STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145735	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of River Oaks	14500 South Manistee Burnham, IL 60633

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on interview and record review, the facility failed to 1) identify emergency care was needed for two residents who exhibited a change in physical and mental status. These failures applied to two (R1, R2) of four residents reviewed for nursing care and resulted in R1 experiencing a delay in care of two hours before emergency services were called, after being assessed with high blood pressure and mental status change; R1 was admitted to the hospital with a critical change in neurological condition; this failure also resulted in R2 going into cardiac arrest approximately two hours after the nurse assessed R2 with low blood sugar. Findings include: R1 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included history of cerebral infarction, type II diabetes and Dementia. According to the Minimum Data Set, R1 demonstrated mild cognitive impairment, but was able to make needs known to staff. Per nurses notes effective [DATE] at 5:14pm, R1 was found in his room vomiting. The nurse on duty (V4 Registered Nurse) assessed vital signs which included abnormal blood pressure (,d+[DATE]) and decreased oxygen saturation (87%) on room air. V4 administered supplemental oxygen via nasal cannula at two liters. No further vital signs were available for review. V4 documented that R1 had four episodes of vomiting within the hour, looked pale and was confused. In the same note, V4 wrote that R1's physician was notified of R1's condition and received orders to send R1 to the emergency room for evaluation. 911 ambulance run sheet of [DATE] indicated that a call was placed from the facility at 7:13pm (two hours after V4 initially assessed R1) and arrived at R1's bedside at 7:25pm. Per the report, paramedics assessed R1 who was alert and complaining of shortness of breath with no relief from O2 (oxygen) via nursing home. Paramedics removed the nasal cannula which at that time was delivering three liters of oxygen and assessed R1 to have 88% oxygen saturation on room air. They then applied a non-rebreather face mask with 15 liters of oxygen which increased saturation to 100%. Blood pressures taken were ,d+[DATE] at 7:35pm and ,d+[DATE] at 7:40PM. Per emergency room reports, R1 underwent a CT head scan and was diagnosed with a large subdural hematoma (blood in brain) with midline shift. Results of the scan recommended emergent neurosurgical consultation. R1 was discharged and air lifted to an associated hospital for advanced care and treatment. R1 expired in the hospital on [DATE]. As of [DATE], cause of death continues to be investigated and is not available at this time. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:45pm V12 R1's Physician was interviewed and said that subdural hematomas can be a result of high blood pressure, especially to someone with chronic hypertension (high blood pressure). V12 said, these patients, as they age are at higher risk of developing brain bleeds and strokes and the risk is increased depending on other medical issues the patient may have. V12 said if a patient is experiencing an increase of blood pressure such as the 170's or higher, it is important to assess mental status. If the mental status has decreased from baseline, it is an emergency and the patient should be rushed to the emergency room via 911 to rule out a stroke, brain bleed or hypertensive encephalopathy. Uncontrolled, the increased blood pressure can cause an increase of any bleeding in the brain leading to a shift from the midline. If that happens, the patient will need to see a neurosurgeon right away to evacuate the bleed and the prognosis is usually poor. V12 said they did not receive any notification from staff regarding R1's condition prior to hospitalization and received notification via text on [DATE] at 7:10pm that R1 was hospitalized . Review of R1's care plan for hypertension initiated [DATE] states in part: Monitor/document/report to Medical Doctor as needed any signs/symptoms of malignant hypertension such as headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea). R2 was a [AGE] year old male admitted to the facility [DATE] with diagnoses that included type II diabetes, chronic kidney disease and hypertension. V7 RN (Registered Nurse) was interviewed via phone on [DATE] at 5:20PM and said that they worked the 7am-3pm and 3pm-11pm shifts on [DATE] and was the primary nurse caring for R1 during that time. V7 said, during evening (9pm) medication pass, R2 was noted with symptoms related to low blood sugar. V7 assessed the blood sugar to be 70 something which was considered to be low. V7 