an observation of medication administration on 9/30/24 at 9:37 a.m., LN 1 administered Resident 31's Glipizide 5 mg after breakfast when the breakfast trays had been removed from the room.<br><br>During a reconciliation of the observation of medication administration with Resident 31's current Physician Orders, indicated an order for Glipizide 5mg, give one tablet by mouth two times a day for DM2. Take 30 minutes before a meal.<br><br>During an interview on 9/30/24 at 11:30 a.m. with LN 1, LN 1 stated Resident 31's breakfast tray was delivered thirty minutes before the medication was given. The LN 1 also acknowledged the order stated the medication should be taken 30 minutes before a meal.<br><br>During a review of the facility's policy and procedure P&P titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber order, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions .<br><br>3. During an observation of medication administration on 9/30/24 at 9:54 a.m., LN 1 administered one tablet of lactobacillus to Resident 103.<br><br>During a reconciliation of the observation of medication administration with Resident 103's Physician Order, the order indicated 1 capsule by mouth one time a day for skin infection.<br><br>Review of dosing recommendation, serving size, and the strength listed on the label printed on the bottle of lactobacillus, indicated to take two 500,000 million unit capsules as single serving size.<br><br>During an interview on 9/30/24 at 11:30 a.m. with LN 1, stated she had not noticed that there was no strength on the Physician Order, and she had not paid attention to the label on the lactobacillus that was in the medication cart.<br><br>During an interview on 9/30/24 at 5:23 p.m. with the DON, the DON acknowledged the nurse should have notified the MD, charge nurse, or the DON. Staff failed to follow standard practice of care to meet resident's needs.<br><br>During a review of the facility's policy and procedure P&P titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber order, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions .Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). |

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| | 056177 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Double Tree Post Acute Care Center | 7400 24th Street<br>Sacramento, CA 95822 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>41600<br><br>Based on observation, interview, and record review, the facility failed to ensure one of 28 sampled residents, Resident 31 was free from significant medication errors when:<br><br>1. For Resident 31, Licensed Nurse (LN) 1 did not administer Resident's Humulin R Insulin, medication used to lower blood sugar level, in accordance with the Physician Order.<br><br>2. For Resident 31, LN 1 did not administer Resident's glipizide, medication to be given 30 minutes before breakfast used to lower blood sugar level, 5 mg (milligram, unit of measure), according to the physician order.<br><br>These failures resulted in Resident 31's elevated blood sugar levels and subsequent signs and symptoms of high blood sugar (headache, dizziness, thirsty, and not feeling well), and had the potential to result in a diabetic coma (a life-threatening condition that occurs when someone with diabetes experiences dangerously high or low blood sugar levels, leading to unconsciousness).<br><br>Findings:<br><br>1. During an observation of medication administration on 9/30/24 at 9:37 a.m., LN 1 was observed to prepare and administer Resident 31's morning medications which did not include Humulin R insulin.<br><br>Reconciliation of the observation of the medication administration with Resident's current Physician Orders indicated an order for Humulin R insulin 100 u/ml (units/milliliter, unit of measure) for Diabetes Mellitus 2, a condition whereby the body ineffectively metabolizes sugar. Furthermore, the order indicated administer insulin based on the resident's blood sugar level before meals according to the following blood sugar levels: 70 - 130 mg/dl (milligram/deciliter, unit of measure) give 0 units; 131 - 150 mg/dl give 1 unit; 151 - 180 mg/dl give 2 units; 181 - 210 mg/dl give 3 units; 211 - 240 mg/dl give 4 units; 241- 270 mg/dl give 5 units; 271 - 300 mg/dl give 6 units; 301 - 330 mg/dl give 7 units; 331 - 360 mg/dl give 8 units; 361- 400 mg/dl give 10 units; If blood sugar is greater than 400 mg/dl, give 12 units and notify MD.<br><br>During an interview on 9/30/24 at 11:25 a.m. with LN 1, LN 1 stated Resident 31 did not receive any insulin per sliding scale (various units of insulin based on blood sugar levels) since the blood sugar level was 466 mg/dl at 6 a.m. LN 1 demonstrated the Medication Administration Record (MAR) insulin dose calculator tool and stated, based on the Blood Sugar Value entered, the sliding scale indicated that the Resident's insulin order did not need to be administered. LN 1 further stated she had not re-checked the blood sugar level since it was checked at 6 a.m.