STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Granite Falls Care Center	250 Jordan Drive Granite Falls, MN 56241

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47497 Based on observation, interview, and record review the facility failed to ensure a homelike, dignified dining experience was provided for 1 of 4 residents (R36). This had the potential to affect all 21 residents who ate meals in the Neighborhood A dining room. Findings Include: R36's 6/26/24, annual Minimum Data Set (MDS) assessment identified she had admitted to the facility in July of 2022, her cognition was intact, and she was independent with activities of daily living (ADL's). Observation on 7/15/24 at 12:17 p.m., registered nurse (RN)-A gathered supplies and insulin pen from the medication cart near the resident dining room. RN-A walked through the dining room and approached a table that had 4 residents (R8, R11, R36, and R22) seated and eating dinner. She told R22 that she had her insulin (a medication that is administered by injection, using a syringe, just under the skin and into the fatty layer). R22 pulled her pants downward to expose her abdomen. RN-A cleaned the site using an alcohol swab and injected the medication. A small drop of blood was visible. RN-A cleaned the blood off using the alcohol wipe and R22 pulled her pants back up. At no time did RN-A ask R22 to leave the public area to administer the insulin. Interview on 7/16/24, at 2:02 p.m., with RN-A identified that as long as it was okay with the resident receiving the insulin, staff can administer insulin in the dining room. It was a routine process to administer insulin injections to residents at the dining room table in the facility. She had not considered how it may affect other residents at the table and was not certain if anyone had asked them if it bothered them. She stated, none of the other residents have mentioned any concerns, they are just used to it I guess. Interview on 7/16/24 at 2:19 p.m., with R8 identified that when she first admitted to the facility she was not used to seeing that, but I got used to it. Nobody has ever asked her how she felt about it or if it bothered her to see a resident being administered an injection while she was eating her meals. (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
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/16/24 at 2:30 p.m., with R36 identified watching someone receive an injection at the table during mealtime is bothersome at times. I wish it could be done in another way it happens often but they (other residents at the table) do not complain because they feel bad about what the resident is going through. Nobody has ever asked her if it bothered her. R36 reports it also bothers her when the other resident receiving the injection pulls her clothing down because she is over weight and it is not pleasant to see. She said she does not say anything because she hates to complain. Review of R36's current care plan lacked any indication that staff had asked R36 how she felt about other residents being administered injections in her presence. Interview on 7/16/24 at 9:10 a.m., with the director of nursing (DON) identified she was aware that residents receive insulin injections at the dining room table in front of other residents. She would prefer they receive their insulin injections in a private area, and identified there is a room off to the side of the dining room that staff could bring resident if they did not want to go back to their rooms. Review of the facilities November 2023, Medication Orders and Administration policy identified medications could be administered in the presence of other residents if the resident or representative agreed and is noted on care plan. There was no mention of how to ensure the rights and dignity would be maintained for other residents present during medication administration.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 34083 Based on interview, the facility failed to ensure mail was consistently delivered to residents on Fridays and Saturdays. This had the potential to affect all 48 residents in the facility who received personal mail, including but not limited to, 5 of 5 residents (R1, R22, R28, R30 and R38) who verbally confirmed mail was not consistently received on Fridays and Saturdays. Findings include: Resident Council was held on 7/17/24 at 10:00 a.m. with R1, R22, R28, R30 and R38 in attendance. When asked whether residents received their mail on Saturdays the 5 residents in attendance voiced they did not receive mail on Saturdays. If the administrative assistant was not in the building on Fridays, mail was also not delivered until the following Monday. The residents reported the facility had requested mail delivery be placed on hold on Saturday due to no staff available to distribute it, and to avoid it sitting from Friday/Saturday until Monday. Interview on 7/17/24 at 10:44 a.m. with the activity director reported the administrative assistant delivered the mail to residents Monday through Friday when she was working. She reported the resident council had expressed concern about security of mail delivered on Saturdays since it was delivered into a box located between the two main entrance doors. Mail in the box remained unless someone took it to a secure location or until the administrative assistant returned to work on Monday. She reported she was not aware of anyone else being responsible for mail delivery. Interview on 7/17/24 at 11:11 a.m. with the administrative assistant identified she was responsible for retrieving and delivery of mail