gave R2 two packets of sugar and two ounces of orange pop to increase the blood sugar and monitored for changes. V7 did not offer R2 any food to eat at that time. V7 said that about 15 minutes after, R2's blood sugar was checked again and was lower- 60 something. V7 gave an emergency glucagon injection which was borrowed from another resident on a different unit. V7 was questioned further and said that they couldn't remember exactly what happened and the times in which they checked on R2. V7 referred the Surveyor to check the chart because everything they did was documented accurately. Per nursing notes recorded by V7 RN on [DATE], at approximately 9:15pm, R2 was assessed with symptoms of low blood sugar including sweating and slow with speech. Blood sugar was documented in the note at 9:15PM to be 73. At 9:40pm the next blood sugar documented in the notes was 62. At 9:40pm V7 noted that an emergency medication commonly used to treat severe low blood sugar (glucagon) was administered. At 10:00pm vital signs were taken and recorded in the progress notes by V7 which included a blood sugar result of 107, and V7 wrote states he feels better. R2 was placed back to bed as he wanted to lie down. At 10:56pm, V7 observed R2 in bed slow to respond, and left to retrieve equipment to take vital signs. When V7 returned at 11:00pm R2 was found unresponsive, not breathing and without a pulse. CPR was initiated and at 11:02pm 911 was called. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Per the ambulance report, paramedics were called at 11:03pm and facility staff informed dispatch that R2 was last seen well at 10:50pm before going into cardiac arrest. Paramedics arrived at the bedside at 11:11pm, administered lifesaving interventions which included dextrose (sugar) to an intraosseous (bone marrow) catheter, CPR and intubation. Blood sugar checked during CPR at 11:27 was 45. R2 was revived by paramedics prior to reaching the hospital. Per hospital emergency room reports, R2 was transported to the nearest emergency room and was treated for diagnoses of hypoglycemia (low blood sugar), respiratory distress, and cardiac arrest. R2 was treated and discharged from the hospital [DATE] to home hospice. Certificate of death reads that R2 expired under care of home hospice on [DATE] and listed cause of death Hypoxic Brain Injury. Care plan initiated [DATE] stated in part: R2 is at risk for hypo/hyperglycemia related to having a diagnosis of diabetes. Blood sugars and other lab values will be within acceptable parameters according to the physician through next review. On [DATE] at 2:45pm V12 R2's Physician was interviewed and said that when it was established that R2 was having symptoms of low blood sugar, the best thing to do would have been to give R2 something to eat. Blood sugars should range typically from ,d+[DATE] for people with diabetes. Although juice and sugar will quickly cause the blood sugar to increase, the result is only temporary and does not address the underlying issue. R2 should have quickly gone out to the emergency room after the nurse determined the blood sugar was critically low and a glucagon injection was needed in order to prevent further lowering of the blood sugar. If the blood sugar gets too low, as in the case of R2 and the patient can stop breathing, the brain loses oxygen and can lead to fatality. Based on observation, interview, and record review, facility staff failed to monitor blood sugar levels for two residents who received diabetic medications daily. These failures applied to two (R5, R6) of four residents reviewed for nursing care and resulted in R5 being assessed with severe low blood sugar and mental status decline requiring emergency treatment after not having orders for blood sugar monitoring; and R6 failed to have any documented blood sugars for two weeks. Findings include: R5 is a [AGE] year old male who admitted to the facility [DATE] with diagnoses that included type II diabetes, hypertension (high blood pressure) and epilepsy (seizures). At 2:45pm, V11 CNA said on [DATE], they were assigned to provide continuous observation for R5 and their roommates. V11 relieved a CNA and believed R5 to be sleeping which was unusual. When V11 went to arouse R5, V11 noticed R5 was not verbally responding as expected and had white foam coming from his nose and mouth. V11 immediately called the nurse for assistance who was passing medications at the end of the hall. On [DATE] at 2:09pm V8 LPN (Licensed Practical Nurse) was interviewed and said that on [DATE], towards the beginning of the morning shift, they were called to R5's room. R5 was found to be staring and not responding to verbal cues. V8 took vital signs and noted that R5's blood sugar was really low. V8 said they had not seen or assessed R5 prior to being called to the room, and it was unknown how long R5 had been in that state. V8 said they gave the glucagon injection to R5 and called 911 because R5 was also having difficulty breathing and had a low oxygen saturation. V8 could not determine when R5's blood sugar was last checked prior to this incident. V8 said they were aware that R5 received medications for diabetes but was unaware of when blood sugars were scheduled to be checked for R5. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Per nurses note on [DATE] at 8:12AM R5 was observed in bed with white foam and blood oozing from the nose. Blood glucose checked by nurse was 48. The nurse administered emergency glucagon and called 911. According to vital signs documented in the electronic health record, the last documented blood sugar checked for R5 was on [DATE]. Physician order sheet active prior to R5's hospitalization included orders for Metformin 1000 mg (milligrams) twice daily, and Insulin glargine (long acting) 30 units once every night. No orders were noted for scheduled blood glucose monitoring. According to hospital emergency room report of [DATE], R5 was treated for hypoglycemia (low blood sugar), encephalopathy (brain dysfunction) likely due to hypoglycemia and sepsis. R5 returned to the facility [DATE]. Orders were placed for blood glucose (sugar) checks to be completed twice daily, in the morning and evening, and were also reflected on the Medication Administration Record. On [DATE] insulin glargine was reduced from 28 units to 5 units every night. V3 ADON (Assistant Director of Nursing) was interviewed on [DATE] at 11:18am and said that every resident who is receiving insulin should have their blood sugar checked and monitored at least once daily to prevent and treat hypoglycemia. R5's nursing care plan was reviewed and did not include a plan for diabetes management. R6 is a [AGE] year old male admitted to the facility [DATE] and had diagnoses that include encephalopathy, type II diabetes and cognitive communication deficit. R6 was observed in bed on [DATE] at 2:30pm, alert but not coherent. R6 was receiving continuous gastric feeding and had a Safety Sitter (Certified Nursing Assistant) at the bedside. At 2:45pm, V11 CNA said that they had been sitting in the room since the morning shift began at 7am and V11 had not noted R6 to have their blood sugar checked when the nurse (V8) administered morning medication. At 2:50pm, V8 said R6 was given medication for diabetes in the morning, that all charting and documentation had been completed for the shift and was unable to determine when R6 last had a blood sugar check. R6's electronic health record indicated that no blood sugars had been documented for R6 since [DATE]. Physician order sheet dated [DATE] included an order for blood glucose checks twice daily at 9am and 5pm for type II diabetes. Care Plan initiated [DATE] stated in part: R3 is at risk for hypo/hyperglycemia related to having a diagnosis of diabetes. Blood sugars and other lab values will be within acceptable parameters according to the physician through next review. [Blood glucose checks] as ordered. The facility was unable to provide a policy related to managing diabetes upon request.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on observation, interview and record review, facility staff failed to 1) identify emergency care was needed for two residents (R1 and R2) who exhibited a change in physical and mental status; 2) failed to monitor blood sugar levels for two residents (R5 and R6) who received diabetic medications daily; 3) failed to accurately demonstrate insulin preparation and 4) failed to ensure availability of resident specific diabetes medications used for emergencies. Findings include: R1 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included history of cerebral infarction, type II diabetes and Dementia. According to the Minimum Data Set, R1 demonstrated mild cognitive impairment, but was able to make needs known to staff. Per nurses notes effective [DATE] at 5:14pm, R1 was found in his room vomiting. The nurse on duty (V4 Registered Nurse) assessed vital signs which included abnormal blood pressure (,d+[DATE]) and decreased oxygen saturation (87%) on room air. V4 administered supplemental oxygen via nasal cannula at two liters. No further vital signs were available for review. V4 documented that R1 had four episodes of vomiting within the hour, looked pale and was confused. In the same note, V4 wrote that R1's physician was notified of R1's condition and received orders to send R1 to the emergency room for evaluation. On [DATE] at 1:04pm V4 (Registered Nurse) was interviewed and said, when they went to administer evening medications to R1 during dinner (5pm), R1 was found in bed with vomit and confused. V4 said after taking vitals, they called for private ambulance however the approximate arrival time was 45 minutes to an hour. V4 said upon hearing this, 911 was called instead. 