<br><br>During an interview on 9/30/24 at 3:36 p.m. with Resident 31, Resident 31 complained of headache, dizziness, being thirsty, and not feeling well. Resident 31 stated she did not receive her morning insulin and she had never felt this way before.<br><br>During an interview on 9/30/24 at 5:23 p.m. with the Director of Nursing (DON), the DON acknowledged LN 1 failed to administer resident's insulin as ordered and LN 1 failed to notify the Physician when the dose was not given.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to Institute for Safe Medication Practices (ISMP), updated in 2017, insulins, all formulations and strengths are considered to be high-alert medications.<br><br>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber order, including any required time frame .The individual administering the medication Checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) before giving the medication.<br><br>During a review of the facility's P&P titled, Insulin Administration, dated September 2014, the P&P indicated, The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure the correspondence with the order on the medication sheet and the Physician's Order. The nurse shall notify the director of nursing services and attending physician of any discrepancies before giving the insulin.<br><br>2. During an observation of medication administration on 9/30/24 at 9:37 a.m., LN 1 administered Resident 31's glipizide 5 mg after breakfast when the breakfast trays had been removed from the room.<br><br>Reconciliation of the observation of medication administration with Resident 31's current Physician Orders indicated an order for glipizide 5 mg, give one tablet by mouth two times a day for Diabetes Mellitus 2. Take 30 minutes before a meal.<br><br>During an interview on 9/30/24 at 11:30 a.m. with LN 1, LN 1 stated Resident 31's breakfast tray was delivered about thirty minutes before the medication was given. LN 1 also acknowledged the order stated to administer the medication 30 minutes before a meal.<br><br>During an interview on 9/30/24 at 5:25 p.m. with the DON, the DON acknowledged LN 1 failed to give resident's glipizide 30 minutes before serving breakfast, as ordered.<br><br>During a review of the facility's P&P titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber order, including any required time frame . Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions .The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) before giving the medication. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50312<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly, when:<br><br>1. Three unopened bottles of latanoprost ophthalmic solution, an eye drop medication used to treat an eye condition, 0.005% (percentage, unit of measure), 2.5 ml (milliliter, unit of measure) were not kept in the medication refrigerator per manufacturer's instructions before opening.<br><br>2. An opened glucose test strip bottle was found in the medication cart #1 did not have an open date to determine its expiration date.<br><br>3. An opened bottle of insulin lispro, medication used to treat high blood sugar levels, 100 unit/ml (unit per milliliter, unit of measure), was found in the medication cart #1 without an open date to determine its expiration date.<br><br>4. Two expired 5 ml multidose vials of Tuberculin purified protein derivative testing agents, a solution used in a skin test to diagnose latent tuberculosis infection, were found in the North Station Medication room's refrigerator.<br><br>5. One prescription bottle of polyethylene glycol with electrolytes, a laxative used to clean out the bowel, was found in the North Station Medication room without patient specific prescription label.<br><br>6. Temperature of medication refrigerator in the North Station Medication room was out of range at 30 degrees F (Fahrenheit, unit of measure).<br><br>These failures had the potential for medication error, misuse, or administering expired and ineffective medications to the residents.<br><br>Findings:<br><br>1. During an inspection of medication cart #1 with Licensed Nurse (LN) 4 on 9/30/24 at 3:31 p.m., three unopened bottles of latanoprost were found in the medication cart #1.<br><br>During a review of latanoprost Provider Information (PI), last revised 8/2011, the PI indicated Store unopened bottle(s) under refrigeration at 36 to 46 degrees F .Once a bottle is opened for use, it may be stored at room temperature up to 77 degrees F for 6 weeks.<br><br>During an interview with LN 4 on 9/30/24 at 3:45 p.m., LN 4 acknowledged that the three bottles were supposed to be refrigerated before opening.