during the week, and if she was not working on a weekday the social services designee (SSD) delivered the mail. She reported mail delivery had been suspended on Saturdays after the resident council agreed to have it held at the post office on Saturday because they did not want packages and personal mail left unsecured in the entry. She confirmed if neither she, nor the SSD were working resident mail was not delivered, unless some other person chose to retrieve and deliver the mail. Interview on 7/17/24 1:00 p.m. with the administrator reported his expectation for mail delivery to take place up to 6 days/week unless the post office was unable to provide mail delivery. He identified it was, not acceptable to place mail delivery on hold due to the administrative assistant and/or SSD not available to retrieve and deliver mail to residents. Interview on 7/17/24 at 1:03 p.m. with the SSD reported the issue of mail delivery had been discussed at a resident council meeting with the option offered to have mail held at the post office on Saturday and delivered on Monday to avoid it sitting in the entry and not delivered until Monday when the administrative assistant or SSD returned to work. The option was addressed by the resident council president who agreed, but not presented facility wide to the residents. The SSD confirmed the facility did not have a process for mail delivery when she or the administrative assistant were not available. A policy was requested but not provided and the director of nursing (DON) identified the facility did not have a policy that addressed delivery of resident mail.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R14) who utilized a self-release belt as a restraint Findings include: Observation/interview on 7/15/24 at 1:09 p.m. of R14 as she sat in her wheelchair with a lap belt attached to the frame of the wheelchair and fastened in front of her lower abdomen. R14 reported she was comfortable in her chair and did not know why she had the belt on, but that staff put it on in the morning and took it off when she went to bed at night. When asked if she was able to release the belt, she stated she did not know and began fumblingly with the belt, turning it and pressing along the sides and buckle, but she was not able to press the large, square button to release the belt. She continued to fumble with the belt when nursing assistant (NA)-A entered the room and asked R14 if she needed help. NA-A attempted to direct R14 on how to release the belt, but she was not able to do so. R14 reported she knew what she was supposed to do to release the belt, but staff usually helped her to put it on and take it off. R14 reported she was not able to transfer herself and staff used the lift to transfer her. She denied any falls and reported staff were good to come when she pushed her light and needed help. Interview on 7/15/24 at 1:15 p.m. with NA-A reported since R14 had returned from her hospital stay she had needed more help and was more confused. She reported for the past couple of weeks R14 had not been able to put on or release her lap belt and staff needed to do it for her. When asked when the belt was put on and taken off, NA-A reported it was on when she was up in her wheelchair, released and reapplied when she was toileted, or transferred to and from her wheelchair. When questioned regarding the lap belt being a restraint, NA-A responded she did not think it was a restraint and replied she thought it was for safety to keep her from falling out of her chair. NA-A identified a restraint was something used to restrain a person's arms and/or legs and she was not aware a lap belt could also be a restraint. Observation on 7/15/24 at 5:30 p.m. of R14 positioned at the livingroom table without the lap belt in place. When questioned she stated she had the belt on, and then moved her shirt to reveal her lap and stated they must have forgotten to put it back on. When asked why she needed the lap belt, R14 replied she did not know, but staff put it on in the morning when she got up and took it off when she went to bed at night. Observation on 7/16/24 at 11:09 a.m. when R14 returned from an outside activity, it was noted she was not wearing the lap belt and stated neither she nor the NA were able to get her belt on when she got up for the day. When asked about the reason she wore the lap belt she responded she did not know. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/16/24 at 10:51 a.m. with NA-A and NA-B reported R14 moved about independently in her wheelchair, and they were not aware of any safety concerns. They reported R14 did not attempt to self-transfer and called for assistance when she needed to use the toilet. NA-B reported R14's belt had been removed due to not being able to self-release the belt. Both NA-A and NA-B confirmed prior to the 7/15/24 p. m. interview R14 was always wearing the lab belt when she was up in her wheelchair. NA-A and B identified they thought R14's had the lab belt due to scooting and sliding forward in her chair as she was moving about. They both reported they were not aware R14 having any recent falls or attempts to self-transfer. R14's 6/28/24 - 7/4/24 quarterly Minimum Data Set (MDS) assessment was pending at the time of review. R14's, 4/11/24 Significant change MDS following her hospitalization and completion of therapy (4/24/24) identified no restraint or devices in use. R14 had moderate cognitive impairment and identified diagnoses of morbid obesity, osteoarthritis, deformity of right foot, left skew foot deformity, degenerative arthritis, and severe