| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 105283 | A. Building<br>B. Wing | 04/11/2025 |

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| Lakeland Hills Center | 610 E Bella Vista Dr<br>Lakeland, FL 33805 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570<br><br>Based on record review and interviews, the facility failed to protect the residents' right to be free from neglect for four residents (#4, #5, #3, and #2) out of six residents sampled related to 1) failure to accurately reconcile medications, 2) failure to follow-up on physician orders for laboratory testing, medical equipment, and outpatient services, 3) failure to provide medication with a physician's order, 4) failure to follow a physician's order for blood sugar testing, and 5) failure to implement hospice consultation orders.<br><br>Serious harm occurred on [DATE], when Resident #4's seizure medications were not reconciled accurately, resulting in Resident #4 experiencing two seizures. After the seizures, physician ordered laboratory tests for seizure medication levels were not implemented, and Resident #4 had a third seizure resulting in a fall with head trauma and transfer to a higher level of care. Resident #4 subsequently died from his injuries.<br><br>Serious harm occurred on [DATE], when Resident #5's seizure medications were not reconciled accurately, resulting in seizure like activity requiring a transfer to a higher level of care.<br><br>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to an E after verification of removal of immediacy of harm.<br><br>Findings included:<br><br>1) Review of Resident #4's admission record revealed a readmitted [DATE] from a hospital stay, and a discharge date of [DATE], with diagnoses to include unspecified fall, difficulty in walking, muscle wasting and atrophy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other seizures, and gastrostomy status.<br><br>Review of Resident #4's hospital discharge records revealed the following:<br><br>-A progress note, dated [DATE], . ,d+[DATE]: Had a seizure episode overnight, now calm and no further episodes, discussed w [with] Neurology, will increase Keppra dose to 1000 mg [milligrams] bid [twice a day] and to continue it on discharge.<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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -DC [discharge] planning note, dated [DATE], Lying in bed in no distress no further seizure episodes on Keppra 1000 mg b.i.d. DC planning ongoing pending authorization and placement .<br><br>Review of Resident #4's hospital after visit summary, dated [DATE] - [DATE], revealed the following:<br><br>--Call [Medical Doctor's name], MD [Medical Doctor] in 1 week . Needs follow-up with his cardiologist for outpatient TEE [transesophageal echocardiogram] and loop recorder placement, As needed, If symptoms worsen.<br><br>The hospital after visit summary, revealed the following change to Resident #4's medication list:<br><br>--Levetiracetam [generic name for Keppra] 1000 MG tablet . 1 tablet (1,000 mg total) by Per G- Tube [gastrostomy tube] route in the morning and 1 tablet (1,000 mg total) before bedtime. Last time this was given: [DATE], 9:00 AM . What changed: medication strength, how much to take, how to take this, when to take this .<br><br>Review of Resident #4's admission assessment, dated [DATE], revealed under the drug regimen review section, Drug Regimen Review was reviewed by the practitioner on admission completed to include medication reconciliation completed upon admission/readmission, [electronic health record] Order Entry Warnings and any applicable Pharmacy Recommendations, and found 1. No clinically significant findings.<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On [DATE] at 10:10 a.m., [Medical Doctor] notified at 0948 by this writer that resident's medications need to be reviewed as the pharmacist stated that the following medications cannot be given via G-tube- . Levetiracetam . This writer requested that [Medical Doctor] give orders to replace the following medications.<br><br>-On [DATE] at 1:21 p.m., a progress note created by Staff G, Licensed Practical Nurse, (LPN) revealed the following, [Medical Doctor] again notified now time is 1321 [1:21 PM], this writer requested that the following 4 medications be reviewed as per the pharmacist the 4 medications cannot be given via G-tube . Keppra . This writer is waiting on [Medical Doctor] to review these 4 medications and give orders for replacement medications.<br><br>-On [DATE] at 1:40 p.m., a progress note created by Staff G, LPN revealed the following, . [Medical Doctor] notified that resident has 4 medications that cannot be given via G-tube per the pharmacist. Awaiting response back from [Medical Doctor].<br><br>-On [DATE] at 2:26 p.m., a progress note created by Staff G, LPN revealed the following, [Medical Doctor] responds with - . 2.) Change the order for the Keppra to a solution.<br><br>Review of Resident #4's physician orders on readmission to the facility revealed the following:<br><br>-Levetiracetam (generic drug name for Keppra) Oral Tablet 750 MG Give 1 tablet by mouth one time a day for Seizure, with a start date of [DATE] and discontinued (d/c) date of [DATE].<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -Levetiracetam Oral Tablet 1000 MG Give 1 tablet via G-Tube every morning and at bedtime for Seizure, with a start date of [DATE], and end date of [DATE].<br><br>-Levetiracetam Oral Solution 100 MG/ML [milliliter] Give 7.5 ml [total dose 750 MG] by mouth one time a day for Seizures, with a start date of [DATE].<br><br>-Levetiracetam Oral Solution 100 MG/ML Give 7.5 ml [total dose 750 MG] via G-Tube one time a day for Seizures, with a start date of [DATE].<br><br>Review of Resident #4's [DATE] Medication Administration Record (MAR) revealed:<br><br>- Levetiracetam oral tablet 1000 mg, give 1 tablet by g-tube every morning and at bedtime for seizures, with a start date of [DATE] and d/c date of [DATE], was administered on [DATE], [DATE], and a code of 9 =Other / See Nurse Notes, on [DATE] for the morning dose.<br><br>-Levetiracetam oral solution 100 mg/ml, give 7.5 ml [total 750 MG] by g-tube one time a day for seizures, with a start date of [DATE] was administered daily as ordered.<br><br>Review of Resident #4's [DATE] MAR revealed:<br><br>-Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered as ordered daily, except on [DATE] which documented 2=Drug Refused.<br><br>Review of Resident #4's [DATE] MAR revealed:<br><br>-Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered daily as ordered.<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On [DATE] a progress note revealed the following, Notified blood was residents sheets, entered room noted was standing next to his bed with no shoe's or socks on. resident had a dressing on the right wrist and the right elbow. resident also has an abrasion above the right eye. Resident stated, i fell , i may have had a seizure' .<br><br>-On [DATE] a progress note created by Staff G, LPN revealed the following, This writer called lab spoke with [lab technician] regarding stat Keppra lab, advised this cannot be done stat that it has to be scheduled to be drawn tomorrow morning.<br><br>Review of Resident #4's laboratory orders revealed the following:<br><br>-STAT [immediately] Keppra level with a start date of [DATE] and the order status was marked as, Completed.<br><br>Review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -STAT Keppra level. STAT, with an order and completed date of [DATE] documented by Staff G, Licensed Practical Nurse (LPN).<br><br>A review of laboratory reports in the medical record revealed no results related to seizure medication levels had been recorded for [DATE].<br><br>Review of Resident #4's February 2025 MAR revealed Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered daily as ordered, with the exception of [DATE].<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On [DATE] a progress note created by Staff J, LPN revealed the following, Resident had seizure while sleeping. It lasted approximately 5 minutes. Family member and DON [Director of Nursing] were notified. The doctor was notified. New orders: . Levetiracetam levels and continue to monitor resident.<br><br>Review of Resident #4's laboratory orders revealed the following:<br><br>-Levetiracetam levels one time only for seizure for 1 Day, with a start date of [DATE] and the order status was marked as, Completed.<br><br>Review of Resident #4's February 2025 TAR revealed the following:<br><br>-Levetiracetam levels one time only for seizure for 1 Day, with a start date of [DATE] and completed on [DATE].<br><br>A review of laboratory reports in the medical record revealed no results related to seizure medication levels had been recorded for [DATE].<br><br>Review of Resident #4's [DATE] MAR revealed Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered daily as ordered, with the exception of [DATE].<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On [DATE] a progress note created by Staff H, LPN/Nurse Supervisor revealed the following, Observed on floor at end of 200 hall laying on his right side .Bleeding noted from right nostril. Patient appeared to be having a seizure like activity. MD notified. EMS [Emergency Medical Services] called. Vitals obtained. Call placed to patients [family member]. Patient appeared to coming out of seizure like activity when he left facility via EMS. Hematoma noted to right side of face and head as patient was leaving facility via EMS.<br><br>Review of Resident #4's hospital records, dated [DATE], revealed the following:<br><br>--An ED [Emergency Department] Urgent Triage note, Per EMS, facility states that pt had a seizure, fell to the ground and hit his nose. No thinners [blood thinners]. No LOC [loss of consciousness]. Pt [patient] is post ictal. Hx [history]: Szs [seizures], Stroke, facial droop and dysphagia .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -- A physician note, At 935 was called to the CT [computed tomography] scan suite after the CT scan the head was initially performed. The patient had appeared to have another seizure. Patient was given 2 mg of Ativan. The patient was altered as well. Patient was not responsive and not answering questions. The CT scan resulted and showed multiple bleeds. There is a subdural bleed on the right side. There is also an intraparenchymal bleed in the temporal parietal lobe that is approximately 6 cm [centimeters] x 3.5 cm in size. Also, intraventricular bleed and now in the occipital plate. No herniation. I was able to speak to the [family member]. She is the POA [power of attorney]. I have informed her about the CT scan results and the blood work so far. I have told her that the patient has a significant intracranial hemorrhage. Patient [family member] has told me that the patient is very demented. He appears to not like the nursing home where he is staying. He has a history of alcohol abuse and several strokes and advanced dementia. I have informed her that the patient is not likely going to return to his previous mental state. I have told her that I am concerned about the patient's airway and think about intubating the patient, but the [family member] does not want that done. She wants comfort measures only. I have informed her that the patient may die within the next 24 to 48 hours depending on how advanced the bleeding is. She states she understands this. She wants the patient to be comfortable. Therefore, the patient will be admitted under comfort measures only. I have spoken to [Palliative Care Physician] and informed him about the POA's decision and also patient's current condition, CT scan results and blood work. He is agreeable with admission. The patient is currently stable with a normal blood pressure pulse oximetry is 94% and he still unarousable.<br><br>--A discharge summary, with an admitted [DATE] and a discharge date of [DATE], revealed the following, . The patient expired on [DATE] at 05:25.<br><br>A phone interview was conducted on [DATE] at 3:15 p.m. with Staff G, LPN. She said she does not remember putting an order in for Levetiracetam for Resident #4, but if she did it was because the doctor told her to. Staff G, LPN said if she put the Levetiracetam order for a solution then, That's what the doctor ordered. She said if the Levetiracetam order was put in for a tablet, then it was done incorrectly. Staff G, LPN stated, You can't put a tablet in a G-tube. She said before making changes to orders, she called the doctor and pharmacy. She said when there's a change from tablet to solution, she would have documented that she called the doctor and pharmacy.<br><br>A phone interview was conducted on [DATE] at 9:01 a.m. with Resident #4's Primary Care Physician (PCP) while admitted at the facility. She said Resident #4 had dementia, falls, confusion, and a G-tube. She stated when a resident is admitted from the hospital, We get notified when we get a patient, nurses go over medications with us, we say continue or stop, they are supposed to transcribe medication list to [electronic health record]. The PCP stated, Whatever hospital sends the patient on [in reference to medications], that's what they should start giving at the facility. She confirmed the order for Keppra 750 mg daily by g-tube was started on [DATE]. The PCP said the initial order at the facility was 750 mg. She said sometimes anti-seizure medication levels are ordered. She said if the levels are low, then they would increase the dosage. She stated, We don't always do levels, only if there is a medical necessity such as seizures. He was pretty stable. The PCP said before Resident #4 fell , they were thinking he had a urinary tract infection (UTI) and therefore ordered blood work. She said Resident #4 had Klebsiella pneumoniae in his urine, which contributed to his confusion and fall.