<br><br>During an interview with the DON on 9/30/24 at 5:23 p.m., the DON stated that staff need to follow manufacturer's instructions and store pharmaceutical products accordingly.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility policy titled, Storage of Medications dated November 2020, Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly.<br><br>2. During an inspection of medication cart 1 with LN 4 on 9/30/24 at 3:31 p.m. an open container of glucose test strips with no open date was found.<br><br>During an interview on 9/30/24 at 3:31 p.m. with LN 4, LN 4 acknowledged that the test strips were supposed to be dated when opened in order to determine the test strips' expiration date.<br><br>A Review of the bottle of test strip's product label printed on the bottle, the product label indicated to use within 6 months after first opening.<br><br>During an interview on 9/30/24 at 5:25 p.m. with the DON, the DON acknowledged that staff were expected to follow the policy and document the expiration and open dates.<br><br>Review of the facility policy titled, Administering Medications dated April 2019, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.<br><br>3. During an inspection of medication cart 1 with LN 4 on 9/30/24 at 3:31 p.m., an opened 10 ml bottle of insulin lispro 100 units/ml was not labeled with the date the bottle was opened.<br><br>During an interview on 9/30/24 at 3:35 p.m. with LN 4, LN 4 acknowledged that the opened bottle of insulin was not labeled with the date it was opened.<br><br>A review of insulin lispro provider information, dated September 2023, indicated, lispro must be used within 28 days after opening.<br><br>During an interview on 9/30/24 at 5:30 p.m. with the DON, the DON acknowledged that staff were expected to follow the policy of labeling a container when opened, and not using beyond the manufacturers recommended expiration date.<br><br>Review of the facility policy titled, Administering Medications, dated April 2019, the policy indicated, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.<br><br>4. During an inspection of the medication room on 10/2/24 at 9:31 a.m. with LN 3, two 1 ml vials of Tuberculin Purified Protein Derivative (PPD) were opened on 8/11/24 and 8/28/24.<br><br>Review of the label printed on the PPD box stated, Discard opened product after 30 days.<br><br>During an interview on 10/2/24 at 9:35 a.m. with LN 3, LN 3 acknowledged that the two vials were expired on 9/9/24 and 9/26/24.<br><br>During an interview on 10/2/24 at 11:52 a.m. with the DON it was acknowledged that the expectation for staff was to remove expired medications.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility policy titled, Administering Medications dated April 2019, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.<br><br>5. During an inspection of the medication room with LN 3 on 10/2/24 at 9:51 a.m. a container of polyethylene glycol with electrolytes was found without a patient specific prescription label on product.<br><br>During an interview on 10/2/24 at 9:55 a.m. with LN 3, LN 3 acknowledged that the required patient label was not on the product and this could have contributed to a medication error.<br><br>During an interview on 10/2/24 at 11:55 a.m. with the DON, the DON acknowledged the container needed to be returned to the pharmacy in order to have a proper patient specific label.<br><br>Review of the facility policy titled, Labeling of Medication Containers dated April 2019, any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy.<br><br>6. During an inspection of the medication room on 10/2/24 at 9:15 a.m. with LN 3, the temperature of the medication refrigerator was out of range. The thermometer inside the refrigerator and the halter monitor both were at 30 degrees F.<br><br>During an interview on 10/2/24 at 9:18 a.m. with LN 3, LN 3 acknowledged that the refrigerator contained pharmaceutical products and the temperature was not within the required range.<br><br>During an interview on 10/2/24 at 11:57 a.m. with the DON, the DON acknowledged that the medication refrigerator was out of range and in order to safely store pharmaceutical medications that require refrigeration the temperature needs to be between 36 degrees F and 46 degrees F.<br><br>A review of facility temperature log for the month of September in 2024, indicated, the refrigerator temperature was out of range for 13 out of 30 days. The range on the temperature log stated Refrigerators should be between 36 degrees F and 46 degrees F. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>46872<br><br>Based on observation, interview, and record review, the facility failed to ensure two of 25 sampled residents' (Resident 100 and Resident 72) planned meal tray tickets (guidance to staff on what to serve for a meal to a resident) were accurate and followed.<br><br>This failure had the potential to negatively impact Resident 100's and Resident 72's nutritional status and potentially result in unplanned weight lost.