scoliosis. R14's 11/16/23, Annual MDS assessment also failed to document the use of the lab belt. R14 had moderate cognitive impairment and her activities of daily living identified she had functional restrictions and had a potential for falls. Interview on 7/16/24 at 2:44 p.m. with RN-C reported she had completed R14's MDS but did not realize she had a restraint in the form of a lap belt. RN-C reported she had it for a long time, and everyone was used to seeing it. RN-C identified R14's lap belt should have been reassessed and identified in the 4/11/24 MDS as a restraint upon her hospital return, but she had not thought about it. Interview on 7/16/24 at 11:11 a.m., with RN-F identified R14 used a lap belt in her chair due to slouching or sliding forward. Review of the current physician's orders with RN-F failed to identify an order for use of a lap belt. RN-F reported he did not think R14 was able to self-release her lap belt, and he was not aware the lap belt would be a restraint if she was not able to release the belt without staff assistance. Interview and document review on 7/16/24 at 11:20 a.m. with the director of nursing (DON) reported R14's utilized a lap belt when in her wheelchair for positioning. The DON reported R14 had been provided a specialized wheelchair for mobility in the past (unable to recall dates) and was unsafe due to sliding in the chair, because it had a short seat. R14 had been able to self-release the belt initially, and she was not aware of when R14's status changed but was likely following her most recent hospitalization [DATE] -3/20/24. The DON reviewed the medical record and confirmed they failed to include orders for use of a seat belt and a restraint assessment had not been completed. The DON reported her expectation for the record to contain MD orders, be included in the care plan, have a restraint assessment completed and updated quarterly, in addition to a signed consent from the resident/family or healthcare power of attorney (POA). The DON confirmed R14 had utilized the lap belt when up in her wheelchair until 7/15/24 afternoon when R14 and staff had been interviewed and she was not able to demonstrate self-release of the belt. The DON identified R14's last covered Medicare day was 4/4/24 and a Significant Change MDS should have included the restraint assessment, with documentation, orders and updating of the care plan. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 12/17/21 LTC-Physical Restraint/Bed Rails Policy identified the purpose as standardization for use of physical restraints in Avera's Long-Term care (LTC) facilities. A physical restraint definition included manual, physical, mechanical device, material, or equipment that an individual was not able to easily remove and restricted freedom of movement or access to their body. Easily removed was defined in the policy as removed intentionally by the resident in the same manner as it had been applied. If a problem was identified the least restrictive method was to be attempted first with results documented in the record. Use of restraints required clinical justification for protection of a resident from injury to self and/or others. If found to be necessary, the health professional was to document in the medical record the assessment to include the medical condition and include the reason for the restraint as an intervention. Physician notification was required for all restraints prior to initiation and an order must be obtained for use. The order was to specify the type of restraint, when it was to be used, medical symptom requiring use, and documentation for staff to check every 30 minutes and release every 2 hours. Both residents, family/POA were required to be educated on the use of restraints with risks verses benefits reviewed. The facility was responsible to include evaluation of the restraint devise and include the medical practioner in the review. In addition, the resident/family or POA must sign a consent for the use of a restraint. Restraint use was to be evaluated monthly by the interdisciplinary team (IDT) and physician, and quarterly at care conferences. All restraints were to be removed during meals unless there was a physician order or medical condition which identified the need for the restrain to remain in place.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on observation, interview, and document review, the facility failed to revise the care plan for 1 of 1 resident (R14) who utilized a self-release belt, she was unable to release. Findings include: R14 received physician orders for a new wheelchair December of 2022 to allow for increased mobility. Occupational Therapy (OT) Evaluation and Plan of Treatment dated 1/25/23 - 3/8/23 with discharge date d 3/1/23 identified discharge instructions to include staff to encourage repositioning into upright seated position when slouching or posterior lean in chair noted. Educated patient to continue bilateral upper extremity exercises to minimize further contracture in bilateral shoulders. There was no mention of a new wheelchair or safety measures identified with use. R14 was hospitalized [DATE] -3/20/24 with a Urinary Tract Infection and pneumonia. Upon return assessment identified decline in cognition, strength, and mobility. R14's, 4/11/24 Significant Change Minimum Data Set (MDS), was completed following hospitalization and completion of therapy on 4/4/24. R14 had moderate cognitive impairment and identified diagnoses of morbid obesity, osteoarthritis, deformity of right foot, left skew foot deformity, degenerative arthritis, and severe scoliosis. The