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A follow-up phone interview was conducted on [DATE] at 9:49 a.m. with the PCP. She said it appears he was underdosed initially and Keppra was increased to 1000 mg twice a day. She said she talked to her team and Resident #4 had sedation and lethargy, which is probably why Keppra was decreased to 750 mg once a day. The PCP said she did not have documentation to support Resident #4 was sedated. She stated, That's the best we remember how that happened. She confirmed she changed the Keppra order to a liquid solution, as that is the preferred consistency for a G-tube medication administration. She stated, Honestly, I don't remember if I gave the order to change the dose or not. The PCP stated, I can't access labs from [electronic health record] to see the Keppra level lab results, it's not integrated. She said on [DATE] his urine culture, complete blood count (CBC), and electrolytes were completed. The PCP said she documented that he had a UTI. She said, I heard that he [Resident #4] was found to have a brain tumor, but I don't have confirmation.<br><br>An interview was conducted on [DATE] at 10:30 a.m. with the Director of Nursing (DON) and Regional Risk Manager/Registered Nurse (RN). The DON said Resident #4 came to the facility with a primary diagnoses of Cerebral Vascular Accident (CVA). The DON confirmed Resident #4 had a history of seizures. He said in morning meetings they review new admissions, readmissions, risk events, return to hospitals, falls and incidents, and changes to orders. He said morning meetings occur Monday through Friday and on Monday's they review a 72-hour report. The DON said he spoke to Resident #4's PCP that morning to confirm she approved the Keppra order for 750 mg once a day. The DON confirmed there was no documentation of the physician requesting the order dose and frequency to be changed. The DON confirmed there is only documentation for the Keppra order to be changed to a solution. The DON said the PCP told him Resident #4 was not having any seizure activity, therefore, there wasn't any reason to check the Keppra levels. The DON said he didn't know the order was changed. He said he heard Resident #4 had a brain tumor and he was given days to weeks to live. He stated, It wasn't a seizure, it was a mass in his whole brain. He said Resident #4 did not return to the facility. The DON said when a new admission comes to the facility, the expectation is the nurses complete an assessment on the resident, call the physician to reconcile the medication with the hospital discharge medications, then the nurses input the medications into the EMR, then the orders are sent to the pharmacy to be filled, and medications are sent to the facility. He said at morning meeting, the next morning or on Monday, if they were admitted over the weekend, the hospital discharge medications are reconciled with the orders that were input into the system to ensure they were input accurately. The DON said when a medication order changes it is also reviewed during morning meetings. The DON confirmed there should be documentation if the nurse talks with the physician and the physician wants to change the dose and/or frequency of a medication.<br><br>On [DATE] at 1:57 p.m., an interview with the DON revealed no Keppra level results were completed for Resident #4 as ordered on [DATE] and [DATE].<br><br>A phone interview was conducted on [DATE] at 2:26 p.m. with Staff M, Director of Admissions. She confirmed she completes a follow-up on orders from the hospital such as a CPAP [continuous positive airway pressure] or oxygen. She stated she might help with facilitating getting a heart monitor for a resident, if she's aware of it. She said she started in the Director of Admissions position in [DATE] and was not involved in Resident #4's initial admission to the facility. She is not aware if the staff member in the position prior knew of Resident #4's outpatient orders. Staff M, Director of Admissions said she never received a referral from the hospital when Resident #4 was admitted on [DATE]. She said she made multiple attempts to speak with the social worker at the hospital. Staff M, Director of Admissions said she was able to confirm Resident #4's diagnosis when he was admitted to the hospital which was, Fall at facility from a seizure.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On [DATE] at 4:26 p.m., an interview with the DON revealed Resident #4's transportation to the cardiology appointment was scheduled through his insurance, but the transportation has no record they came to the building. The DON confirmed Resident #4 never went to the cardiologist appointment. He stated, He [Resident #4] never had the monitor. He said the order for the appointment should have returned to the transportation scheduler. The DON stated the orders from the hospital to schedule an appointment with cardiology, Should have come to me.<br><br>A phone interview was conducted on [DATE] at 9:50 a.m. with the consulting pharmacist. He said on [DATE], Resident #4's physician order for Keppra was initially a tablet by mouth. He said the original order on [DATE] was 750 mg once a day for seizures. The consulting pharmacist said on [DATE] there was an order for 1000 mg every morning, then it was discontinued on [DATE]. He said the order for Keppra 1000 mg, Never went out, and confirmed they had a discontinued electronic order. The consulting pharmacist said there's no documentation of why it didn't go out to the facility. He stated, It looks like the first liquid order was [DATE]. The consulting pharmacist said the Keppra solution order was 750 mg one time a day for seizures. He said the only medication that was delivered on [DATE] was for Keppra 750 mg tablet, once a day. He confirmed 7. 5 ml/mg is not equivalent to a 1000 mg tablet. He stated, 1000 mg would be equivalent to 10 ml.<br><br>2) A review of Resident #5's admission record revealed an initial admitted [DATE] and a re-admitted [DATE], with diagnoses to include epilepsy, anoxic brain damage, muscle wasting and atrophy, muscle weakness, gastrostomy status, and tracheostomy status.<br><br>Review of Resident #5's hospital discharge medication list, dated [DATE], revealed the following:<br><br>-Aspirin, 81 mg, per feeding tube, tab [tablet], daily, first dose: [DATE] 09:00, last dose given: [DATE] 08:40 continue medication: yes .<br><br>-Lacosamide, 200 mg, per feeding tube, tab, q 12 h [every 12 hours], first dose: [DATE] 09:00, last dose given: [DATE] 08:41 continue medication: yes .<br><br>-Levetiracetam, 1,500 mg, per feeding tube, soln [solution], q 12 h, first dose: [DATE] 09:00, last dose given: [DATE] 08:41 continue medication: yes .<br><br>-Sodium Zirconium Cyclosilicate, 10 g [grams], per feeding tube, packet, STAT x1, first dose: [DATE] 18:01 [6:01] continue medication: yes .<br><br>Review of Resident #5's physician orders for February 2025 revealed no evidence of an order for Levetiracetam, 1,500 mg, every 12 hours; Aspirin, 81 mg, daily; or Sodium Zirconium Cyclosilicate, 10 grams, as documented on the hospital discharge medications list.<br><br>Review of Resident #5's physician orders, with a start date of [DATE] and an end date of [DATE], revealed an order for Lacosamide Oral Tablet 200 MG (Lacosamide) *Controlled Drug* Give 1 tablet via PEG-Tube every 12 hours related to essential (primary) hypertension.<br><br>Review of Resident #5's physician orders, with a start date of [DATE] and an end date of [DATE], revealed an order for Lacosamide Oral Tablet 200 MG (Lacosamide) *Controlled Drug* Give 1 tablet via PEG-Tube every 12 hours for seizures.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A review of Resident #5's MAR, for February 2025 and [DATE], revealed Lacosamide was not administered on the following dates/times: ,d+[DATE] at 9:00 a.m., ,d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 a.m., , d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 a.m., ,d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 a.m., and ,d+[DATE] at 9:00 p.m.<br><br>A review of Resident #5's progress note, dated [DATE] at 07:06 a.m., revealed the following:<br><br>Resident had an episode of involuntary movement of shoulders and foaming at the mouth. The vital signs were as follows: Temp [temperature] 97.2, oxygen 94%, BP [blood pressure] ,d+[DATE] pulse 86, respirations 18. The seizure medication (Lacosamide) was not available. The pharmacy was contacted and notified me that the medication will be delivered in the AM. The lab was unable to do venipuncture to get sample for CBC and BMP [basic metabolic panel]. Nurse paged doctor and still awaiting response.<br><br>A review of Resident #5's progress note, dated [DATE] at 11:00 a.m., revealed the following: Observed patient with involuntary movement of bilateral shoulders. [NAME] frothy coming from her mouth. Mouth was cleaned. MD notified. Orders to notify family and discuss if they wanted a DNR [do not resuscitate] or her sent to [Hospital] for evaluation. The [family member] aware of orders.<br><br>An interview was conducted on [DATE] at 2:50 p.m. with Staff J, Risk Manager (RM)/RN. She said on [DATE] the Unit Manager and Assistant Director of Nursing (ADON) talked to the family member of Resident #5 by phone. Staff J, RM/RN spoke to Resident #5's family member who made her aware the resident had a blood infection, dehydration, and her seizure medication had not been administered since her last hospitalization . She confirmed Resident #5 was transferred to the hospital following seizure like activity. Staff J, RM/RN said she spoke to Resident #5's PCP who said it may or may not have been seizure like activity. She said the PCP stated it could have been carbon dioxide retention, and her prognosis was not good from the start. Staff J, RM/RN stated, I'm starting to dive into this one. She said a hospital discharge medication list was never sent to the facility until she asked the admissions coordinator to obtain it. She said the nurses were using a medication list that was sent from the hospital, but it wasn't the discharge medication list. Staff J, RM/RN said Lacosamide for seizures was on the list the nurses used, but when she received the hospital discharge medication list there were two medications that were not on Resident #5's orders at the facility. She said one of the two medications not reconciled was a seizure medication and confirmed Resident #5 never received it. Staff J, RM/RN stated, We are still investigating this situation. DCF [Department of Children and Families], police notified on [DATE].<br><br>On [DATE] at 2:29 p.m., a phone interview was conducted with Staff H, LPN/Nurse Supervisor. She said Resident #5 was having seizure like activity on [DATE]. She stated, I never saw her do that before. I've never seen her have a seizure. Staff H, LPN/Nurse Supervisor said Resident #5's right arm was twitching and jerking. She said Resident #5's seizure like activity was on-going the morning of [DATE]. She said the day shift nurse made her aware and they both saw Resident #5 twitching. Staff H, LPN/Nurse Supervisor said it was a big question with the family related to DNR status. Staff H, LPN/Nurse Supervisor said the 11:00 am - 7:00 p.m. shift nurse, Staff J, LPN, had already called the on-call doctor and she's the one who initially saw the seizure like activity. She said the observation of Resident #5 occurred around the change of shift in the morning. She said she advised the 11:00 am - 7:00 p.m. shift nurse to call the PCP directly. She said she recalled the nurse telling her, Something was going on with medication.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An interview was conducted on [DATE] at 11:11 a.m. with the DON. He said a family member of Resident #5 called and said the hospital told her the resident had not been receiving her seizure medications since her last hospital stay. He said they initiated an investigation, reported an allegation of neglect, then identified the nurse who failed to adhere to the facility admissions checklist. He said they started an investigation related to incorrect admission/readmission data collection and the nurse failed to identify the correct medication discharge reconciliation list.<br><br>On [DATE] at 11:41 a.m., a phone interview was conducted with Staff E, LPN. She said Staff I, LPN was the admitting nurse for Resident #5 on [DATE], and she was the assisting nurse. Staff E, LPN said she was helping Staff I, LPN with Resident #5's medication list and putting notes in. She said Staff I, LPN was supposed to go back and verify the medication list with the physician. Staff E, LPN stated, What I probably did was put the medications in. Staff E, LPN stated, How it goes is they put medicine in, the nurse is supposed to verify. I was just helping.<br><br>3) Review of Resident #3's admission record revealed he was admitted to the facility on [DATE] and discharged on [DATE] to an acute care hospital. He was admitted with medical diagnoses of Type 2 Diabetes Mellitus with hyperglycemia, legal blindness, epilepsy, and acute kidney failure.<br><br>Review of Resident #3's progress notes revealed a note, dated [DATE] at 6:11 a.m., written by Staff E, Licensed Practical Nurse (LPN) as: During nurse to nurse report the off going nurse informed that resident Blood Glucose levels was reading high even after receiving short acting insulin twice on his shift. Further Assessment of resident Blood Glucose levels and was still reading high that was unreadable. Called on call NP [Nurse Practitioner] for Primary Physician of my concerns and was advised to send resident to ER [emergency room ] for further observation and treatment.<br><br>An interview was conducted on [DATE] at 3:30 p.m. with Staff E, LPN, she said on [DATE] she was working the 11:00 p.m.