STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie View Senior Living	250 Fifth Street East Tracy, MN 56175

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 2 of 12 sampled residents (R13 and R14). Findings include: R13 was admitted [DATE]. R13's undated, current diagnosis list identified R13 received a diagnosis of bipolar disorder 11/05/24. R13's 3/03/25, Level II PASARR had indicated R13 had meet criteria for severe mental illness. R13's 3/28/25, Significant change Minimum Data Set (MDS) identified R13 was moderately, cognitively impaired and had a diagnoses of anxiety, bipolar disease and dementia. R13 had little interest or pleasure in doing things, never to 1 day and felt down, depressed or hopeless 2 to 6 days. R13 was dependent with ADLS and required substantial maximal assist with transfers. R13 had taken antipsychotics, antianxiety and antidepressant on a routine basis. Section A 1500 PASARR: resident been evaluated by [NAME] II PASARR and determined to have a serious mental illness and/or mental retardation, or a related condition was marked no. Interview on 4/15/25 at 12:56 p.m., with Registered nurse (RN)-A identified the Level II (PASARR) was missed and would have to modify the entry error and update the correct data on R13's MDS. Interview on 4/16/25 at 8:49 a.m., with the director of nursing and assistant director of nursing voiced in agreement they would expect the MDS entry to be coded accurately. Interview on 4/16/25 at 9:12 a.m., with the administrator would expect residents MDS submission to be accurate. He identified the facility did not have a policy for MDS but used the RAI manual for guidance. Review of the Resident Assessment Instrument (RAI) manual identify residents MDS submissions must be accurate during the look back period, in accordance with standards of clinical practice and documentation. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39988 R14's 3/31/25, significant change Minimum Data Set (MDS) assessment identified R14 had severe cognitive impairments, and he was dependent on staff for cares. The assessment identified he did not have a prognosis that may result in a life expectancy of less than 6 months, and he was not on hospice. R14's prior significant change MDS dated [DATE] and his quarterly MDS dated [DATE] both identified he was on hospice. R14's medical record identified an order on 11/29/24 for hospice services. Medical record further identified R14 had been admitted to [NAME] at Home Hospice on 12/3/24. R14's 12/4/24, care plan identified terminal prognosis requiring hospice services. R14's comfort would be maintained. Staff were to adjust provisions of cares to compensate changing abilities. Assess coping strategies and respect wishes. Staff were to contact [NAME] Hospice with concerns or question. Encourage support systems of friends and family. There were multiple other interventions identified for comfort and coordination of care with hospice. On 4/16/25 at 12:51 p.m., an attempt was made to contact the regional clinical reimbursement specialist that was identified as the staff completing R14's MDS assessments. A voice mail was left to return call with no response. Interview on 4/16/25 at 2:30 p.m., with director of nursing (DON) identified she would expect that the MDS assessment accurately reflected the resident status. She confirmed that R14's significant change MDS lacked identification of hospice.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on interview and document review the facility failed to ensure 1 of 1 resident (R15) rapid acting insulin injection was administered according to the manufactures instructions. Finding include: R15's 1/21/25, Significant Change Minimum Data Set (MDS) assessment identified R15 cognition was intact, he had no pain, no behaviors, was on a therapeutic diet, received insulin, anticoagulant, diuretic, hypoglycemic medication daily and was on isolation. R15's diagnosis list identified he had diabetes mellitus type 2, long term use of insulin, heart failure, chronic kidney disease, edema, atrial fibrillation, and hypertension. R15's January 2025, Medication Administration Record identified R15 received insulin Glargine Solution 48 units every morning and evening and Fiasp insulin aspart injection solution 32 units three times a day at 8:00 a.m., noon, and 5:00 p.m R15's medication administration audit report identified documentation on 1/26/25 at: 1) 9:17 a.m., Fiasp insulin 32 units had been administered. 2) 9:18 a.m. insulin Glargine 48 units had been administered. 