STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report potential neglect (the failure of the facility, it's employees of service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional stress) to the State Agency (SA), no later than 24 hours for 1 of 3 (R1) residents reviewed for reporting. R1 was given insulin at the incorrect time without a provider's order. R1 was sent to the hospital later that day for hypoglycemia (low blood glucose which includes dizziness, fatigue, sweating, and confusion).Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams per deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 - 400 mg/dl give 15 units. Normal blood glucose is 70 mg/dl - 110 mg/dl fasting. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the medication was administered, the number 2 indicating she refused the insulin and the number 15 indicating 15 units of Aspart insulin was given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 was noted to have had cold clammy hands and weak. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), Pulse was 61 beats per minute (normal range 60-100), O2 saturation rate 22 (normal 92-100). R1 was immediately offered a glass of apple juice and blood glucose went up to 74 mg/dl, another glass of orange juice was offered, and the blood glucose rose to 92 mg/dl. R1 continued to be weak and hospitalized . R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment.R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 was noted to have blood glucose of 33 mg/dl despite facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the hospital. Upon interview on 4/1/26 at 9:40 a.m. R1 stated she did not recall any events that happened on 3/13/26 leading up to her hospitalization. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. RN-A tested R1's blood glucose, and it was above 200 mg/dl. RN-A immediately gave R1 15 units of Aspart insulin. RN-A noticed the day nurse (RN)-B had not recorded R1's noon insulin administration. RN-B was still onsite. RN-A told RN-B that she had taken R1's blood glucose, it was high, and she administered insulin. RN-A told RN-B to chart the insulin as administered at noon because her blood glucose level was high at noon, but not to give the insulin because RN-A gave it around 2:15 p.m. RN-A stated RN-B did chart the insulin as given at noon. RN-A also charted R1's eMAR, the insulin had been given at 5:00 p.m. even though it was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	04/01/2026

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given at 2:30 p.m. RN-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. RN-A was told the DON would take care of the error on the e-MAR and write a progress note. RN-A was not certain if the correction was completed. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and got her blood glucose to rise to 92 mg/dl. R1 was still incoherent, cold, and clammy so she was sent to the hospital. RN-A reported the hospitalization to the family and R1's provider, she did not call the DON. RN-A stated the facility had not addressed the medication error or charting with her. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A stated he was aware that R1 had been sent to the hospital for low glucose levels. He denied any knowledge of her rapid acting insulin being given at the incorrect time or both nurses charting the insulin at incorrect times. He was onsite working on 3/13/26 at the time of the incident, however he was not notified. He denied knowledge of a medication error report form filled out or re-education to RN-A. He stated maybe the DON had investigated. Upon interview on 4/1/26 at 2:43 p.m. the DON stated RN-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart at 2:15 p.m. The DON stated she instructed RN-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both RN-A and RN-B had charted the insulin. The DON was not certain what dose of insulin was given. The DON denied filling out a medication error form, investigating the error or re-educating RN-A. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware of the medication error, and the facility did not report the incident. She was not certain if the DON had completed a medication error, investigated, or re-educated RN-A if needed. Attempts were made to reach out to RN-B during the survey; however, no response was received. An investigation policy was requested, however none received.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate an investigation for potential neglect (the failure of the facility, it's employees of service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional stress) for 1 of 3 residents (R1) reviewed for investigation, prevention and correction of alleged allegation. R1 was given insulin at the incorrect time without a provider's order. R1 was sent to the hospital later that day for hypoglycemia (low blood glucose which includes dizziness, fatigue, sweating, and confusion).Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams per deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 - 400 mg/dl give 15 units. Normal blood glucose is 70 mg/dl - 110 mg/dl fasting. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the medication was administered, the number 2 indicating she refused the insulin and the number 15 indicating 15 units of Aspart insulin was given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 was noted to have had cold clammy hands and weak. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), Pulse was 61 beats per minute (normal range 60-100), O2 saturation rate 22 (normal 92-100). R1 was immediately offered a glass of apple juice and blood glucose went up to 74 mg/dl, another glass of orange juice was offered, and the blood glucose rose to 92 mg/dl. R1 continued to be weak and hospitalized . R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 was noted to have a blood glucose of 33 mg/dl despite facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the hospital. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment.R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. Upon interview on 4/1/26 at 9:40 a.m. R1 stated she did not recall any events that happened on 3/13/26 leading up to her hospitalization. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. RN-A tested R1's blood glucose, and it was above 200 mg/dl. RN-A immediately gave R1 15 units of Aspart insulin. RN-A noticed the day nurse (RN)-B had not recorded R1's noon insulin administration. RN-B was still onsite. RN-A told RN-B that she had taken R1's blood glucose, it was high, and she administered insulin. RN-A told RN-B to chart the insulin as administered at noon because her blood glucose level was high at noon, but not to give the insulin because RN-A gave it around 2:15 p.m. RN-A stated RN-B did chart the insulin as given at noon. RN-A also charted R1's eMAR, the insulin had been given at 5:00 p.m. even though it was given at 2:30 p.m. RN-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. RN-A was told the DON would take care of the error on the e-MAR and write a progress note. RN-A was not certain if the correction was completed. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and got her blood glucose to rise to 92 mg/dl. R1 was still incoherent, cold, and clammy so she was sent to the hospital. RN-A reported the hospitalization to the family and R1's provider, she did not call the DON. RN-A stated the facility had not addressed the medication error or charting with her. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A stated he was aware that R1 had (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been sent to the hospital for low glucose levels. He denied any knowledge of her rapid acting insulin being given at the incorrect time or both nurses charting the insulin at incorrect times. He was onsite working on 3/13/26 at the time of the incident, however he was not notified. He denied knowledge of a medication error report form filled out or re-education to RN-A. He stated maybe the DON had investigated. Upon interview on 4/1/26 at 2:43 p.m. the DON stated RN-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart at 2:15 p.m. The DON stated she instructed RN-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both RN-A and RN-B had charted the insulin. The DON was not certain what dose of insulin was given. The DON denied filling out a medication error form, investigating the error or re-educating RN-A. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware of the medication error, and the facility did not report the incident. She was not certain if the DON had completed a medication error, investigated, or re-educated RN-A if needed. Attempts were made to reach out to RN-B during the survey; however, no response was received. An investigation policy was requested, however none received.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent a significant medication error for 1 of 3 residents reviewed for medication errors. R1's Aspart (a short acting insulin) was given at the incorrect time. The Aspart insulin was ordered as an insulin sliding scale (an order in which the insulin dose is based on a resident's blood glucose level) to be taken with meals and was given at 2:15 p.m. without a meal. In addition, during the survey process R1's 8:00 a.m. medications were administered nearly three hours late. Findings include: Upon observation on 4/1/26 at 10:40 a.m. registered nurse (RN)-C was setting up R1's medications for administration. Upon observation on 4/1/26 at 10:51 a.m. (RN)-C entered R1's room to give R1 her morning mediations. R1 was asleep. (RN)-C aroused R1 and assisted her to a sitting position on the side of her bed. R1 stated that her medications were late again and that she had to be woken up to take them. RN-A acknowledged the medications were late to R1 and continued to administer. R1's medication administration record (MAR) dated 4/1/26 indicated the following medications were scheduled for administration at 8:00 a.m. on 4/1/26:Amiodarone HCl tablet 200 mg (milligrams) give one table by mouth daily for antiarrhythmic (irregular heart rate)Apixaban Calcium 80 mg tablet give one tablet one tablet by mouth twice daily for atrial fibrillation (rapid irregular heart rhythm).Buprenorphine HCL-Naloxone HCl sublingual film 4-1 mg. Give one film sublingually (under the tongue) three times a day for history of substance use.Calcium Carbonate-Vitamin D oral tablet 500-5 mg give one tablet by mouth daily with breakfast for supplemental.Cyclobenzaprine HCl oral tablet give 1 tab by mouth three times a day for muscle spasmsFenofibrate 40 mg tablet give one tablet by mouth daily for cholesterol.Insulin Glargine Solution 100 unit/ml (milliliter) inject 15 units subcutaneously two times a day for diabetes.Lasix 20 mg tablet give three tablets daily for diuretic (water pill).Metoprolol Tartrate give 25 mg by mouth twice daily for hypertension (high blood pressure).MiraLAX oral power 17 gm/scoop (grams) give one scoop by mouth daily for constipation.Mucinex tablet extended release 12-hour 600 mg give one tablet by mouth twice daily for Chronic bronchitis.Potassium 20 meq (milliequivalents) give one tablet by mouth daily for hypokalemia (low potassium).Pregabalin 50 mg capsule give one capsule by mouth three times a day for pain.Prozac 20 mg capsule give one capsule by mouth daily for antidepressantSenna oral tablet 8.6 mg tablet give one tablet by mouth daily for constipation.Spiriva Respimat inhalation aerosol solution 2.5 mcg (microgram) inhale two puffs orally daily for COPD (chronic obstructive pulmonary disease).Thiamine HCl 100 mg tablet give one tablet by mouth daily for supplemental.Nystop External Powder 100000 unit/gram apply to peri-area twice daily for skin protection R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams/deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 - 400 mg/dl give 15 units. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the Aspart insulin was administered, the number 2 indicating R1 refused the insulin and the number 15 indicating 15 units were given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 had cold clammy hands and weakness. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), her pulse was 61 beats per minute (normal range 60-100), her oxygen saturation rate was 92 (normal 92-100). R1 was immediately offered a glass of apple juice and her blood glucose rose to 74 mg/dl, another glass of orange juice was offered, and the blood glucose was 92 mg/dl. R1 continued to be weak and thus the hospitalization.R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was noted to have a blood glucose of 33 mg/dl despite the facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the hospital. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicted R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment.R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma and respiratory failure. R1's hospital discharge order summary dated 3/27/26 indicated R1's morning medications were:Amiodarone HCl tablet 200 mg (milligrams) give one table by mouth daily for antiarrhythmic (irregular heart rate)Apixaban Calcium 80 mg tablet give one tablet one tablet by mouth twice daily for atrial fibrillation (rapid irregular heart rhythm).Buprenorphine HCL-Naloxone HCl sublingual film 4-1 mg. Give one film sublingually (under the tongue) three times a day for history of substance use.Calcium Carbonate-Vitamin D oral tablet 500-5 mg give one tablet by mouth daily with breakfast for supplemental.Cyclobenzaprine HCl oral tablet give 1 tab by mouth three times a day for muscle spasmsFenofibrate 40 mg tablet give one tablet by mouth daily for cholesterol.Insulin Glargine Solution 100 unit/ml (milliliter) inject 15 units subcutaneously two times a day for diabetes.Lasix 20 mg tablet give three tablets daily for diuretic (water pill).Metoprolol Tartrate give 25 mg by mouth twice daily for hypertension (high blood pressure).MiraLAX oral power 17 gm/scoop (grams) give one scoop by mouth daily for constipation.Mucinex tablet extended release 12-hour 600 mg give one tablet by mouth twice daily for Chronic bronchitis.Potassium 20 meq (milliequivalents) give one tablet by mouth daily for hypokalemia (low potassium).Pregabalin 50 mg capsule give one capsule by mouth three times a day for pain.Prozac 20 mg capsule give one capsule by mouth daily for antidepressantSenna oral tablet 8.6 mg tablet give one tablet by mouth daily for constipation.Spiriva Respimat inhalation aerosol solution 2.5 mcg (microgram) inhale two puffs orally daily for COPD (chronic obstructive pulmonary disease).Thiamine HCl 100 mg tablet give one tablet by mouth daily for supplemental. Upon interview on 4/1/26 at 9:40 a.m. R1 was in her room seated on bed. R1 had completed breakfast, her breakfast tray on her wheelchair chair ready to be removed from her room. R1 stated she was waiting for medications which should have been given on or around 8:00 a.m. with her breakfast. R1 did not recall the incidents that happened on 3/13/26 which led to her hospitalization; however, she was told her blood glucose was very low. R1 she was glad the hospital discontinued her Aspart rapid acting insulin and kept her on a scheduled dosage of insulin only. Upon interview on 4/1/26 at 11:00 a.m. R1 stated her medications were given late a few times a week. R1 stated when her medications are over an hour late, it messed with pain control and her breathing because of having to wait for the medications. R1 asked if it was safe for her insulin to be administered almost three hours late because then the second dose would be given early, and she has had hyper and hypoglycemia (high and low blood glucose levels) episodes at the facility which led her to the hospital. R1 stated when her pain medication is given late her pain sets in and then it takes longer for it to go away, and her breathing becomes more obstructed when she has had to wait on her Mucinex. Upon interview on 4/1/26 at 11:11 a.m. R1's Nurse Practitioner (NP) stated the Aspart insulin should not have been given between meals because rapid acting insulin without food can drop the blood glucose levels significantly. The facility nurse should have called the provider if they felt the need or the resident was requesting the insulin be administered at an off-scheduled time. The NP's expectation was that the facility administered the medications an hour before or an after the scheduled time, if they cannot meet those time frames they should change the times. Upon interview on 4/1/26 at 11:55 a.m. the Pharmacist stated R1's Glargine insulin and her Mucinex should be given as close to 12-hours as they can be for the best results for diabetic and COPD control. It is important to keep pain medications on a schedule as well because it prevents pain from becoming severe and harder to manage. As far as the nurse who gave the Aspart insulin incorrectly, may or may not be the reason her blood glucose dropped to abnormal levels requiring her to be sent to the hospital. There are too many factors unknown. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. (RN)-A tested R1's blood (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glucose and found it was above 200 mg/dl. (RN)-A immediately gave R1 15 units of Aspart insulin. RN-A then noticed the day nurse (RN)-B had not recorded R1's noon Aspart insulin administration. (RN)-B was still onsite. (RN)-A told (RN)-B that she had given R115 units of Aspart insulin because her blood glucose was 356 mg/dl. (RN)-A then told (RN-B) to chart the Aspart insulin as administered at noon because her blood glucose level was also high at noon, but not to give any insulin. (RN)-A stated (RN)-B charted the insulin as administered at noon, even though it was not. (RN)-A also charted insulin administration under the 5:00 p.m. slot on the eMAR, even though it was given at 2:15 p.m. and not charted. (RN)-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. (RN)-A was told the DON would take care of the error on the e-MAR and write a progress note for (RN)-A. (RN)-A was not certain if the correction was completed by the DON. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and her blood glucose rose to 92 mg/dl. R1 was still incoherent, cold, and clammy was sent to the hospital. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A the nurse manager denied knowledge that R1's Aspart insulin had been given at 2:15 p.m. and the eMAR documentation indicated the Aspart insulin was administered at 12:00 p.m. and 5:00 p.m. (LPN)-A stated he was working onsite and the (RN)-A should have reached out to him and he would have directed (RN)-A to call the provider because giving the insulin between the meal times was a medication error. Upon interview on 4/1/26 at 2:43 p.m. the DON stated (RN)-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and (RN)-A had given the Aspart insulin at 2:15 p.m. The DON stated she instructed (RN)-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both (RN)-A and (RN)-B had charted the insulin as administered. The DON was not certain what dose of insulin was actually given. The DON stated (RN)-A's giving insulin at the incorrect time was a medication error and (RN)-C giving medications almost three hours late was a medication error. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware that R1's Aspart insulin was administered at 2:15 p.m., however documented on the eMAR at 12:00 p.m. and 5:00 p.m. as administered. The Administrator stated all medications should be given within an hour before or after the ordered time of the medication. If they cannot be for any reason the nurse needed to notify the provider for any further details. Attempts were made to reach out to RN-B during the survey; however, no response was received. An insulin medication policy was requested. A facility standing order sheet was provided titled Standing Orders for nursing Facilities and Skilled Nursing facilities dated 2026. The order sheet did not indicate an intervention for hyperglycemia treatment in regard to a sliding scale.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain accurate medical records for 1 of 3 residents (R1) reviewed for resident records. R1's medication administration was inaccurately documented when R1's medication Aspart (fast acting insulin) was only administered on 3/13/26 at 2:15 p.m. R1's electronic medical record (eMAR) indicated R1's Aspart insulin was administered on 3/13/26 at 12:00 p.m. and 5:00 p.m. Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams/deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 - 400 mg/dl give 15 units. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the Aspart insulin was administered, the number 2 indicating R1 refused the insulin and the number 15 indicating 15 units were given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. (RN)-A gave R1 15 units of Aspart insulin. (RN)-A was aware that the timing of the Aspart administration was not as ordered. (RN)-A told (RN)-B to document that she had given the Aspart insulin at noon because R1 had refused at that time. (RN)-B documented at 12:00 p.m. that the insulin was refused, however 15 units was administered. (RN)-A documented 15 units of insulin was given at 5:00 p.m. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A denied knowledge that R1's Aspart insulin had been given at 2:15 p.m. and the eMAR documentation indicated the Aspart insulin was administered at 12:00 p.m. and 5:00 p.m. Upon interview on 4/1/26 at 2:43 p.m. the DON stated (RN)-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart insulin at that time. The DON stated she instructed (RN)-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated both (RN)-A and (RN)-B had charted the insulin as administered. The DON was not certain what dose of insulin was given. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware that R1's Aspart insulin was administered at 2:15 p.m., however documented on the eMAR at 12:00 p.m. and 5:00 p.m. as administered. Attempts were made to reach out to RN-B during the survey; however, no response was received. A medical records policy was requested, however none received.