-7:00 a.m. shift, and she received report from Staff D, LPN who said Resident #3's blood sugar was high and he gave 20 units of insulin at 6:00 p.m. and it was still high when he rechecked the blood sugar so he gave another 20 units at 11:00 p.m. Staff E, LPN said when Staff D, LPN told her what he did, she said she thought Resident #3 was going to bottom out and crash so she went and checked his blood sugar and it was still high. She said the monitor wouldn't even read the blood sugar, it just said high, Staff E, LPN said Staff D, LPN tried to tell her Resident #3's blood sugar was 600. But I know the blood sugar machine doesn't even read that high. Staff E, LPN said Staff D, LPN never charted about the blood sugar readings or how much insulin he gave. Staff E, LPN said Staff D, LPN told her he did not call the doctor before he gave the insulin. So, after she heard that she immediately checked Resident #3's blood sugar and that is when the monitor read high, she checked it again and it still read high so at 12:42 a.m. on [DATE] she called the doctor and told the doctor what Staff D, LPN told her and said she was worried Resident #3 was going to bottom out and die and she wouldn't know because he was not verbal, and he always just laid there. The doctor gave her orders to send the resident out to the hospital, so she did and told the Nursing Home Administrator and the Director of Nursing (DON) on [DATE] at 12:42 a.m. what Staff D, LPN did.<br><br>Review of Resident #3's physician orders revealed an order with a start date of [DATE] and an end date of [DATE] as:<br><br>-Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | if 0 - 150 = 0 No Insulin needed;<br><br>151 - 199 = 1 ;<br><br>200 - 249 = 2;<br><br>250 - 299 = 4;<br><br>300 - 349 = 6;<br><br>350 - 399 = 8 > [greater than] 400 call MD [Medical Doctor], subcutaneously before meals for BS [blood sugar].<br><br>-A physician order with a start date of [DATE] and an end date of [DATE] revealed Insulin Aspart Injection Solution (Insulin Aspart) Inject 2 unit subcutaneously before meals for PREVENTATIVE.<br><br>Review of Resident #3's medical record revealed no documentation from Staff D, LPN Resident #3 had a high blood sugar reading. There was no documentation of the physician being notified, and there was no order to administer 20 units of insulin for high blood sugar readings.<br><br>An interview was conducted on [DATE] at 2:50 p.m. with Staff K, Registered Nurse (RN)/ Risk Manager, she said on [DATE] Staff E, LPN informed the previous Nursing Home Administrator (NHA) of an allegation of neglect related to Staff D, LPN not following Resident #3's insulin orders for Insulin Aspart. She said Staff D, LPN was interviewed, and he said Resident #3's blood sugar was high, so he gave 20 units of insulin. He checked it again and it was still high, so he gave another 20 units of insulin. She stated Staff D, LPN did not get a physician order to administer 20 units of insulin either time he administered it. The Risk Manager said Resident #3 was sent to the hospital and found to have hyperglycemia and Influenza A. The last she knew Resident #3 was still at the hospital during the investigation.<br><br>An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:55 a.m. he said they found a situation where the licensed nurse failed to adhere with the scope of practice in relation to Resident #3. The DON said when he interviewed Staff D, LPN related to administering insulin without a physician's order twice, Staff D, LPN said he did that because that is what the doctor would have told him to do anyway.<br><br>A phone interview was conducted on [DATE] at 2:13 p.m. with Staff D, LPN he said Resident #3 was nonverbal and, in a Geri-chair, But, that evening ([DATE]) around dinner time four white people who were visiting came into his [Resident #3's] room and he was a black man who didn't talk. So, I just waited until they left, after dinner, so I checked the sugar after dinner, because I was busy before that. And when I checked his sugar the monitor said high typically that means the blood sugar is over 600, and I did something kind of stupid and instead of waiting to call the doctor I kind of panicked, so I gave him 20 units of Aspart because that's what they normally tell me to give when the sugar is high. Then I waited about three to four hours after giving him the insulin because that type of insulin us [TRUNCATED] |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570<br><br>Based on record review and interviews, the facility failed to ensure licensed nursing staff were knowledgeable and competent to provide care and services for six residents (#4, #5, #1, #3, #6, and #2) out of ten residents sampled related to 1) failure to accurately reconcile medications upon admission, 2) failure to follow-up on laboratory orders, 3) failure to provide medication only with a physician's order, 4) failure to report and document malfunctions with a gastrostomy tube (G-tube), 5) failure to practice within the nursing scope of responsibility, 5) failure to follow a physician's order related to blood sugar testing, and 6) failure to implement hospice consultation orders.<br><br>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to residents and resulted in the determination of Immediate Jeopardy on 04/07/2025. The findings of Immediate Jeopardy were determined to be removed on 04/11/2025 and the scope and severity was reduced to an E after verification of removal of immediacy of harm.<br><br>Findings included:<br><br>1. Review of Resident #4's admission record revealed a readmitted [DATE] from a hospital stay, and a discharge date of [DATE], with diagnoses to include unspecified fall, difficulty in walking, muscle wasting and atrophy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other seizures, and gastrostomy status.<br><br>Review of Resident #4's laboratory orders revealed the following:<br><br>-STAT [immediately] Keppra level with a start date of 1/27/25 and the order status was marked as, Completed.<br><br>-Levetiracetam levels one time only for seizure for 1 Day, with a start date of 2/6/25 and the order status was marked as, Completed.<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On 1/25/25 a progress note revealed the following, Notified blood was residents sheets, entered room noted was standing next to his bed with no shoe's or socks on. resident had a dressing on the right wrist and the right elbow. resident also has an abrasion above the right eye. Resident stated, i fell , i may have had a seizure' .<br><br>-On 1/27/25 a progress note created by Staff G, LPN revealed the following, This writer called lab spoke with [lab technician] regarding stat Keppra lab, advised this cannot be done stat that it has to be scheduled to be drawn tomorrow morning.<br><br>-On 2/6/25 a progress note created by Staff J, LPN revealed the following, Resident had seizure while sleeping. It lasted approximately 5 minutes. Family member and DON [Director of Nursing] were notified. The doctor was notified. New orders: . Levetiracetam levels and continue to monitor resident.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #4's January 2025 Treatment Administration Record (TAR) revealed the following:<br><br>-STAT Keppra level. STAT, with an order and completed date of 1/27/25 documented by Staff G, Licensed Practical Nurse (LPN).<br><br>A review of laboratory reports in the medical record revealed no results related to seizure medication levels had been recorded for 1/27/2025.<br><br>Review of Resident #4's February 2025 TAR revealed the following:<br><br>-Levetiracetam levels one time only for seizure for 1 Day, with a start date of 2/6/25 and completed on 2/7/25.<br><br>A review of laboratory reports in the medical record revealed no results related to seizure medication levels had been recorded for 2/7/2025.<br><br>A review of Resident #4's care plan revealed the following:<br><br>- Focus: Fall<br><br>The resident is at Risk for falls or fall related injury because of: Gait/balance problems, has seizures, (initiated on 11/22/2024 and revised on 01/25/2025).<br><br>Goal: Will minimize the risk of fall, (initiated on 11/22/2024).<br><br>A phone interview was conducted on 4/8/25 at 3:15 p.m. with Staff G, LPN. She said she does not remember putting an order in for Levetiracetam for Resident #4, but if she did it was because the doctor told her to. Staff G, LPN said if she put the Levetiracetam order for a solution then, That's what the doctor ordered. She said if the Levetiracetam order was put in for a tablet, then it was done incorrectly. Staff G, LPN stated, You can't put a tablet in a G-tube. She said before making changes to orders, she called the doctor and pharmacy. She said when there's a change from tablet to solution, she would have documented that she called the doctor and pharmacy.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An interview was conducted on 4/9/25 at 10:30 a.m. with the Director of Nursing (DON) and Regional Risk Manager/Registered Nurse (RN). The DON said Resident #4 came to the facility with a primary diagnoses of Cerebral Vascular Accident (CVA). The DON confirmed Resident #4 had a history of seizures. He said in morning meetings they review new admissions, readmissions, risk events, return to hospitals, falls and incidents, and changes to orders. He said morning meetings occur Monday through Friday and on Monday's they review a 72-hour report. The DON said he spoke to Resident #4's PCP that morning to confirm she approved the Keppra order for 750 mg once a day. The DON confirmed there was no documentation of the physician requesting the order dose and frequency to be changed. The DON confirmed there is only documentation for the Keppra order to be changed to a solution. The DON said the PCP told him Resident #4 was not having any seizure activity, therefore, there wasn't any reason to check the Keppra levels. The DON said he didn't know the order was changed. He said the nursing staff put the order in the electronic health record, which automatically notified the lab. The DON said staff only call if it is a stat order. The DON reviewed lab orders for Resident #4, dated 1/25/25 and 2/9/25, and confirmed Keppra levels were not obtained. He said orders are reviewed through the order listing report. He said the nurses are expected to input orders into the resident's electronic health record. The DON said the admission process included the nurse evaluating the resident and verifying orders with the physician. He further explained the admission process expectations to include reviewing the medication discharge (d/c) list from the hospital, calling the physician and asking if they agree or want to make changes, inputting the physician approved orders into the electronic health record, which is then transferred to the pharmacy. The DON said the pharmacy has two runs, which includes 5:00 p.m. and 5:00-6:00 a.m. He said the cut off is 1:00 p.m. He said if staff don't make the cut off, they can order the medication stat or go to the electronic drug station which has the emergency stash. The DON said they double check orders in the morning clinical meeting where they compared the hospital d/c medication list to new orders and make sure it's all correct. He confirmed there should be documentation of the nurse communicating with the physician about changing the medication dose.<br><br>A review of the emergency drug kit (EDK) contents list revealed anti-seizure medications to include Levetiracetam and Lacosamide were not available in the kit.<br><br>A review of the electronic medication dispensing machine list revealed anti-seizure medications are available for nursing to access and include, Keppra [Levetiracetam] 500 mg tablets, and Vimpat [Lacosamide] 50 mg tablets.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 4/10/25 at 2:41 p.m., an interview was conducted with the DON. He said the nurse needed to sign into the vendor laboratory portal to obtain lab orders. He said the lab order goes into the electronic health record. The DON said the nurse sends an order requisition to the vendor through the lab portal. He said it's the nurse's responsibility to ensure labs are drawn. He said the unit manager brings the lab binder to morning meetings to review with the clinical Interdisciplinary Team (IDT). The DON said there's a report of all the labs for the phlebotomist to collect orders. He said through the vendor website nursing staff can generate a report, and the report goes into the binder. He said in the morning clinical IDT meetings ordered labs are reviewed, as well as, if they were collected. If the labs weren't completed, the DON said they notify the doctor and obtain a new order if the doctor wants to re-collect. He said the expectation is to document in a progress note about communication with the doctor. He said it's the unit manager's responsibility to ensure the lab was drawn. He said the unit managers have a follow-up homework sheet to follow-up with the nurses about lab results. He said if labs were not completed, the expectation is to call the doctor, take orders from the doctor, and start the process over again. The DON confirmed it's the nurse's responsibility to ensure the lab was completed and to notify the doctor of the lab results. He said the laboratory binder has pending lab orders. He said if the nurse hasn't received lab results, then they should go down the list to see which one of their patients had their blood drawn or not. He said if no labs are found, they can call the lab to confirm and follow-up. The DON said the nurse can go to the lab portal, look up results, and print as needed. He said lab results typically are sent to the facility through the fax. He said the expectation is for nurses to check the fax machine for results. He said critical lab result calls go to the DON's phone. Regarding Resident #4's Keppra lab results he stated, The process was broken. He said the unit manager and nurses were expected to follow-up. He confirmed the orders were not put into the lab system. He said at the time of the Keppra level orders for Resident #4, there was only one unit manager. Regarding reconciliation of medications, the DON confirmed staff are not supposed to reconcile medications and put in orders before communicating with the physician. He said the process is to contact the physician, reconcile medications with the hospital list, then go into the electronic health record and input medications. He said if the physician doesn't answer to reconcile medications, the expectation is to call the DON, then call the medical director.