3) 12:17 p.m. Fiasp insulin 32 units had been administered. R15's 1/26/25 at 1:46 p.m., progress note identified LPN-A documented R15 was given his dinner medication and insulin around 11:45 a.m. Staff brought R15 his dinner at 12:30 p.m. (forty-five minutes later) and found R15 to be sweating and drooling from his mouth. R15 was unable to answer appropriately, blood pressure was 135/86 millimeters/mercury (mm/hg) (normal 120/80 mm/hg), temperature 97.5 Fahrenheit (F) (within normal limits), pulse 80 beats per minute (bpm) (normal), respirations 20 per minute (normal), and oxygen saturation 95% (normal) on room air. The ambulance was called at 1:20 p.m., and R15 left the facility at 1:30 p.m. The progress note lacked identification of what R15's BS was at 12:30 when staff identified his level of conscious changes, or what, if any, interventions had been implemented at the facility. R15's vital signs documentation identified on 1/26/25 at 9:18 a.m., R15's BS was 103 milligrams/deciliter (mm/dL). At 12:22 p.m., R15's BS was 99 mg/dL, and at 1:44 p.m. (after R15 had left the facility), staff recorded R15's BS was 68 mg/dL. It is unknown if this was a late entry. Interview on 4/15/25 at 7:55 a.m., with registered nurse (RN)-B identified she would check the resident blood sugar, if it was low at all she would wait to see what the resident ate before giving fast acting insulin. She was unsure if there was any protocol on what to do or what other nurses did for insulin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/15/25 at 8:31 a.m., with LPN-A identified on 1/26/25, from what she could recall, R15 never usually had a low blood sugar, but it was low that day. R15 ate his meal, but occasionally he would get bucky and not want to come out for his meal right away. She thought perhaps staff likely went to get him, but he would not come out, so they brought him his meal and that was when they found him unable to answer appropriately. Staff then came and got her to go and assess him. R15's blood sugar level and blood pressure had gone down so she sent him to the ED for evaluation. Further interview on 4/16/25 at 7:33 a.m., with LPN-A identified on 1/26/25, the day she sent R15 to the emergency department (ED) she had assessed him, attempted to give him orange juice with sugar in it. She reported she did not use the glucagon gel because she was unsure if he would have been able to swallow that as it was thicker. From what she could recall, she wasn't aware if the facility had glucagon injectable medication and did not report what she had not used that if she had concerns about R15's ability to swallow medication. Review of the June 2023, Fiasp insulin aspart injection 100 units/ml manufacturer instructions identified Fiasp was a rapid-acting human insulin analog indication to improve glycemic control for patients with diabetes mellitus (1). Fiasp insulin was to be given at the start of a meal or within 20 minutes after starting a meal. R15's 1/26/25, emergency department record identified R15 with a history of diabetes, the facility reported that R15 had a BS of 68 and was given 4 packets of sugar while at nursing home. Upon arrival R15 had a BS of 33. R15 had tested positive for influenza on 1/20/25 and had not been eating or drinking well however, and the facility had continued to give him his usual insulin doses. He had been receiving Lantus 48 units twice a day along with NovoLOG 32 units three times a day with meals. R15's 1/30/25, hospital discharge summary identified R15 had been admitted on [DATE] for hypoglycemia, influenza A, and acute renal disease and hypotension secondary to dehydration. Review of the current, undated, American Diabetes Association (ADA) , Severe Hypoglycemia (Severe Low Blood Glucose) article, located at https://diabetes. org/living-with-diabetes/hypoglycemia-low-blood-glucose/severe, identified severe hypoglycemia, which may also be referred to as an insulin reaction or insulin shock, is when your blood glucose (blood sugar) drops dangerously low. If you have severe hypoglycemia, you may become confused, pass out (lose consciousness), or treatments for a low blood glucose aren ' t working. People on blood glucose-reducing medications (insulin) were at risk. Signs and symptoms of severe hypoglycemia were listed as: 1) An altered mental state 2) Fainting or losing consciousness 3) Incredibly weak and unable to help yourself 4) Seizure 5) Coma If left untreated for too long, severe hypoglycemia can lead to brain or organ damage or even death. Glucagon, preferably ready-to-use, should be used to treat severe hypoglycemia. It quickly raises blood glucose levels by causing the liver to release the glucose it stores into your bloodstream. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 12/10/2016, ADA and EASD Joint Statement on Hypoglycemia (low BS) article, located at https://www.diabetesincontrol.com/ada-easd-joint-statement-on-hypoglycemia/, identified 3 stages of low blood sugar: 1) Level 1: A glucose alert value of 70mg/dL. 2) Level 2: A glucose level of 54 mg/dL is sufficiently low to indicate serious, clinically important hypoglycemia. 3) Level 3: Severe hypoglycemia, as defined by the ADA, denotes severe cognitive impairment requiring external assistance for recovery. R15's 5/7/24, signed Prairie View Senior Living Physician Standing Orders identified diabetics: administer glucose gel 15 gram by mouth if resident with hypoglycemia is alert enough to swallow get. Administer the glucagon injection, 1 milligram via intramuscular or subcutaneously for hypoglycemia if resident was unresponsive and has a low blood glucose (BS) level. Call the physician to update and implement further orders as soon as possible. Interview on 4/15/25 at 2:10 p.m., with consulting pharmacist identified no one should be taking insulin more than 30 minutes prior to eating in general. Diabetics even if sick still need to take their insulin however, if the resident was not eating the facility should have reached out to the provider to make sure the insulin dose did not need to be