MDS failed to identify a seat belt type lap belt in use on her wheelchair, and a restraint assessment was not completed. R14's, 4/3/24 OT Discharge Summary Recommendations included she was demonstrating requirement for assistance of 1-2 staff for bed mobility, dressing, and toileting. Had an upright positioning wedge to be used on whichever side toward patient leaning when in chair. Hoyer lift for transfers and use of a standard wheelchair with lap belt for mobility in the facility. R14's current 12/21/22 care plan identified she was able to independently remove the seatbelt. Her care plan was not updated to identify her change in status following hospitalization due to no longer able to self-release seat belt when the belt was to be used and when it was to be released. The care plan also failed to include quarterly assessments for use of the lap belt, restraint assessment and review by physician and family or power of attorney for orders, and consent for use of device. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/interview on 7/15/24 at 1:09 p.m. as R14 sat in her wheelchair with a lap belt attached to the frame of the wheelchair and fastened in front of her lower abdomen. R14 reported she was comfortable in her chair and did not know why she had the belt on, but that staff put it on in the morning and took it off when she went to bed at night. When asked if she was able to release the belt, she stated she did not know and began fumblingly with the belt, turning it and pressing along the sides and buckle, but she was not able to press the large, square button to release the belt. She continued to fumble with the belt when nursing assistant (NA)-A entered the room and asked R14 if she needed help. NA-A attempted to direct R14 on how to release the belt, but she was not able to do so. R14 reported she knew what she was supposed to do to release the belt, but staff usually helped her to put it on and take it off. R14 reported she was not able to transfer herself and staff used the lift to transfer her. She denied any falls and reported staff were good to come when she pushed her light and needed help. Observation on 7/15/24 at 5:30 p.m. of R14 positioned at the Livingroom table without the lap belt in place. When questioned she stated she had the belt on, and then moved her shirt to reveal her lap and stated they must have forgotten to put it back on. When asked why she needed the lap belt, R14 replied she did not know, but staff put it on in the morning when she got up and took it off when she went to bed at night. Interview on 7/15/24 at 1:15 p.m. with NA-A reported since R14 had returned from her hospital stay she had needed more help and was more confused. She reported for the past couple of weeks R14 had not been able to put on or release her lap belt and staff needed to do it for her. When asked when the belt was put on and taken off, NA-A reported it was on when she was up in her wheelchair, released and reapplied when she was toileted, or transferred to and from her wheelchair. When questioned regarding the lap belt being a restraint, NA-A responded she did not think it was a restraint and replied she thought it was for safety to keep her from falling out of her chair. NA-A identified a restraint was something used to restrain a person's arms and/or legs and she was not aware a lap belt could also be a restraint. Interview on 7/16/24 at 2:44 p.m. with registered nurse (RN)-C who identified she had completed the MDS assessments for R14 reported she had not completed a Restraint Assessment, nor documented the use of the lab belt for R14. She reported she was so used to seeing R14 with the belt in place that she had not thought about the need for an assessment. RN-C reported she was not aware R14 was no longer able to self-release her belt, not that staff were applying and releasing the belt when needed. RN-C identified the lab belt had been in place since December 2022, and had not been included in MDS assessments as it should have been. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/16/24 at 11:20 a.m. with the director of nursing (DON) reported R14's utilized a lap belt when in her wheelchair for positioning. and the belt had been consistently utilized since December 2022 when she had been provided a specialized wheelchair for mobility. The DON reported R14 had been able to self-release the belt initially, and she was not aware of when R14's status changed but was likely following her most recent hospitalization [DATE] -3/20/24. Her expectation was for the medical record to contain MD orders, be included in the care plan, have a restraint assessment completed and updated quarterly, in addition to a signed consent from the resident/family or healthcare power of attorney (POA). The DON confirmed R14 had utilized the lap belt when up in her wheelchair until 7/15/24 afternoon when R14 and staff had been interviewed and she was not able to demonstrate self-release of the belt. The DON identified the care plan failed to include any mention of the use of a lap belt, nor was there any monitoring in place. She reported the care plan should have been updated when the lap belt was initially put into use, and again following her most recent hospitalization . Review of the December 17, 2023, policy LTC-Physical Restraint/Bed Rails Policy identified the resident/family/power of attorney must sign a consent for the use of a restraint device prior to its use. The care plan was to include: 1. Restorative Care 2. Identified risk factors and targeted interventions 3. Education to both resident/family/staff 