<br><br>On 4/10/25 at 4:06 p.m., a phone interview was conducted with Staff I, LPN. She said she doesn't have access or log-in for the lab portal. Staff I, LPN said the doctor communicates lab orders by phone and she puts them in the electronic health system. She said the 11:00 p.m. - 7:00 a.m. shift takes care of the lab process. She said she wasn't trained in the lab process. She stated, I've asked the nurses, and they tell me what to do. She said she can't ensure the labs are completed. Staff I, LPN stated, I do my part as far as putting the order in the system. I don't have a way of knowing they're done. She said when she comes back to work, she will receive lab results and notify the doctor. She confirmed other nurses have a log in for the lab portal. She stated, I end up having to ask my hall partner to print out or put something in for me. She confirmed she does not have access to the electronic medication dispenser. She said she has to go to another nurse for that.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 4/10/25 at 5:07 p.m., an interview was conducted with Staff J, LPN. She stated when a new admission arrives, It is best to receive a nurse to nurse report to be more aware of how to set up the resident. She said for admissions she has an evaluation sheet with information they need to go through. She said she enters the resident's medication into the Medication Administration Record (MAR) and verifies them with their physician. She said any prescriptions they receive, they fax to the pharmacy. Staff J, LPN confirmed she checks with the physician first to verify medication orders. She said residents come with the medication list from the hospital and that is what she uses. She said she has not been formally trained on the admission process. Staff J, LPN said she has learned by asking and observing what other nurses are doing. Regarding labs, she said she now checks the lab books, but previously she would communicate with the nurse who would tell her which residents had labs. She said usually they see results in the electronic health record if a resident had labs. Staff J, LPN said on the Treatment Administration Record (TAR) the results are signed off as completed. She said when she gets the results, she faxes them to the doctor. Staff J, LPN said if she gets new orders, after communicating with the doctor, she puts them in the MAR. She said if there's no new orders, she documents in the resident's progress note. She said lab work results are usually in the laboratory binder at the nurse's station. She said if it is a stat order, she puts it immediately in the electronic health record and calls the lab. She said if it is a standard lab, the 11 p.m. - 7 a.m. shift nurse will pull the order and let the lab staff know to collect the sample. She said the night shift nurse prints the lab orders. She said the lab staff pull orders from the laboratory book. She said to obtain results, she calls the lab to get them faxed, then faxes the results to the doctor. She said if lab results were not completed, she calls the doctor and confirms if they want to repeat as stat or routine. She said she documents communication with the physician in progress notes. Staff J, LPN confirmed she did not have access to electronic medication system. She said she's asked the DON for access. She said she asks senior nurses to pull medications when needed. She confirmed she received access today to the lab portal. Regarding Resident #4's lab orders and results, she cannot recall if he had orders and if they were completed. She said he was in the 200 hall before, and she doesn't normally work in that area.<br><br>On 4/11/25 at 10:42 a.m., a phone interview was conducted with Staff G, LPN. She confirmed she never had access to the lab portal. She said she called the lab to obtain access, but she was told she could not do that. She confirmed she spoke to the DON multiple times about obtaining access to the lab portal. Staff G, LPN said if there was a specific lab she needed she would go to the supervisor to print them or call the lab to fax results. She said she would call the lab for critical orders. Staff G, LPN said she never had education on the lab process. She stated, I only ever knew to put the order in the lab portal. She said the lab orders are put into the electronic health record. Staff G, LPN said when the lab staff would come, she'd give them the order and resident's face sheet. She stated, The lab book was always in disarray. She said she would keep lab orders on her medication cart. Regarding the admission process, she said she had no education or training on new admissions. She stated, I'd have to ask a co-worker to show me what to do. She said she would verify the medication list with the doctor before sending orders to the pharmacy. Staff G, LPN said the doctor would come in every other day and make changes to medications after the admission, if needed. She said she'd receive instructions from the physician to, Keep them on same medications until I come in and review. She said she obtained access to the Pyxis about 6 weeks after employment.<br><br>On 4/11/25 the Regional RN Consultant provided a list of staff who have access to the lab portal. She said all nursing staff were provided access today.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. A review of Resident #5's admission record revealed an initial admitted [DATE] and a re-admitted [DATE], with diagnoses to include epilepsy, anoxic brain damage, muscle wasting and atrophy, muscle weakness, gastrostomy status, and tracheostomy status.<br><br>On 4/10/25 at 11:41 a.m., a phone interview was conducted with Staff E, LPN. She said Staff I, LPN was the admitting nurse for Resident #5 on 2/11/25, and she was the assisting nurse. Staff E, LPN said she was helping Staff I, LPN with Resident #5's medication list and putting notes in. She said Staff I, LPN was supposed to go back and verify the medication list with the physician. Staff E, LPN stated, What I probably did was put the medications in. She confirmed she was helping the admitting nurse with inputting medications. Staff E, LPN stated, How it goes is they put medicine in, nurse supposed to verify. I was just helping. She said the facility did not train her on the admission process. She stated, There's no way to call [Primary Care Physician], she prefers you text her. You don't know how late she is going to respond through text. Staff E, LPN said during the admission process they put medications in, then pharmacy will call back if something, Dings, and the doctor will come the next day to check medications. Staff E, LPN said Staff I, LPN texted the Primary Care Physician (PCP) when Resident #5 was admitted . She said when a new resident arrives, they text the PCP. She said they have to wait until the PCP calls them back and sometimes that won't be until the next day. Staff E, LPN said she has to input medication orders to get the process going with the pharmacy. She confirmed they usually have an admission check list to go by. She stated, The checklist is a requirement, but it's not enforced. She said the admission process can sometimes be confusing when there is not an extra nurse. Staff E, LPN said in the electronic health record it's going to say one nurse completed the admission, but it was another nurse's assigned resident. She said they help each other with certain parts of the admission process. Staff E, LPN said the clinical team is supposed to go back and look at the admissions.<br><br>On 4/10/25 at 4:06 p.m., an interview was conducted with Staff I, LPN. She said the admission process includes notifying the doctor the resident is at the facility. She said she looks at the medication orders the resident comes from the hospital with, puts the medications in the electronic health record, then notifies the pharmacy and the doctor. Staff I, LPN said she looks at the discharge medications from the hospital. She said a lot of times the discharge medication list provides information about the last dose given and when the next dose should be provided. She stated, You go by the medication list you receive and place the orders inside the computer. She stated, I don't talk to the doctor about medications. She confirmed she doesn't go over the resident's medications with the doctor upon admission. She stated, I've never went through the medication list with the doctor. They look at it when they come in. Staff I, LPN confirmed she put in the information for Resident #4 on her admission. She said she was the extra nurse that was assisting with Resident #4's admission. Staff I, LPN said sometimes there are several admissions that come to one hall, therefore, the nurse's split up the admission responsibilities. She stated, I don't know if I put medications in or put in the evaluation. She said she had help from Staff E, LPN. She said as the extra nurse she will start the admission process to include inputting medications. She said she cannot recall if she, Did or did not, follow up on medication orders that Staff E, LPN put in.<br><br>Review of the facility's, Admission Checklist, revealed the following:<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | CHART (H&P) [History and Physical] - Hospital H&P on Chart . Chart/eMAR/Kardex - *Allergy IN [electronic health record], eMAR, Kardex . CHART (Phy. Orders [physician orders] AND [electronic health record]) - *Orders Transcribed correctly. [electronic health record]- *All Medication Have Corresponding Dx [diagnoses]. [electronic health record] (Nurse's Note) - *Orders Verified doc [document] in [electronic health record] . MED [medication]/TX [treatment] CART check - Meds in med cart / Tx. Supplies in Tx. Cart.<br><br>3. Review of Resident #1's admission record revealed an admitted [DATE], and discharge date of [DATE] to an acute care hospital. Resident #1's diagnoses included dysphagia, oropharyngeal phase, other seizures, tracheostomy status, and gastrostomy status.<br><br>Review of Resident #1's discharge MDS, dated [DATE], showed:<br><br>Section B - Hearing, Speech, and Vision, indicated the resident was comatose and in a persistent vegetative state/no discernible consciousness therefore, she does not have a BIMS score.<br><br>Review of Resident #1's physician orders revealed the following,<br><br>-NPO diet NPO texture, NPO consistency. Start date: 1/8/2025, End date 3/5/25,<br><br>-Juven two times a day for Supplement 1 packet via G-tube for 90 Days Flush with 300mL water before and after supplement dose. Start date: 1/8/25. End date 1/8/25,<br><br>-Prostat or Equivalent >=15 g pro/oz [grams of protein per ounce]. one time a day for Supplement Via G-tube. Start date 1/8/25. End date 1/8/25,<br><br>-Juven two times a day for Nutrition Supplementation ENTERAL Supplementation. Administer 1 packet mixed with 120 mL water. VIA G-TUBE. 2 times daily. Record the % [percentage] administered. Start date 1/8/25, End date 2/3/25,<br><br>-every shift Dilute each crushed/sprinkles/powdered med [medication] with at least 15 ML of water and rinse the cup with 5 to 15 ml to ensure all residue is out of the cup. Start date 1/7/25, End date 2/3/25,<br><br>-every shift Enteral Feed: Nepro Continuous via G-tube to infuse at a rate of 60 mL/hr [hour]. Total volume of 1200 mL infused in 24 H [hours]. May turn off for care/services. Start at 2pm. Verify infusing Q [every] shift. Clear pump when total volume has infused. Start date 1/8/25, 1/27/25,<br><br>every shift Enteral Feed: TwoCal Continuous via G-tube to infuse at a rate of 350mL/hr. Total volume of 100ml infused in 24 H. May turn off for care/services. Start at 2pm. Verify infusing Q shift. Clear pump when total volume has infused.<br><br>-Flush tube with 300mL of water before and after med administration and feeding. every shift for Patency and hydration. Start date: 1/7/25, End date: 2/3/25,<br><br>-Flush feeding tube with 5ML of water between meds. every shift for Patency and hydration. Start date: 1/7/25, End date: 2/3/25,<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -Flush enteral tube with 120 mL of water every 4 hours. every shift for Patency and hydration. Start date: 1/7/25. End date: 1/8/25,<br><br>-May give medications via tube. every shift. Start date: 1/7/25, End date: 2/3/25,<br><br>-Evaluate for displacement of tube by observing for abdominal distress, nausea/vomiting, pain, distention. If displacement is suspected, clamp tube, call MD. every shift. Start date: 1/7/25, End date 2/3/25,<br><br>-Flush enteral tube with 240 ML of water every 4 hours for Patency and hydration. Start date: 1/8/25, End date 2/3/25.<br><br>Review of Resident #1's care plan revealed the following,<br><br>-NUTRITIONAL: [Resident #1] has a potential nutritional problem r/t [related to] Has feeding tube Dx/hx [history]: encephalopathy, heart disease, DM [diabetes mellitus], GERD [gastroesophageal reflux disease], respiratory failure, hemiplegia/hemiparesis, anemia, quadriplegia, dysphagia, hyponatremia, CKD [chronic kidney disease], seizures, impaired skin Weight: fluid shifts possible w/ [with] CKD & hx edema Date Initiated: 01/07/2025 Revision on: 03/25/2025,<br><br>-TUBE FEEDING: The resident is receiving enteral nutrition. Date Initiated: 01/08/2025 Revision on: 03/25/2025 Canceled Date: 03/25/2025. Interventions include the following, Observe/document/report to MD PRN [as needed]: Aspiration- fever, SOB [shortness of breath], Tube dislodged, Infection at tube site, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Diarrhea, Nausea/vomiting, Date Initiated: 01/08/2025 Revision on: 03/25/2025.