911 ambulance run sheet of [DATE] indicated that a call was placed from the facility at 7:13pm (two hours after V4 initially assessed R1) and arrived at R1's bedside at 7:25pm. Per the report, paramedics assessed R1 who was alert and complaining of shortness of breath with no relief from O2 (oxygen) via nursing home. Paramedics removed the nasal cannula which at that time was delivering three liters of oxygen and assessed R1 to have 88% oxygen saturation on room air. They then applied a non-rebreather face mask with 15 liters of oxygen which increased saturation to 100%. Blood pressures taken were ,d+[DATE] at 7:35pm and ,d+[DATE] at 7:40PM. Per emergency room reports, R1 underwent a CT head scan and was diagnosed with a large subdural hematoma (blood in brain) with midline shift. Results of the scan recommended emergent neurosurgical consultation. R1 was discharged and air lifted to an associated hospital for advanced care and treatment. R1 expired in the hospital on [DATE]. As of [DATE], cause of death continues to be investigated and is not available at this time. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:45pm V12 R1's Physician was interviewed and said that subdural hematomas can be a result of high blood pressure, especially to someone with chronic hypertension (high blood pressure). V12 said, these patients, as they age are at higher risk of developing brain bleeds and strokes and the risk is increased depending on other medical issues the patient may have. V12 said if a patient is experiencing an increase of blood pressure such as the 170's or higher, it is important to assess mental status. If the mental status has decreased from baseline, it is an emergency and the patient should be rushed to the emergency room via 911 to rule out a stroke, brain bleed or hypertensive encephalopathy. Uncontrolled, the increased blood pressure can cause an increase of any bleeding in the brain leading to a shift from the midline. If that happens, the patient will need to see a neurosurgeon right away to evacuate the bleed and the prognosis is usually poor. V12 said they did not receive any notification from staff regarding R1's condition prior to hospitalization and received notification via text on [DATE] at 7:10pm that R1 was hospitalized . R2 was a [AGE] year old male admitted to the facility [DATE] with diagnoses that included type II diabetes, chronic kidney disease and hypertension. V7 RN (Registered Nurse) was interviewed via phone on [DATE] at 5:20PM and said that they worked the 7am-3pm and 3pm-11pm shifts on [DATE] and was the primary nurse caring for R1 during that time. V7 said, during evening (9pm) medication pass, R2 was noted with symptoms related to low blood sugar. V7 assessed the blood sugar to be 70 something which was considered to be low. V7 gave R2 two packets of sugar and two ounces of orange pop to increase the blood sugar and monitored for changes. V7 did not offer R2 any food to eat at that time. V7 said that about 15 minutes after, R2's blood sugar was checked again and was lower- 60 something. V7 gave an emergency glucagon injection which was borrowed from another resident on a different unit. V7 said every resident with diabetes taking insulin did not have orders for glucagon and V7 did not have access to the emergency medication cabinet. V7 also said they could not confirm if any nurses working at the time had login information to access the cabinet. V7 was questioned further and said that they couldn't remember exactly what happened and the times in which they checked on R2. V7 referred the surveyor to check the chart because everything they did was documented accurately. Per nursing notes recorded by V7 RN on [DATE], at approximately 9:15pm, R2 was assessed with symptoms of low blood sugar including sweating and slow with speech. Blood sugar was documented in the note at 9:15PM to be 73. At 9:40pm the next blood sugar documented in the notes was 62. At 9:40pm V7 noted that an emergency medication commonly used to treat severe low blood sugar (glucagon) was administered. At 10:00pm vital signs were taken and recorded in the progress notes by V7 which included a blood sugar result of 107, and V7 wrote states he feels better. R2 was placed back to bed as he wanted to lie down. At 10:56pm, V7 observed R2 in bed slow to respond, and left to retrieve equipment to take vital signs. When V7 returned at 11:00pm R2 was found unresponsive, not breathing and without a pulse. CPR was initiated and at 11:02pm 911 was called. V7 documented a new order for glucagon on the Physician's Order Sheet at 10:25pm. It was also noted that the ordered times for insulin Lispro was modified at 10:09pm to change the 9pm dose to 5pm (dinner time). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V3 ADON (Assistant Director of Nursing) was interviewed on [DATE] at 11:18am and said the primary cause of low blood sugar is a result of receiving an inappropriate dose of insulin. The nurses should know that blood sugars should be taken prior to meals and rapid acting insulin should be given when meals are immediately available or after the resident is eating. V3 said that the insulin administration times for R2 did not align with the mealtimes and that it was possible that if R2's blood sugar was taken after meals, the result would be increased and not an accurate measure to safely give insulin. V3 also said that the facility does not provide meals at 9pm. Per the ambulance report, paramedics were called at 11:03pm and facility staff informed dispatch that R2 was last seen well at 10:50pm before going into cardiac arrest. Paramedics arrived at the bedside at 11:11pm, administered lifesaving interventions which included dextrose (sugar) to an intraosseous (bone marrow) catheter, CPR and intubation. Blood sugar checked during CPR at 11:27 was 45. R2 was revived by paramedics prior to reaching the hospital. Per hospital emergency room reports, R2 was transported to the nearest emergency room and was treated for diagnoses of hypoglycemia (low blood sugar), respiratory distress, and cardiac arrest. R2 was treated and discharged from the hospital [DATE] to home hospice. Certificate of death reads that R2 expired under care of home hospice on [DATE] and listed cause of death Hypoxic Brain Injury. On [DATE] at 2:45pm V12 (R2's Physician) was interviewed and said that when it was established that R2 was having symptoms of low blood sugar, the best thing to do would have been to give R2 something to eat. Blood sugars should range typically from ,d+[DATE] for people with diabetes. Although juice and sugar will quickly cause the blood sugar to increase, the result is only temporary and does not address the underlying issue. R2 should have quickly gone out to the emergency room after the nurse determined the blood sugar was critically low and a glucagon injection was needed in order to prevent further lowering of the blood sugar. If the blood sugar gets too low, as in the case of R2 and the patient can stop breathing, the brain loses oxygen and can lead to fatality. R5 is a [AGE] year old male who admitted to the facility [DATE] with diagnoses that included type II diabetes, hypertension (high blood pressure) and epilepsy (seizures). At 2:45pm, V11 CNA said on [DATE], they were assigned to provide continuous observation for R5 and their roommates. V11 relieved a CNA and believed R5 to be sleeping which was unusual. When V11 went to arouse R5, V11 noticed R5 was not verbally responding as expected and had white foam coming from his nose and mouth. V11 immediately called the nurse for assistance who was passing medications at the end of the hall. On [DATE] at 2:09pm V8 LPN (Licensed Practical Nurse) was interviewed and said that on [DATE], towards the beginning of the morning shift, they were called to R5's room. R5 was found to be staring and not responding to verbal cues. V8 took vital signs and noted that R5's blood sugar was really low. V8 said they had not seen or assessed R5 prior to being called to the room, and it was unknown how long R5 had been in that state. V8 said they gave the glucagon injection to R5 and called 911 because R5 was also having difficulty breathing and had a low oxygen saturation. V8 could not determine when R5's blood sugar was last checked prior to this incident. V8 said they were aware that R5 received medications for diabetes but was unaware of when blood sugars were scheduled to be checked for R5. Per nurses note on [DATE] at 8:12AM R5 was observed in bed with white foam and blood oozing from the nose. Blood glucose checked by nurse was 48. The nurse administered emergency glucagon borrowed from another resident on the unit and called 911. According to vital signs documented in the electronic health record, the last documented blood sugar checked for R5 was on [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician order sheet active prior to R5's hospitalization included orders for Metformin 1000 mg (milligrams) twice daily, and Insulin glargine (long acting) 30 units once every night. No orders were noted for scheduled blood glucose monitoring. According to hospital emergency room report of [DATE], R5 was treated for hypoglycemia (low blood sugar), encephalopathy (brain dysfunction) likely due to hypoglycemia and sepsis. R5 returned to the