adjusted. Fiasp insulin was a rapid acting insulin and should be given just before eating and staff should follow the manufacturer's instruction for any insulin they are administering. The dispensing pharmacy confirmed that the facility emergency kit (E-kit) contained both glucagon gel and glucagon injections 2 doses of each at the time of the incident. Once the facility used an item out of the E-kit the facility would send a fax and they would replace the item the next delivery day. Interview on 4/15/25 at 2:43 p.m., with director of nursing (DON) identified that fast acting insulin should never be given more than 15 minutes prior to eating. On 1/26/25, LPN-A had attempted to give R15 sugar packets with orange juice prior to breaking into the emergency kit (E-kit). She agreed that R15 should have been given his insulin with his meal and the nurse should have made sure he started to eat. She revealed that insulin was an issue with R15 because if he did not like his insulin order he would seek out another provider and make an appointment and set up a ride independently to have his insulin order changed. Further interview on 4/16/25 at 2:30 p.m., director of nursing (DON) revealed that R15's progress note on 1/26/25, indicated that R15 had been given his insulin 45 minutes prior to being served his meal, resulting in a low blood sugar. R15 took Fiasp insulin which was a rapid acting insulin and should have been given with food confirming that LPN-A did not follow the manufacture instruction and gave R15 the insulin before he ate his meal. She further confirmed that LPN-A did not follow the facility standing order protocol for low blood sugar to administer either glucagon gel or glucagon injection according to standing orders. She reported at the time of the incident, LPN-A stated she had given juice or sugar to R15 related to his low blood sugar instead of the correct procedure outlined in the standing orders. She had re-educated LPN-A at that time and had planned to re-educate all the licensed nurses on using the facility standing order protocol for low blood sugars. She had performed a new competency for LPN-A on 1/27/25, however she could not recall if all nursing staff had received competencies yearly. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN-A's employee file identified education on insulin administration occurred on 3/10/23, 3/13/23, and 3/20/23. On 4/1/23, LPN-A met the requirements for competency of medication pass. There were no competencies listed for 2024 related to insulin adminisistration or identifying potential complications. On 1/27/25, LPN-A had re-education and met the requirements for competency of insulin administration including checking times insulin should be administered. Interview on 4/16/25 at 3:52 p.m., with the emergency department provider who had who treated R15 on 1/26/25 and treated him previously in the past also identified R15 had received his mealtime insulin before he was given his meal. R15 had not been eating well and when she spoke to the facility nurse, she reported that she re-educated the nurse for R15 who had previous concerns with low blood sugars, that the facility should have used critical thinking and brought him out to dining area to ensure he ate his meal after administering his insulin. She confirmed R15 should not be administered his rapid acting Fiasp insulin without eating his meal, his order was insulin at mealtime which means he gets it with a meal and the facility needs to watch that better. She reported the facility was doing the best they can, but they needed to work on critical thinking skills as some nurses just follow orders and do not question anything. If R15 had not been feeling well and had been eating poorly, the nurse should R15 ate within the required timeframe. Review of the 2/17/25, Blood Glucose Monitoring policy identified the policy notes after checking a resident's blood sugar level, staff were to report critical results and test results outside parameters timely. There was no mention on what staff should look for with diabetic complications, if they should follow insulin manufacturer's guidelines, or what to do if those complications should arise. Review of 8/1/24, Facility Assessment identified 9 licensed nurses were employed at the facility. The facility was to ensure nursing staff were to maintain competencies required to meet the residents needs including pharmacological. Staff were to be trained on procedures and policies consistent with their roles. There was no mention staff should be deemed competent at least yearly, or more often as necessary, according to the roles and duties they provide in order to ensure those competencies were maintained. There was no policy related to following manufacture instruction provided by end of survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39988 Based on observation and interview the facility failed to ensure only authorized personnel entered 1 of 1 medication storage room. Findings include: Observation and interview on 4/16/25 at 8:24 a.m. of licensed practical nurse (LPN)-A wheeled R8 into the medication storage room adjacent to the dining room. LPN-A donned gloves and primed Humulin Kwik pen with 2 units. LPN-A identified R8's blood sugar was 171 and then dialed up 20 units of insulin for