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 4/7/25 at 2:23 p.m., an interview was conducted with Staff K, RN/Risk Manager (RM) related to a reportable and investigation for Resident #1. She said on 2/3/25 the police informed the administrator that Resident #1's family was alleging neglect. Staff K, RN/RM said Resident #1 had gone to [Hospital] on 2/1/25 for critical labs, with a hemoglobin of 6.6. She said DCF was called. She said she spoke to the police on 2/3/25. Staff K, RN/RM said a police report was made. She said she spoke to Resident #1's family members and started an investigation on the same day. She said when she spoke to one of Resident #1's family members, he said the G-tube was cut, needed to be replaced and would be done on 2/4/25. She said she didn't document the date of when she spoke to Resident #1's family member, but it was after the police came to the facility. She said Resident #1's son told her the hospital physician and all the nurses told him the G-tube was cut. She stated she started staff education on the abuse prevention program with emphasis on neglect. She said all staff were educated. She said the Registered Dietitian (RD) confirmed Resident #1 received the ordered tube feeding regimen, had no intolerance's, and her weight was stable. She said during her investigation she talked to Staff C, LPN. She said Staff C, LPN told her the G-tube was a little bit longer. She stated they were using a [NAME] valve, and the tube became clogged. Staff K, RN/RM said they tried to use a de-clogger. She said during her interview with Staff C, LPN, she said the tube was cut a little bit. She said she spoke to Staff A, LPN, who told her she was trying to flush Resident #1's G-tube and wasn't able to because there was a hole/slit. She said Staff A, LPN told her she asked Staff B, LPN for help. Staff K, RN/RM said Staff A, LPN put a stopper, [NAME] valve, on the tube and was able to flush without difficulties after cutting it. She said three residents with G-tubes were reviewed and interviewed. She said the outcome was not substantiated because Resident #1 didn't lose weight and was not affected negatively. Staff K, RN/RM stated it is, Probably not normal practice to cut the G-tube.<br><br>Review of Resident #1's progress notes revealed:<br><br>- On 1/7/25 by Staff C, LPN, .Peg-tube intact with feeding of Nephro at 35 CC[ml]/hr initiated.<br><br>-On 1/8/25 created by Staff C, LPN .Peg tube flushed with some difficulty. Nephro infusing at 33 cc[ml]/hr. Resident tolerating well. Dietician reviewing chart. All meds provided per tube.<br><br>-Resident #1's progress notes revealed no documentation of the G-tube having a hole or being cut by staff.<br><br>On 4/7/25 at 12:33 p.m., an interview was conducted with Staff B, LPN. He confirmed he was present with Staff A, LPN when she cut Resident #1's G-tube. He said Resident #1 was not his assigned resident that shift as he was working on the 300 unit. Staff B, LPN confirmed there was a hole in Resident #1's G- tube and it was not flushing. He said he went to assist Staff A, LPN as she was trying to give medications, but she couldn't flush the G-tube. He said he wasn't aware of issues with the G-tube previously and he was able to flush it with no issues. He said that was the first time he saw the hole/slit in Resident #1's G-tube. Staff B, LPN said the hole was located at the top of the G-tube. He said, Staff A, LPN cut the top piece off where the hole was. He stated, It's a normal thing to do. It's the nurse's judgement to cut the tube. She didn't do nothing wrong. Staff, B LPN said if the tube is not flushing, there's something you can put in to help flush the tube. He confirmed he was interviewed regarding this incident with Resident #1 and provided a statement. He stated, I was told to notify someone before you do something with the tube.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 4/7/25 at 12:46 p.m., an interview was conducted with Staff A, LPN. She said Resident #1's G-tube had a hole in the tape. She said she first noticed on a Monday, but can't recall the date, that Resident #1's G-tube tip was leaking. Staff A, LPN said she observed this approximately 2-3 weeks before the resident was hospitalized on [DATE]. She said Staff B, LPN, was the nurse that assisted her on the day she cut Resident #1's G-tube. She said she asked Staff B, LPN, to assist with flushing the tube as she was having difficulties. She said the Orange collar, lock was not working, and the G-tube had a hole in it. Staff A, LPN said she replaced the lock. She said the tube flushed with no issues after replacement of the lock and cutting the G-tube. Staff A, LPN said she inserted the adapter in the tube. She confirmed she didn't document what she did or let anyone know. Staff A, LPN said the DON spoke to her and explained it wasn't what she was supposed to do. She said the DON instructed her to call him or consult with the nurse supervisor in the building.<br><br>On 4/7/25 at 1:25 p.m., a phone interview was conducted with Staff C, LPN. She said when Resident #1 was admitted the G-tube was very long and occluded. She stated, It was an excessively long tube, at about 8 inches long. She stated the G-tube would, Plug up, and did not flush. She stated the unit manager and herself tried to unclog it. She stated, We cut about an inch. Staff C, LPN said she could not recall if she documented it in the admission note about cutting Resident #1's G-tube. She said if it was documented, it would have been included in the admission note. She stated she received education from the DON about the importance of not cutting the tube too short, making sure it's not occluded, and flushing frequently.<br><br>On 4/7/25 at 1:44 p.m., an interview was conducted with the DON. He said the facility doesn't have a policy related to how to care for a G-tube. He said they are expected to follow the Lippincott Manual of Nursing.<br><br>On 4/7/25 at 2:52 p.m., an interview was conducted with the DON. He said he did not provide education to staff related to the reportable and investigation for Resident #1. He said he was involved in the disciplinary action for Staff A, LPN. She stated, Yes, it is okay to cut the tube. He stated, If the de-clogger is not helping, with MD [medical doctor] orders you can cut the tube. The DON confirmed there were no orders to cut Resident #1's G-tube. He said cutting the tube should have been consulted with the physician and documented. The DON stated Staff A, LPN was, Acting out of scope of practice and didn't notify the physician. He said he was not aware the G-tube was cut initially by Staff C, LPN and the unit manager. He stated, This is potentially a failure to report if there was a second incident of the tube feeding being cut.<br><br>4. Review of Resident #3's admission record revealed he was admitted to the facility on [DATE] and discharged on [DATE] to an acute care hospital. He was admitted with medical diagnoses of Type 2 Diabetes Mellitus with hyperglycemia, legal blindness, epilepsy, and acute kidney failure.<br><br>Review of Resident #3's progress notes revealed a note, dated 2/4/25 at 6:11 a.m., written by Staff E, Licensed Practical Nurse (LPN) as: During nurse to nurse report the off going nurse informed that resident Blood Glucose levels was reading high even after receiving short acting insulin twice on his shift. Further Assessment of resident Blood Glucose levels and was still reading high that was unreadable. Called on call NP [Nurse Practitioner] for Primary Physician of my concerns and was advised to send resident to ER [emergency room ] for further observation and treatment.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An interview was conducted on 4/7/25 at 3:30 p.m. with Staff E, LPN, she said on 2/3/25 she was working the 11:00 p.m.-7:00 a.m. shift, and she received report from Staff D, LPN who said Resident #3's blood sugar was high and he gave 20 units of insulin at 6:00 p.m. and it was still high when he rechecked the blood sugar so he gave another 20 units at 11:00 p.m. Staff E, LPN said when Staff D, LPN told her what he did, she said she thought Resident #3 was going to bottom out and crash so she went and checked his blood sugar and it was still high. She said the monitor wouldn't even read the blood sugar, it just said high, Staff E, LPN said Staff D, LPN tried to tell her Resident #3's blood sugar was 600. But I know the blood sugar machine doesn't even read that high. Staff E, LPN said Staff D, LPN never charted about the blood sugar readings or how much insulin he gave. Staff E, LPN said Staff D, LPN told her he did not call the doctor before he gave the insulin. So, after she heard that she immediately checked Resident #3's blood sugar and that is when the monitor read high, she checked it again and it still read high so at 12:42 a.m. on 2/4/25 she called the doctor and told the doctor what Staff D, LPN told her and said she |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570<br><br>Based on record review and interviews, the facility failed to ensure three residents (#4, #5, and #3) out of six residents sampled for medication administration were free from a significant medication error as evidenced by 1) failure to accurately reconcile medications upon admission, and 2) failure to provide physician ordered medications.<br><br>Serious harm occurred on [DATE], when Resident #4's seizure medications were not reconciled accurately, resulting in Resident #4 experiencing two seizures. After the seizures, physician ordered laboratory tests for seizure medication levels were not implemented, and Resident #4 had a third seizure resulting in a fall with head trauma and transfer to a higher level of care. Resident #4 subsequently died from his injuries.<br><br>Serious harm occurred on [DATE], when Resident #5's seizure medications were not reconciled accurately, resulting in seizure like activity requiring a transfer to a higher level of care.<br><br>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to the residents and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to an E after verification of removal of immediacy of harm.<br><br>Findings included:<br><br>1) Review of Resident #4's admission record revealed a readmitted [DATE] from a hospital stay, and a discharge date of [DATE], with diagnoses to include unspecified fall, difficulty in walking, muscle wasting and atrophy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other seizures, and gastrostomy status.<br><br>Review of Resident #4's hospital discharge records revealed the following:<br><br>-A progress note, dated [DATE], . ,d+[DATE]: Had a seizure episode overnight, now calm and no further episodes, discussed w [with] Neurology, will increase Keppra dose to 1000 mg [milligrams] bid [twice a day] and to continue it on discharge.<br><br>-DC [discharge] planning note, dated [DATE], Lying in bed in no distress no further seizure episodes on Keppra 1000 mg b.i.d. DC planning ongoing pending authorization and placement .<br><br>Review of Resident #4's hospital after visit summary, dated [DATE] - [DATE], revealed the following:<br><br>--Call [Medical Doctor's name], MD [Medical Doctor] in 1 week . Needs follow-up with his cardiologist for outpatient TEE [transesophageal echocardiogram] and loop recorder placement, As needed, If symptoms worsen.<br><br>The hospital after visit summary, revealed the following change to Resident #4's medication list:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | --Levetiracetam [generic name for Keppra] 1000 MG tablet . 1 tablet (1,000 mg total) by Per G- Tube [gastrostomy tube] route in the morning and 1 tablet (1,000 mg total) before bedtime. Last time this was given: [DATE], 9:00 AM . What changed: medication strength, how much to take, how to take this, when to take this .<br><br>Review of Resident #4's admission assessment, dated [DATE], revealed under the drug regimen review section, Drug Regimen Review was reviewed by the practitioner on admission completed to include medication reconciliation completed upon admission/readmission, [electronic health record] Order Entry Warnings and any applicable Pharmacy Recommendations, and found 1. No clinically significant findings.<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On [DATE] at 10:10 a.m., [Medical Doctor] notified at 0948 by this writer that resident's medications need to be reviewed as the pharmacist stated that the following medications cannot be given via G-tube- . Levetiracetam . This writer requested that [Medical Doctor] give orders to replace the following medications.<br><br>-On [DATE] at 1:21 p.m., a progress note created by Staff G, Licensed Practical Nurse, (LPN) revealed the following, [Medical Doctor] again notified now time is 1321 [1:21 PM], this writer requested that the following 4 medications be reviewed as per the pharmacist the 4 medications cannot be given via G-tube . Keppra . This writer is waiting on [Medical Doctor] to review these 4 medications and give orders for replacement medications.<br><br>-On [DATE] at 1:40 p.m., a progress note created by Staff G, LPN revealed the following, . [Medical Doctor] notified that resident has 4 medications that cannot be given via G-tube per the pharmacist. Awaiting response back from [Medical Doctor].<br><br>-On [DATE] at 2:26 p.m., a progress note created by Staff G, LPN revealed the following, [Medical Doctor] responds with - . 2.) Change the order for the Keppra to a solution.<br><br>Review of Resident #4's physician orders on readmission to the facility revealed the following:<br><br>-Levetiracetam (generic drug name for Keppra) Oral Tablet 750 MG Give 1 tablet by mouth one time a day for Seizure, with a start date of [DATE] and discontinued (d/c) date of [DATE].<br><br>-Levetiracetam Oral Tablet 1000 MG Give 1 tablet via G-Tube every morning and at bedtime for Seizure, with a start date of [DATE], and end date of [DATE].