facility [DATE]. Orders were placed for blood glucose (sugar) checks to be completed twice daily, in the morning and evening, and were also reflected on the Medication Administration Record. On [DATE] insulin glargine was reduced from 28 units to 5 units every night. V3 ADON (Assistant Director of Nursing) was interviewed on [DATE] at 11:18am and said it is expected that every resident who has a diagnosis and receiving medications for treating diabetes should have regular blood sugar monitoring and their own supply of emergency glucagon. V3 said they were unaware of nurses borrowing medications to use in an emergency and that there is always a nurse in the building that has access to the automated emergency cabinet. V3 said while the frequency of the monitoring is determined by the Resident's physician, the times should coincide with administration of insulin and oral medications. V3 said there was a system in place for new orders to be triple checked meaning at least three different nurses or nurse supervisors are responsible for auditing new orders to identify errors or interventions that need to be place. V3 was unaware that insulin administration was scheduled outside of mealtimes for R2. V3 was also unaware that R5- who received long acting insulin did not have any orders for blood sugar monitoring and that R6 did not have blood sugars documented daily as ordered. An observation was conducted on [DATE] at 3pm with V10 Registered Nurse. V10 said that they administered insulin to multiple residents during the shift and was asked to demonstrate drawing up a dose of insulin from a vial. Using an insulin syringe, R10 verified drawing up 5 units of insulin however, on observation, Surveyor noted 7 units were drawn which was confirmed with V2 Director of Nursing at 3:27pm. V10 and V11 were also asked to demonstrate how they would administer insulin via an insulin pen, and the nurses demonstrated that they use syringes to draw from the pen in the same manner as the vial. V10 and V11 said that the safety needles that should be used with the insulin pens are not always available for every Resident and are often borrowed from others otherwise the nurses use the syringes. During this observation, V2 said they were unaware of this concern. On [DATE] at 2:45pm V12 Physician was interviewed and said that while insulin in vial and pen form are the same, the difference is that the pen allows ease of use and a more accurate dose. In order to draw from the pen, a manufacture compatible needle is screwed to the top and the amount of insulin to be administered is dialed in numbers on the other end allowing a proper dose. On the manufacturer website for insulin lispro, patient education indicated insulin lispro to be a fast acting insulin which starts working in about 15 minutes after injection. Each injection lasts up to ,d+[DATE] hours after administration. Insulin lispro manufacture information revised ,d+[DATE] states in part; 2.2 Administration Instructions for the Approved Routes of Administration Subcutaneous Injection: Administer the dose of [insulin lispro] within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.3 Hypoglycemia Hypoglycemia is the most common adverse reaction associated with insulins, including [insulin lispro]. Severe hypoglycemia can cause seizures, may be life-threatening, or cause death. Hypoglycemia can impair concentration ability and reaction time; this may place an individual and others at risk in situations where these abilities are important (e.g., driving or operating other machinery). Hypoglycemia can happen suddenly, and symptoms may differ in each individual and change over time in the same individual. Symptomatic awareness of hypoglycemia may be less pronounced in patients with longstanding diabetes, in patients with diabetic nerve disease, in patients using medications that block the sympathetic nervous system (e.g., betablockers) or in patients who experience recurrent hypoglycemia. Risk Factors for Hypoglycemia The risk of hypoglycemia after an injection is related to the duration of action of the insulin and, in general, is highest when the glucose lowering effect of the insulin is maximal. As with all insulins, the glucose lowering effect time course of [insulin lispro] may vary in different individuals or at different times in the same individual and depends on many conditions, including the area of injection as well as the injection site blood supply and temperature. Other factors which may increase the risk of hypoglycemia include changes in meal pattern (e.g., macronutrient content or timing of meals), changes in level of physical activity, or changes to co-administered medication. Patients with renal or hepatic impairment may be at higher risk of hypoglycemia.