administration. LPN-A administered the insulin in R8's left abdomen and discarded the insulin needle in the sharp's container and removed her gloves. LPN-A then wheeled R8 back out to the dining room table. LPN-A reported that typically she did not give insulin in the medication room however R8 had gotten out the dining room before she caught her to give her insulin. She also revealed that there were typically 2 licensed nurses on duty during the daytime hours and today she was the only licensed nurse on duty with a trained medication aide (TMA) so she had to give all the insulins in the facility so that was why she gave the insulin in the medication room. Interview on 4/16/25 at 8:30 a.m., with the assistant director of nursing (ADON)/infection control nurse identified that if a resident needed insulin that she had taken them into the medication room to provide privacy before. Interview on 4/16/25 at 2:30 p.m., with the director of nursing (DON) identified that she was unaware nurses had been taking residents into the medication room to administer insulin. She agreed that would be an infection control concern and a medication storage concern if the nurse had to run out for some reason like an emergency, the resident could potentially get left unattended. The DON was surprised to hear more than one nurse had brought a resident into the medication room to administer insulin. Review of the undated, Medication Storage in the Facility policy identified the medication supply was only accessible to licensed nursing personnel, staff members lawfully authorized to administer medications, or the pharmacy personnel.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39988 Based on observation and interview the facility failed to ensure 1 of 1 nursing assistant (NA-A) entering the food preparation area in the kitchen wore a hair net. Findings include: Observation and interview on 4/14/25 at 12:25 p.m., of NA-A standing in the kitchen food preparation area where the cook was dishing up the meal onto plates. NA-A was standing within 2 feet of the cook dishing up the food onto the plate with no hair net on. NA-A obtained a meal tray and exited the kitchen. When asked about hair nets when in the kitchen NA-A stated, I do not think the nurse aides have to wear one. She denied that she typically goes into the kitchen to retrieve a meal, then reported, the resident was out in the dining room, but then changed their mind and wanted to eat in their room. Interview on 4/14/25 at 12:32 p.m., with dietary manager identified staff were able to enter the kitchen as far as the hand washing sink which was just inside the kitchen door. Any distance after that they need to have the hair net on. She confirmed there should be no staff without hair nets in the kitchen serving area. Interview on 4/16/25 at 2:30 p.m., with director of nursing (DON) identified she would expect that any staff entering the kitchen would be donning a hair net prior to entering the kitchen for any reason. She reported the rule has always been you either put on a hair net or you wait at the door. The facility had no policy related to wearing hair nets in the kitchen however, they provided The Safe Food Handler protocol they followed that identified that hair restraints or hats were required when in the food-prep area. Hair nets or hats kept hair from falling into food and onto food-contact surfaces.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on interview and document review, the facility failed to implement thier facility assessment to ensure 1 of 1 licensed practical nurse (LPN)-A and potentially 8 other licensed nurses (registered nurses (RN's) and LPN's) who administered insulin had yearly competencies for safe administration of insulin, and identifcation of complications of low or high blood sugar levels and any actions needed. This had the potential to affect all residents who were diabetic. Finding include: R15's 1/21/25, Significant Change Minimum Data Set (MDS) assessment identified R15 cognition was intact, he had no pain, no behaviors, was on a therapeutic diet, received insulin, anticoagulant, diuretic, hypoglycemic medication daily and was on isolation. R15's diagnosis list identified he had diabetes mellitus type 2, long term use of insulin, heart failure, chronic kidney disease, edema, atrial fibrillation, and hypertension. R15's January 2025, Medication Administration Record identified R15 received insulin Glargine Solution 48 units every morning and evening and Fiasp insulin aspart injection solution 32 units three times a day at 8:00 a.m., noon, and 5:00 p.m R15's medication administration audit report identified documentation on 1/26/25 at: 1) 9:17 a.m., Fiasp insulin 32 units had been administered. 2) 9:18 a.m. insulin Glargine 48 units had been administered. 