<br><br>-Levetiracetam Oral Solution 100 MG/ML [milliliter] Give 7.5 ml [total dose 750 MG] by mouth one time a day for Seizures, with a start date of [DATE].<br><br>-Levetiracetam Oral Solution 100 MG/ML Give 7.5 ml [total dose 750 MG] via G-Tube one time a day for Seizures, with a start date of [DATE].<br><br>Review of Resident #4's [DATE] Medication Administration Record (MAR) revealed:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | - Levetiracetam oral tablet 1000 mg, give 1 tablet by g-tube every morning and at bedtime for seizures, with a start date of [DATE] and d/c date of [DATE], was administered on [DATE], [DATE], and a code of 9 =Other / See Nurse Notes, on [DATE] for the morning dose.<br><br>-Levetiracetam oral solution 100 mg/ml, give 7.5 ml [total 750 MG] by g-tube one time a day for seizures, with a start date of [DATE] was administered daily as ordered.<br><br>Review of Resident #4's [DATE] MAR revealed:<br><br>-Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered as ordered daily, except on [DATE] which documented 2=Drug Refused.<br><br>Review of Resident #4's [DATE] MAR revealed:<br><br>-Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered daily as ordered.<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-On [DATE] a progress note revealed the following, Notified blood was residents sheets, entered room noted was standing next to his bed with no shoe's or socks on. resident had a dressing on the right wrist and the right elbow. resident also has an abrasion above the right eye. Resident stated, i fell , i may have had a seizure' .<br><br>-On [DATE] a progress note created by Staff G, LPN revealed the following, This writer called lab spoke with [lab technician] regarding stat Keppra lab, advised this cannot be done stat that it has to be scheduled to be drawn tomorrow morning.<br><br>Review of Resident #4's laboratory orders revealed the following:<br><br>-STAT [immediately] Keppra level with a start date of [DATE] and the order status was marked as, Completed.<br><br>Review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following:<br><br>-STAT Keppra level. STAT, with an order and completed date of [DATE] documented by Staff G, Licensed Practical Nurse (LPN).<br><br>A review of laboratory reports in the medical record revealed no results related to seizure medication levels had been recorded for [DATE].<br><br>Review of Resident #4's February 2025 MAR revealed Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered daily as ordered, with the exception of [DATE].<br><br>Review of Resident #4's progress notes revealed the following:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -On [DATE] a progress note created by Staff J, LPN revealed the following, Resident had seizure while sleeping. It lasted approximately 5 minutes. Family member and DON [Director of Nursing] were notified. The doctor was notified. New orders: . Levetiracetam levels and continue to monitor resident.<br><br>-[DATE] medication administration note, Levetiracetam Oral Solution 100 MG/ML Give 7.5 ml via G-Tube one time a day for Seizures Awaiting medication from pharmacy<br><br>Review of Resident #4's laboratory orders revealed the following:<br><br>-Levetiracetam levels one time only for seizure for 1 Day, with a start date of [DATE] and the order status was marked as, Completed.<br><br>Review of Resident #4's February 2025 TAR revealed the following:<br><br>-Levetiracetam levels one time only for seizure for 1 Day, with a start date of [DATE] and completed on [DATE].<br><br>A review of laboratory reports in the medical record revealed no results related to seizure medication levels had been recorded for [DATE].<br><br>Review of Resident #4's [DATE] MAR revealed Levetiracetam oral solution 100 mg/ml, give 7.5 ml [750 MG total] by g-tube one time a day for seizures, with a start date of [DATE], was administered daily as ordered, with the exception of [DATE].<br><br>Review of Resident #4's progress notes revealed the following:<br><br>-[DATE] medication administration note, Levetiracetam Oral Solution 100 MG/ML<br><br>Give 7.5 ml via G-Tube one time a day for Seizures Awaiting medication from pharmacy.<br><br>-[DATE] progress note, Levetiracetam Oral Solution 100 MG/ML Give 7.5 ml via G-Tube one time a day for Seizures Awaiting medication from pharmacy.<br><br>-On [DATE] a progress note created by Staff H, LPN/Nurse Supervisor revealed the following, Observed on floor at end of 200 hall laying on his right side .Bleeding noted from right nostril. Patient appeared to be having a seizure like activity. MD notified. EMS [Emergency Medical Services] called. Vitals obtained. Call placed to patients [family member]. Patient appeared to coming out of seizure like activity when he left facility via EMS. Hematoma noted to right side of face and head as patient was leaving facility via EMS.<br><br>Review of Resident #4's hospital records, dated [DATE], revealed the following:<br><br>--An ED [Emergency Department] Urgent Triage note, Per EMS, facility states that pt had a seizure, fell to the ground and hit his nose. No thinners [blood thinners]. No LOC [loss of consciousness]. Pt [patient] is post ictal. Hx [history]: Szs [seizures], Stroke, facial droop and dysphagia .<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -- A physician note, At 935 was called to the CT [computed tomography] scan suite after the CT scan the head was initially performed. The patient had appeared to have another seizure. Patient was given 2 mg of Ativan. The patient was altered as well. Patient was not responsive and not answering questions. The CT scan resulted and showed multiple bleeds. There is a subdural bleed on the right side. There is also an intraparenchymal bleed in the temporal parietal lobe that is approximately 6 cm [centimeters] x 3.5 cm in size. Also, intraventricular bleed and now in the occipital plate. No herniation. I was able to speak to the [family member]. She is the POA [power of attorney]. I have informed her about the CT scan results and the blood work so far. I have told her that the patient has a significant intracranial hemorrhage. Patient [family member] has told me that the patient is very demented. He appears to not like the nursing home where he is staying. He has a history of alcohol abuse and several strokes and advanced dementia. I have informed her that the patient is not likely going to return to his previous mental state. I have told her that I am concerned about the patient's airway and think about intubating the patient, but the [family member] does not want that done. She wants comfort measures only. I have informed her that the patient may die within the next 24 to 48 hours depending on how advanced the bleeding is. She states she understands this. She wants the patient to be comfortable. Therefore, the patient will be admitted under comfort measures only. I have spoken to [Palliative Care Physician] and informed him about the POA's decision and also patient's current condition, CT scan results and blood work. He is agreeable with admission. The patient is currently stable with a normal blood pressure pulse oximetry is 94% and he still unarousable.<br><br>--A discharge summary, with an admitted [DATE] and a discharge date of [DATE], revealed the following, . The patient expired on [DATE] at 05:25.<br><br>A phone interview was conducted on [DATE] at 3:15 p.m. with Staff G, LPN. She said she does not remember putting an order in for Levetiracetam for Resident #4, but if she did it was because the doctor told her to. Staff G, LPN said if she put the Levetiracetam order for a solution then, That's what the doctor ordered. She said if the Levetiracetam order was put in for a tablet, then it was done incorrectly. Staff G, LPN stated, You can't put a tablet in a G-tube. She said before making changes to orders, she called the doctor and pharmacy. She said when there's a change from tablet to solution, she would have documented that she called the doctor and pharmacy.<br><br>A phone interview was conducted on [DATE] at 9:01 a.m. with Resident #4's Primary Care Physician (PCP) while admitted at the facility. She said Resident #4 had dementia, falls, confusion, and a G-tube. She stated when a resident is admitted from the hospital, We get notified when we get a patient, nurses go over medications with us, we say continue or stop, they are supposed to transcribe medication list to [electronic health record]. The PCP stated, Whatever hospital sends the patient on [in reference to medications], that's what they should start giving at the facility. She confirmed the order for Keppra 750 mg daily by g-tube was started on [DATE]. The PCP said the initial order at the facility was 750 mg. She said sometimes anti-seizure medication levels are ordered. She said if the levels are low, then they would increase the dosage. She stated, We don't always do levels, only if there is a medical necessity such as seizures. He was pretty stable. The PCP said before Resident #4 fell , they were thinking he had a urinary tract infection (UTI) and therefore ordered blood work. She said Resident #4 had Klebsiella pneumoniae in his urine, which contributed to his confusion and fall.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A follow-up phone interview was conducted on [DATE] at 9:49 a.m. with the PCP. She said it appears he was underdosed initially and Keppra was increased to 1000 mg twice a day. She said she talked to her team and Resident #4 had sedation and lethargy, which is probably why Keppra was decreased to 750 mg once a day. The PCP said she did not have documentation to support Resident #4 was sedated. She stated, That's the best we remember how that happened. She confirmed she changed the Keppra order to a liquid solution, as that is the preferred consistency for a G-tube medication administration. She stated, Honestly, I don't remember if I gave the order to change the dose or not. The PCP stated, I can't access labs from [electronic health record] to see the Keppra level lab results, it's not integrated. She said on [DATE] his urine culture, complete blood count (CBC), and electrolytes were completed. The PCP said she documented that he had a UTI. She said, I heard that he [Resident #4] was found to have a brain tumor, but I don't have confirmation.<br><br>An interview was conducted on [DATE] at 10:30 a.m. with the Director of Nursing (DON) and Regional Risk Manager/Registered Nurse (RN). The DON said Resident #4 came to the facility with a primary diagnoses of Cerebral Vascular Accident (CVA). The DON confirmed Resident #4 had a history of seizures. He said in morning meetings they review new admissions, readmissions, risk events, return to hospitals, falls and incidents, and changes to orders. He said morning meetings occur Monday through Friday and on Monday's they review a 72-hour report. The DON said he spoke to Resident #4's PCP that morning to confirm she approved the Keppra order for 750 mg once a day. The DON confirmed there was no documentation of the physician requesting the order dose and frequency to be changed. The DON confirmed there is only documentation for the Keppra order to be changed to a solution. The DON said the PCP told him Resident #4 was not having any seizure activity, therefore, there wasn't any reason to check the Keppra levels. The DON said he didn't know the order was changed. The DON said when a new admission comes to the facility, the expectation is the nurses complete an assessment on the resident, call the physician to reconcile the medication with the hospital discharge medications, then the nurses input the medications into the EMR, then the orders are sent to the pharmacy to be filled, and medications are sent to the facility. He said at morning meeting, the next morning or on Monday, if they were admitted over the weekend, the hospital discharge medications are reconciled with the orders that were input into the system to ensure they were input accurately. The DON said when a medication order changes it is also reviewed during morning meetings. The DON confirmed there should be documentation if the nurse talks with the physician and the physician wants to change the dose and/or frequency of a medication.<br><br>On [DATE] at 1:57 p.m., an interview with the DON revealed no Keppra level results were completed for Resident #4 as ordered on [DATE] and [DATE].<br><br>A phone interview was conducted on [DATE] at 9:50 a.m. with the consulting pharmacist. He said on [DATE], Resident #4's physician order for Keppra was initially a tablet by mouth. He said the original order on [DATE] was 750 mg once a day for seizures. The consulting pharmacist said on [DATE] there was an order for 1000 mg every morning, then it was discontinued on [DATE]. He said the order for Keppra 1000 mg, Never went out, and confirmed they had a discontinued electronic order. The consulting pharmacist said there's no documentation of why it didn't go out to the facility. He stated, It looks like the first liquid order was [DATE]. The consulting pharmacist said the Keppra solution order was 750 mg one time a day for seizures. He said the only medication that was delivered on [DATE] was for Keppra 750 mg tablet, once a day. He confirmed 7. 5 ml/mg is not equivalent to a 1000 mg tablet. He stated, 1000 mg would be equivalent to 10 ml.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. A review of Resident #5's admission record revealed an initial admitted [DATE] and a re-admitted [DATE], with diagnoses to include epilepsy, anoxic brain damage, muscle wasting and atrophy, muscle weakness, gastrostomy status, and tracheostomy status.<br><br>Review of Resident #5's hospital discharge medication list, dated [DATE], revealed the following:<br><br>-Aspirin, 81 mg, per feeding tube, tab [tablet], daily, first dose: [DATE] 09:00, last dose given: [DATE] 08:40 continue medication: yes .