4. Any modifications in environment 5. Supervision/monitoring by staff 6. A plan to address any identified areas of concern Both the Interdisciplinary team (IDT) and MD need to address use of the restraint/device monthly and as needed. Use was also to be reviewed at the quarterly care conferences. Restraints are to be checked by staff every 30 minutes and removed at meals and every 2 hours. Quarterly documentation of attempts for restraint reduction are to be completed with a Restraint assessment and included on MDS assessments and in the Care Area Assessments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47497 Based on observation, interview, and record review the facility failed to groom [ROOM NUMBER] of 1 resident (R22) to maintain their highest practicable well-being. Findings include: R22's 7/3/24, quarterly Minimum Data Set (MDS) assessment identified R22's cognition was intact, she had diagnosis of diabetes, depression, heart disease, arthralgia (joint pain), and cataract (visual impairment). She required moderate assistance from one staff for personal hygiene and dressing. R22's current care plan identified that R22 had diagnosis that could potentially affect her ability to complete ADL's (activities of daily living). Staff were to assist her to meals and assist with daily washing. R22's care plan made no mention that staff should assist with facial grooming or shaving. Observation on 7/15/24 at 2:06 p.m., of R22 seated in her recliner in her room. She was observed to have a thick patch of facial hair on her chin, approximately 1/8 inch in length. Interview on 7/15/24 at 2:06 p.m., with R22 identified that she was aware of her facial hair but often forgets to shave. Staff do not remind her or offer to shave her, but she states, I would love it if staff would come in and offer to shave me. She tries to remember to ask the beautician when she is getting her hair done but says she forgets. Observation on 7/16/24 at 2:42 p.m., of R22 seated in room, chin hair remained unshaven and appeared longer than the day prior. Interview on 7/16/24 at 2:43 p.m., with R22 she identified that staff had still not offered to shave her, she has not asked anyone but would like it if someone would just come in to do it because she forgets. Interview on 7/16/24 at 2:48 p.m., with nursing assistant (NA)-E identified that if she notices that a resident is not doing self-care, she offers to assist them. She thinks that morning staff usually assist R22 with shaving. She had not noticed that R22 had thick facial hair on her chin and stated, I guess I hadn't paid attention. Interview on 7/16/24, at 4:00 p.m., with registered nurse (RN)-A identified that she was responsible for updating care plans, she would expect staff to offer to shave female residents who have facial hair regardless of if it is on the care plan or not. She agrees it should have been added to the care plan. A policy was requested, nothing was provided by the end of the survey.

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Avera Granite Falls Care Center	250 Jordan Drive Granite Falls, MN 56241

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47497 Based on interview and document review, the facility failed to ensure insulin was administered timely for 1 of 1 resident (R27). Findings include: R27's 7/8/24, significant change Minimum Data Set (MDS) assessment identified R27's cognition was intact. She has a diagnosis of diabetes mellitus. Interview on 7/15/24, at 12:54 p.m., with R27 identified that she had not received her a.m., insulin administration until 11:00 a.m., that day and said her blood sugar was well over 300. A different nurse approached her at around 11:30 a.m., to administer her noon insulin but R27 told her she had just had insulin and it would be too close together. The nurse did not administer the insulin. R27's current administration record identified she had an order for Lispro 100 units/milliliter (ml), 2 units before meals plus a sliding scale dose (based on blood sugar levels). Interview on 7/15/24 at 5:52 p.m., with registered nurse (RN)-A identified she had approached R27 to administer her insulin at 11:30, R27 refused the insulin administration and reported to her that another nurse had just administered her morning dose. RN-A held the insulin but did not follow up with the other nurse, did not complete a medication error report, and did not contact the physician for guidance. Interview on 7/16/24 at 1:36 p.m., with RN-B identified it was a hectic morning she had gathered her supplies to administer R27's insulin and signed it off in the medical record, when she went to administer the insulin R27 was exercising so she left the area with the intention of returning in a few minutes, but she forgot. RN-A returned later and administered the insulin around 10:30, she identified that she should have changed the time in the administration record but she got side-tracked and did not make the adjustment. RN-B did not report the late insulin administration to anyone at the facility, she did not complete a medication error report, and did not notify the physician. Interview on 7/16/24, at 4:49 p.m., with the director of nursing identified she would have expected better communication in the nursing department. She would expect nursing to notify the physician for guidance and complete a medication error report. Review of the November 2023 Medication Orders Administration Policy identified medication errors would be reported and the physician will be notified. Staff will document administration of medication immediately after administration.