<br><br>Findings:<br><br>Resident 100 was admitted to the facility January 2024 with multiple diagnoses which included muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue) and protein-calorie malnutrition.<br><br>Resident 72 was admitted to the facility February 2024 with multiple diagnoses which included muscle weakness and protein-calorie malnutrition.<br><br>During a concurrent observation and interview on 9/30/24, at 11:57 a.m., in the Dining Room, Resident 100's supplement drink was observed missing from his meal tray. Resident 100's meal tray ticket indicated, House Supplement. The Dietary Supervisor (DS) acknowledged the supplement drink was missing and stated, Will grab it now, not sure why it didn't come.<br><br>During a concurrent observation and interview on 9/30/24, at 12:01 p.m., in the Dining Room, Resident 72's supplement drink was observed missing from her meal tray. Resident 72's meal tray ticket indicated, House Supplement. Certified Nursing Assistant (CNA) confirmed that Resident 72's meal tray was supposed to have the supplement drink. CNA stated it was the kitchen staff's responsibility to put the house supplement drink on the meal tray.<br><br>During an interview with the Registered Dietician (RD), on 10/1/24, at 10:27 a.m., the RD stated Resident 100 and Resident 72 were receiving house supplement drinks during meals to prevent weight loss. The RD confirmed residents not receiving meal trays that accurately reflect the meal tray ticket could potentially result in their nutritional needs not being met. The RD stated the expectation was for the meal tray tickets to accurately match the meal tray the residents received.<br><br>During an interview with the Director of Nursing (DON), on 10/2/24, at 12:34 p.m., the DON stated the expectation were that residents received meals trays that match their meal tray ticket. The DON confirmed residents not receiving their ordered supplement drinks had the potential to have continued weight lost.<br><br>During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, revised 10/17, the P&P indicated, Each resident is provided with a nourishing .diet that meets his or her daily nutritional and special dietary needs .Food and nutrition services staff will inspect food trays to ensure that the correct meals is provided to each resident . |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>46872<br><br>Based on observation and interview, the facility failed to maintain the walk-in freezer in safe operating condition in a census of 115 residents who received facility prepared foods, when the walk-in freezer had ice buildup on the walls, ceiling, and boxes of food.<br><br>This failure had the potential to cause the freezer to not operate efficiently, which would result in possible contamination of food leading to food borne illnesses and decreased food quality.<br><br>Findings:<br><br>During a concurrent observation and interview with the Dietary Manager (DM), on 9/30/24, at 8:56 a.m., the walk-in freezer revealed ice buildup on two separate food boxes, on the floor, walls, and ceiling. The DM stated he was aware of the ice buildup in the freezer, and it was caused by the fluctuating temperature from the door opening and closing.<br><br>During an interview with the Maintenance Supervisor (MS), on 10/1/24, at 8:36 a.m., the MS confirmed he was aware of the ice buildup in the freezer. MS stated the ice buildup was probably due to old equipment and insulation issues. MS stated he was not aware that ice buildup could potentially affect the quality of the food in the freezer.<br><br>During an interview with the Registered Dietician (RD), on 10/1/24, at 10:27 a.m., the RD confirmed she was aware of the ice buildup in the freezer. RD stated the ice buildup could potentially cause ice burn to the food and affect food quality.<br><br>During an interview with the Director of Nursing (DON), on 10/2/24, at 12:34 p.m., the DON confirmed she was aware of the ice buildup in the freezer and that it was an ongoing issue. The DON stated the ice could potentially seep through boxes and contaminate food which would affect food quality and food safety for all residents.<br><br>During a review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness-Food Handling, revised 7/14, the P&P indicated, Food will be stored .so that the risk of foodborne illness is minimized .facility recognizes that the critical factors implicated in foodborne illness are .contaminated equipment .facility strives to minimize the risk of foodborne illness to our residents.<br><br>During a review of the facility's job description, Maintenance Director, revised 3/22/21, the job description indicated, .ensure that .equipment are maintained in a safe, clean, attractive, efficient and fully operational manner . |