<br><br>-Lacosamide, 200 mg, per feeding tube, tab, q 12 h [every 12 hours], first dose: [DATE] 09:00, last dose given: [DATE] 08:41 continue medication: yes .<br><br>-Levetiracetam, 1,500 mg, per feeding tube, soln [solution], q 12 h, first dose: [DATE] 09:00, last dose given: [DATE] 08:41 continue medication: yes .<br><br>-Sodium Zirconium Cyclosilicate, 10 g [grams], per feeding tube, packet, STAT x1, first dose: [DATE] 18:01 [6:01] continue medication: yes .<br><br>Review of Resident #5's physician orders for February 2025 revealed no evidence of an order for Levetiracetam, 1,500 mg, every 12 hours; Aspirin, 81 mg, daily; or Sodium Zirconium Cyclosilicate, 10 grams, as documented on the hospital discharge medications list.<br><br>Review of Resident #5's physician orders, with a start date of [DATE] and an end date of [DATE], revealed an order for Lacosamide Oral Tablet 200 MG (Lacosamide) *Controlled Drug* Give 1 tablet via PEG-Tube every 12 hours related to essential (primary) hypertension.<br><br>Review of Resident #5's physician orders, with a start date of [DATE] and an end date of [DATE], revealed an order for Lacosamide Oral Tablet 200 MG (Lacosamide) *Controlled Drug* Give 1 tablet via PEG-Tube every 12 hours for seizures.<br><br>A review of Resident #5's MAR, for February 2025 and [DATE], revealed Lacosamide was not administered on the following dates/times: ,d+[DATE] at 9:00 a.m., ,d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 a.m., , d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 a.m., ,d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 p.m., ,d+[DATE] at 9:00 a.m., and ,d+[DATE] at 9:00 p.m.<br><br>A review of Resident #5's progress note, dated [DATE] at 07:06 a.m., revealed the following:<br><br>Resident had an episode of involuntary movement of shoulders and foaming at the mouth. The vital signs were as follows: Temp [temperature] 97.2, oxygen 94%, BP [blood pressure] ,d+[DATE] pulse 86, respirations 18. The seizure medication (Lacosamide) was not available. The pharmacy was contacted and notified me that the medication will be delivered in the AM. The lab was unable to do venipuncture to get sample for CBC and BMP [basic metabolic panel]. Nurse paged doctor and still awaiting response.<br><br>A review of Resident #5's progress note, dated [DATE] at 11:00 a.m., revealed the following: Observed patient with involuntary movement of bilateral shoulders. [NAME] frothy coming from her mouth. Mouth was cleaned. MD notified. Orders to notify family and discuss if they wanted a DNR [do not resuscitate] or her sent to [Hospital] for evaluation. The [family member] aware of orders.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | An interview was conducted on [DATE] at 2:50 p.m. with Staff J, Risk Manager (RM)/RN. She said on [DATE] the Unit Manager and Assistant Director of Nursing (ADON) talked to the family member of Resident #5 by phone. Staff J, RM/RN spoke to Resident #5's family member who made her aware the resident had a blood infection, dehydration, and her seizure medication had not been administered since her last hospitalization . She confirmed Resident #5 was transferred to the hospital following seizure like activity. Staff J, RM/RN said she spoke to Resident #5's PCP who said it may or may not have been seizure like activity. She said the PCP stated it could have been carbon dioxide retention, and her prognosis was not good from the start. Staff J, RM/RN stated, I'm starting to dive into this one. She said a hospital discharge medication list was never sent to the facility until she asked the admissions coordinator to obtain it. She said the nurses were using a medication list that was sent from the hospital, but it wasn't the discharge medication list. Staff J, RM/RN said Lacosamide for seizures was on the list the nurses used, but when she received the hospital discharge medication list there were two medications that were not on Resident #5's orders at the facility. She said one of the two medications not reconciled was a seizure medication and confirmed Resident #5 never received it.<br><br>On [DATE] at 2:29 p.m., a phone interview was conducted with Staff H, LPN/Nurse Supervisor. She said Resident #5 was having seizure like activity on [DATE]. She stated, I never saw her do that before. I've never seen her have a seizure. Staff H, LPN/Nurse Supervisor said Resident #5's right arm was twitching and jerking. She said Resident #5's seizure like activity was on-going the morning of [DATE]. She said the day shift nurse made her aware and they both saw Resident #5 twitching. Staff H, LPN/Nurse Supervisor said it was a big question with the family related to DNR status. Staff H, LPN/Nurse Supervisor said the 11:00 am - 7:00 p.m. shift nurse, Staff J, LPN, had already called the on-call doctor and she's the one who initially saw the seizure like activity. She said the observation of Resident #5 occurred around the change of shift in the morning. She said she advised the 11:00 am - 7:00 p.m. shift nurse to call the PCP directly. She said she recalled the nurse telling her, Something was going on with medication.<br><br>An interview was conducted on [DATE] at 11:11 a.m. with the DON. He said a family member of Resident #5 called and said the hospital told her the resident had not been receiving her seizure medications since her last hospital stay. He said they initiated an investigation, reported an allegation of neglect, then identified the nurse who failed to adhere to the facility admissions checklist. He said they started an investigation related to incorrect admission/readmission data collection and the nurse failed to identify the correct medication discharge reconciliation list.<br><br>On [DATE] at 11:41 a.m., a phone interview was conducted with Staff E, LPN. She said Staff I, LPN was the admitting nurse for Resident #5 on [DATE], and she was the assisting nurse. Staff E, LPN said she was helping Staff I, LPN with Resident #5's medication list and putting notes in. She said Staff I, LPN was supposed to go back and verify the medication list with the physician. Staff E, LPN stated, What I probably did was put the medications in. Staff E, LPN stated, How it goes is they put medicine in, the nurse is supposed to verify. I was just helping.<br><br>3) Review of Resident #3's admission record revealed he was admitted to the facility on [DATE] and discharged on [DATE] to an acute care hospital. He was admitted with medical diagnoses of Type 2 Diabetes Mellitus with hyperglycemia, legal blindness, epilepsy, and acute kidney failure.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #3's progress notes revealed a note, dated [DATE] at 6:11 a.m., written by Staff E, Licensed Practical Nurse (LPN) as: During nurse to nurse report the off going nurse informed that resident Blood Glucose levels was reading high even after receiving short acting insulin twice on his shift. Further Assessment of resident Blood Glucose levels and was still reading high that was unreadable. Called on call NP [Nurse Practitioner] for Primary Physician of my concerns and was advised to send resident to ER [emergency room ] for further observation and treatment.<br><br>An interview was conducted on [DATE] at 3:30 p.m. with Staff E, LPN, she said on [DATE] she was working the 11:00 p.m.-7:00 a.m. shift, and she received report from Staff D, LPN who said Resident #3's blood sugar was high and he gave 20 units of insulin at 6:00 p.m. and it was still high when he rechecked the blood sugar so he gave another 20 units at 11:00 p.m. Staff E, LPN said when Staff D, LPN told her what he did, she said she thought Resident #3 was going to bottom out and crash so she went and checked his blood sugar and it was still high. She said the monitor wouldn't even read the blood sugar, it just said high, Staff E, LPN said Staff D, LPN tried to tell her Resident #3's blood sugar was 600. But I know the blood sugar machine doesn't even read that high. Staff E, LPN said Staff D, LPN never charted about the blood sugar readings or how much insulin he gave. Staff E, LPN said Staff D, LPN told her he did not call the doctor before he gave the insulin. So, after she heard that she immediately checked Resident #3's blood sugar and that is when the monitor read high, she checked it again and it still read high so at 12:42 a.m. on [DATE] she called the doctor and told the doctor what Staff D, LPN told her and said she was worried Resident #3 was going to bottom out and die and she wouldn't know because he was not verbal, and he always just laid there. The doctor gave her orders to send the resident out to the hospital, so she did and told the Nursing Home Administrator and the Director of Nursing (DON) on [DATE] at 12:42 a.m. what Staff D, LPN did.<br><br>Review of Resident #3's physician orders revealed an order with a start date of [DATE] and an end date of [DATE] as:<br><br>-Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale:<br><br>if 0 - 150 = 0 No Insulin needed;<br><br>151 - 199 = 1 ;<br><br>200 - 249 = 2;<br><br>250 - 299 = 4;<br><br>300 - 349 = 6;<br><br>350 - 399 = 8 > [greater than] 400 call MD [Medical Doctor], subcutaneously before meals for BS [blood sugar].<br><br>-A physician order with a start date of [DATE] and an end date of [DATE] revealed Insulin Aspart Injection Solution (Insulin Aspart) Inject 2 unit subcutaneously before meals for PREVENTATIVE.<br><br>(continued on next page) |

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| | 105283 | A. Building<br>B. Wing | 04/11/2025 |

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| Lakeland Hills Center | 610 E Bella Vista Dr<br>Lakeland, FL 33805 |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #3's medical record revealed no documentation from Staff D, LPN Resident #3 had a high blood sugar reading. There was no documentation of the physician being notified, and there was no order to administer 20 units of insulin for high blood sugar readings.<br><br>An interview was conducted on [DATE] at 2:50 p.m. with Staff K, Registered Nurse (RN)/ Risk Manager, she said on [DATE] Staff E, LPN informed the previous Nursing Home Administrator (NHA) of an allegation of neglect related to Staff D, LPN not following Resident #3's insulin orders for Insulin Aspart. She said Staff D, LPN was interviewed, and he said Resident #3's blood sugar was high, so he gave 20 units of insulin. He checked it again and it was still high, so he gave another 20 units of insulin. She stated Staff D, LPN did not get a physician order to administer 20 units of insulin either time he administered it. The Risk Manager said Resident #3 was sent to the hospital and found to have hyperglycemia and Influenza A. The last she knew Resident #3 was still at the hospital during the investigation.<br><br>An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:55 a.m. he said they found a situation where the licensed nurse failed to adhere with the scope of practice in relation to Resident #3. The DON said when he interviewed Staff D, LPN related to administering insulin without a physician's order twice, Staff D, LPN said he did that because that is what the doctor would have told him to do anyway.<br><br>A phone interview was conducted on [DATE] at 2:13 p.m. with Staff D, LPN he said Resident #3 was nonverbal and, in a Geri-chair, But, that evening ([DATE]) around dinner time four white people who were visiting came into his [Resident #3's] room and he was a black man who didn't talk. So, I just waited until they left, after dinner, so I checked the sugar after dinner, because I was busy before that. And when I checked his sugar the monitor said high typically that means the blood sugar is over 600, and I did something kind of stupid and instead of waiting to call the doctor I kind of panicked, so I gave him 20 units of Aspart because that's what they normally tell me to give when the sugar is high. Then I waited about three to four hours after giving him the insulin because that type of insulin usually gets out the system in about four hours so when I rechecked it was still reading high, so I gave another 20 units and by that time the nurse from the next shift was on shift and I told her what I did and then I left. I don't remember if I documented anything<br><br>An interview was conducted on [DATE] at 10:20 a.m. with Resident #3's physician. He said he was the Medical Director and Resident #3 was one of his patients. He said he remembered when the nurse gave insulin twice without a physician's order. He said there should have been no reason a nurse did not contact the physician when the blood sugar monitor read high. He said the resident had an order to notify the physician if the blood sugar is above 400 so the nurse should have contacted a physician. He said his Advanced Practical Registered Nurse (APRN) is at the facility every day and there is always a physician on call 24 hours a day. He said nurses should not be administering medications without an order.<br><br>Review of the facility's policy titled Physician Orders, with an effective date of [DATE], revealed the following:<br><br>Policy . At the time each resident is admitted , the facility will have physician orders for their immediate care. Physician orders will be dated and signed at next physician visit. Nurses, therapists and pharmacists may take verbal and/or telephone orders as permitted by their State licensure board.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Procedure<br><br>1. Obtain one of the following types of physician orders:<br><br>a. Verbal<br><br>b. Telephone order<br><br>c. [NAME] [TRUNCATED] |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866<br><br>Based on interviews and record review, the facility Quality Assurance and Performance Improvement Committee (QAPI) failed to implement an effective Performance Improvement Plan (PIP) related to Diabetes Management for one out of two sampled QAPI plans reviewed.<br><br>Findings included:<br><br>1. Review of Resident #3's admission record revealed he was admitted to the facility on [DATE] and discharged on [DATE] to an acute care hospital. He was admitted with medical diagnoses of Type 2 Diabetes Mellitus with hyperglycemia, legal blindness, epilepsy, and acute kidney failure.<br><br>Review of Resident #3's progress notes revealed a note, dated [DATE] at 6:11 a.m., written by Staff E, Licensed Practical Nurse (LPN) as: During nurse to nurse report the off going nurse informed that resident Blood Glucose levels was reading high even after receiving short acting insulin twice on his shift. Further Assessment of resident Blood Glucose levels and was still reading high that was unreadable. Called on call NP [Nurse Practitioner] for Primary Physician of my concerns and was advised to send resident to ER [emergency room ] for further observation and treatment.<br><br>An interview was conducted on [DATE] at 3:30 p.m. with Staff E, LPN, she said on [DATE] she was working the 11:00 p.m.-7:00 a.m. shift, and she received report from Staff D, LPN who said Resident #3's blood sugar was high and he gave 20 units of insulin at 6:00 p.m. and it was still high when he rechecked the blood sugar so he gave another 20 units at 11:00 p.m. Staff E, LPN said when Staff D, LPN told her what he did, she said she thought Resident #3 was going to bottom out and crash so she went and checked his blood sugar and it was still high. She said the monitor wouldn't even read the blood sugar, it just said high, Staff E, LPN said Staff D, LPN tried to tell her Resident #3's blood sugar was 600. But I know the blood sugar machine doesn't even read that high. Staff E, LPN said Staff D, LPN never charted about the blood sugar readings or how much insulin he gave. Staff E, LPN said Staff D, LPN told her he did not call the doctor before he gave the insulin. So, after she heard that she immediately checked Resident #3's blood sugar and that is when the monitor read high, she checked it again and it still read high so at 12:42 a.m. on [DATE] she called the doctor and told the doctor what Staff D, LPN told her and said she was worried Resident #3 was going to bottom out and die and she wouldn't know because he was not verbal, and he always just laid there. The doctor gave her orders to send the resident out to the hospital, so she did and told the Nursing Home Administrator and the Director of Nursing (DON) on [DATE] at 12:42 a.m. what Staff D, LPN did.<br><br>Review of Resident #3's physician orders revealed an order with a start date of [DATE] and an end date of [DATE] as:<br><br>-Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale:<br><br>if 0 - 150 = 0 No Insulin needed;<br><br>151 - 199 = 1 ;<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 200 - 249 = 2;<br><br>250 - 299 = 4;<br><br>300 - 349 = 6;<br><br>350 - 399 = 8 > [greater than] 400 call MD [Medical Doctor], subcutaneously before meals for BS [blood sugar].<br><br>-A physician order with a start date of [DATE] and an end date of [DATE] revealed Insulin Aspart Injection Solution (Insulin Aspart) Inject 2 unit subcutaneously before meals for PREVENTATIVE.<br><br>Review of Resident #3's medical record revealed no documentation from Staff D, LPN Resident #3 had a high blood sugar reading. There was no documentation of the physician being notified, and there was no order to administer 20 units of insulin for high blood sugar readings.<br><br>An interview was conducted on [DATE] at 2:50 p.m. with Staff K, Registered Nurse (RN)/ Risk Manager, she said on [DATE] Staff E, LPN informed the previous Nursing Home Administrator (NHA) of an allegation of neglect related to Staff D, LPN not following Resident #3's insulin orders for Insulin Aspart. She said Staff D, LPN was interviewed, and he said Resident #3's blood sugar was high, so he gave 20 units of insulin. He checked it again and it was still high, so he gave another 20 units of insulin. She stated Staff D, LPN did not get a physician order to administer 20 units of insulin either time he administered it. The Risk Manager said Resident #3 was sent to the hospital and found to have hyperglycemia and Influenza A. The last she knew Resident #3 was still at the hospital during the investigation. The Risk Manager said Resident #3 was sent to the hospital and found to have hyperglycemia and influenza A. The last she knew Resident #3 was still at the hospital during the investigation. The Risk Manager said the family was notified on [DATE] and Department of Children and Families (DCF) and the police were notified on [DATE]. Staff K, RN/Risk Manager said they did a quality assurance/performance improvement plan (QAPI), and education. She said all residents with insulin sliding scales were reviewed and staff were provided with abuse and neglect education.<br><br>(continued on next page) |

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|---|---|
| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:55 a.m. he said they found a situation where the licensed nurse failed to adhere with the scope of practice in relation to Resident #3. On February 5th, 2025, a QAPI was put in place with a goal of the nurse will administer medications ordered by a medical practitioner. The target date of compliance was [DATE]th, 2025. On [DATE] is when the Quality Assurance meeting occurred, and the Interdisciplinary Team (IDT) team discussed and approved the QAPI plan. The medical doctor was involved and approved of the plan. The DON said they did a full house audit on every resident who had an order for insulin, and they looked at the insulin orders and the sliding scale orders to ensure the nurses were administering the insulin according to the sliding scale orders. He said he also looked at hemoglobin A1c lab orders to ensure the lab was drawn and reported if needed to the physician and they also made sure the labs were drawn within three to six months. The DON said 100% of all the licensed nurses did in services to include medication administration, following physician orders, and contacting the physician if blood sugars are out of parameters. The education was provided on [DATE] with the goal of completing the education on [DATE]. The DON said, Right now, we are doing competencies of administration of injections. We review all the new admissions and readmitted residents in the morning clinical meetings every 24 hours or every 72 hours on Monday to ensure their insulin is being administered as ordered and the order was transcribed correctly. The DON said they do not document the reviews, and he said he does not have an audit tool but that's a good idea.<br><br>A phone interview was conducted on [DATE] at 2:13 p.m. with Staff D, LPN he said Resident #3 was nonverbal and, in a Geri-chair, But, that evening ([DATE]) around dinner time four white people who were visiting came into his [Resident #3's] room and he was a black man who didn't talk. So, I just waited until they left, after dinner, so I checked the sugar after dinner, because I was busy before that. And when I checked his sugar the monitor said high typically that means the blood sugar is over 600, and I did something kind of stupid and instead of waiting to call the doctor I kind of panicked, so I gave him 20 units of Aspart because that's what they normally tell me to give when the sugar is high. Then I waited about three to four hours after giving him the insulin because that type of insulin usually gets out the system in about four hours so when I rechecked it was still reading high, so I gave another 20 units and by that time the nurse from the next shift was on shift and I told her what I did and then I left. I don't remember if I documented anything<br><br>An interview was conducted on [DATE] at 10:20 a.m. with Resident #3's physician. He said he was the Medical Director and Resident #3 was one of his patients. He said he remembered when the nurse gave insulin twice without a physician's order. He said there should have been no reason a nurse did not contact the physician when the blood sugar monitor read high. He said the resident had an order to notify the physician if the blood sugar is above 400 so the nurse should have contacted a physician. He said his Advanced Practical Registered Nurse (APRN) is at the facility every day and there is always a physician on call 24 hours a day. He said nurses should not be administering medications without an order.<br><br>2. Review of Resident #6's Admission Record revealed he was admitted the facility on [DATE] with medical diagnoses including: Type 2 Diabetes Mellitus with other specified complication, difficulty in walking, lack of coordination, hydrocele, syncope and collapse, muscle wasting and atrophy, abnormalities of gait and mobility, and unsteadiness on feet.<br><br>Review of Resident #6's physician orders revealed an order, dated [DATE], without an end date for Humalog Injection Solution 100 units/ml [100 units per milliliters] (insulin Lispro) Inject as per sliding scale:<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | If ,d+[DATE]= no insulin<br><br>,d+[DATE] = 2 units<br><br>,d+[DATE] = 4 units<br><br>,d+[DATE] = 6 units<br><br>,d+[DATE] = 8 units<br><br>,d+[DATE] = 10 units<br><br>,d+[DATE] = 12 units Greater than 350 notify MD.,<br><br>Subcutaneously two times a day for DM [diabetes mellitus].<br><br>Review of Resident #6's March MAR revealed the following:<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 360 and 12 units of insulin was administered.<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 383 and 12 units of insulin was administered.<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 399 and 12 units of insulin was administered.<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 375 and 12 units of insulin was administered.<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 365 and 12 units of insulin was administered.<br><br>Review of Resident #6's April MAR revealed the following:<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 379 and 12 units of insulin was administered.<br><br>-On [DATE] at 6:30 a.m. there was no documentation Resident #6 had his blood sugar checked or insulin administration.<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 373 and 12 units of insulin was administered.<br><br>-On [DATE] at 5:00 p.m. his blood sugar was documented as 374 and 12 units of insulin was administered.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On [DATE] at 5:00 p.m. his blood sugar was documented as 388 and 12 units of insulin was administered.<br><br>Resident 6's medical record did not reveal documentation Resident #6's physician was notified of blood sugar levels above 350 as ordered for the months of March and [DATE].<br><br>An interview was conducted with the DON on [DATE] at 10:13 a.m. He reviewed Resident #6's physician orders and MAR and said he feels the physician order to notify the MD if his blood sugar was greater than 350 was a typo. The DON said the staff should have been following the order and the typo could have been changed. He said he reviewed Resident #6's order during his full house audit and it was missed.<br><br>A phone interview was conducted on [DATE] at 9:01 a.m. with Resident #6's physician. She confirmed she is the primary physician for Resident #6. She said the protocol is to call her if the blood sugar is above 350, but the standard changed to notify her at 400. She said now the expectation is to notify her if the blood sugar is above 400. She stated, If it is a one-time occurrence, she will provide an order to give extra coverage. She said if it is a continued pattern, they will look at the baseline blood sugar and, It's a case-by-case basis.<br><br>Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI) Plan, with an effective date of [DATE], showed the following:<br><br>Policy: The Facility will develop a QAPI Plan to describe how the facility will track and measure performance; establish goals and thresholds for performance measurement; identify and prioritize deviations for performance and other problems and issues; systematically investigate and analyze to determine underlying causes of systemic problems and adverse events; develop and implement corrective actions or performance improvement activities; monitor/evaluate the effects of corrective actions/performance activities.<br><br>The QAPI Plan is reported to QA&A Compliance Committee with regular updates regarding progress with improvement activity, or corrective actions when there is unplanned or unexpected response to such activities.<br><br>It is the responsibility of the QA&A Compliance Committee to consider all data presented by the improvement team(s) and to direct the team(s) to continue, change or conclude the assignment.<br><br>.Identify and prioritize<br><br>Once issues are identified through tracking, trending and analysis, the QA&A Compliance Committee will assist with prioritizing the concerns in order that high risk areas are studied and corrected first.<br><br>.Develop and implement corrective actions<br><br>o .Plan, Do, Study, Act (PDSA)<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Once items are prioritized a specific plan is developed to address the issue, the plan is implemented and monitored to see the effect the action has on the area being studied . The PIP [performance improvement plan] team will act on these findings by continuing the action if effective, changing the action if ineffective (after further planning), or discontinuing the action once the issues resolved.<br><br>Monitor and evaluate the effects<br><br>o PDSA continues until the PI [performance improvement] team is assured that the appropriate correction has occurred.<br><br>o PI team selects a team member to report activity to QA&A Compliance Committee for comment and recommendations.<br><br>o The QA&A Compliance Committee will ensure the team(s) are provided with resources to review, inspect, validate and analyze concerns related to the assignment. |