3) 12:17 p.m. Fiasp insulin 32 units had been administered. R15's 1/26/25 at 1:46 p.m., progress note identified LPN-A documented R15 was given his dinner medication and insulin around 11:45 a.m. Staff brought R15 his dinner at 12:30 p.m. (forty-five minutes later) and found R15 to be sweating and drooling from his mouth. R15 was unable to answer appropriately, blood pressure was 135/86 millimeters/mercury (mm/hg) (normal 120/80 mm/hg), temperature 97.5 Fahrenheit (F) (within normal limits), pulse 80 beats per minute (bpm) (normal), respirations 20 per minute (normal), and oxygen saturation 95% (normal) on room air. The ambulance was called at 1:20 p.m., and R15 left the facility at 1:30 p.m. The progress note lacked identification of what R15's BS was at 12:30 when staff identified his level of conscious changes, or what, if any, interventions had been implemented at the facility. R15's vital signs documentation identified on 1/26/25 at 9:18 a.m., R15's BS was 103 milligrams/deciliter (mm/dL). At 12:22 p.m., R15's BS was 99 mg/dL, and at 1:44 p.m. (after R15 had left the facility), staff recorded R15's BS was 68 mg/dL. It is unknown if this was a late entry. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/15/25 at 7:55 a.m., with registered nurse (RN)-B identified she would check the resident blood sugar, if it was low at all she would wait to see what the resident ate before giving fast acting insulin. She was unsure if there was any protocol on what to do or what other nurses did for insulin. Interview on 4/15/25 at 8:31 a.m., with LPN-A identified on 1/26/25, from what she could recall, R15 never usually had a low blood sugar, but it was low that day. R15 ate his meal, but occasionally he would get bucky and not want to come out for his meal right away. She thought perhaps staff likely went to get him, but he would not come out, so they brought him his meal and that was when they found him unable to answer appropriately. Staff then came and got her to go and assess him. R15's blood sugar level and blood pressure had gone down so she sent him to the ED for evaluation. Further interview on 4/16/25 at 7:33 a.m., with LPN-A identified on 1/26/25, the day she sent R15 to the emergency department (ED) she had assessed him, attempted to give him orange juice with sugar in it. She reported she did not use the glucagon gel because she was unsure if he would have been able to swallow that as it was thicker. From what she could recall, she wasn't aware if the facility had glucagon injectable medication and did not report what she had not used that if she had concerns about R15's ability to swallow medication. Review of the June 2023, Fiasp insulin aspart injection 100 units/ml manufacturer instructions identified Fiasp was a rapid-acting human insulin analog indication to improve glycemic control for patients with diabetes mellitus (1). Fiasp insulin was to be given at the start of a meal or within 20 minutes after starting a meal. R15's 1/26/25, emergency department record identified R15 with a history of diabetes, the facility reported that R15 had a BS of 68 and was given 4 packets of sugar while at nursing home. Upon arrival R15 had a BS of 33. R15 had tested positive for influenza on 1/20/25 and had not been eating or drinking well however, and the facility had continued to give him his usual insulin doses. He had been receiving Lantus 48 units twice a day along with NovoLOG 32 units three times a day with meals. R15's 1/30/25, hospital discharge summary identified R15 had been admitted on [DATE] for hypoglycemia, influenza A, and acute renal disease and hypotension secondary to dehydration. Review of the current, undated, American Diabetes Association (ADA) , Severe Hypoglycemia (Severe Low Blood Glucose) article, located at https://diabetes. org/living-with-diabetes/hypoglycemia-low-blood-glucose/severe, identified severe hypoglycemia, which may also be referred to as an insulin reaction or insulin shock, is when your blood glucose (blood sugar) drops dangerously low. If you have severe hypoglycemia, you may become confused, pass out (lose consciousness), or treatments for a low blood glucose aren ' t working. People on blood glucose-reducing medications (insulin) were at risk. Signs and symptoms of severe hypoglycemia were listed as: 1) An altered mental state 2) Fainting or losing consciousness 3) Incredibly weak and unable to help yourself 4) Seizure (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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) Coma If left untreated for too long, severe hypoglycemia can lead to brain or organ damage or even death. Glucagon, preferably ready-to-use, should be used to treat severe hypoglycemia. It quickly raises blood glucose levels by causing the liver to release the glucose it stores into your bloodstream. Review of the 12/10/2016, ADA and EASD Joint Statement on Hypoglycemia (low BS) article, located at https://www.diabetesincontrol.com/ada-easd-joint-statement-on-hypoglycemia/, identified 3 stages of low blood sugar: 1) Level 1: A glucose alert value of 70mg/dL. 2) Level 2: A glucose level of 54 mg/dL is sufficiently low to indicate serious, clinically important hypoglycemia. 3) Level 3: Severe hypoglycemia, as defined by the ADA, denotes severe cognitive impairment requiring external assistance for recovery. R15's 5/7/24, signed Prairie View Senior Living Physician Standing Orders identified diabetics: administer glucose gel 15 gram by mouth if resident with hypoglycemia is alert enough to swallow get. Administer the glucagon injection, 1 milligram via intramuscular or subcutaneously for hypoglycemia if resident was unresponsive and has a low blood glucose (BS) level. Call the physician to update and implement further orders as soon as possible. Interview on 4/15/25 at 2:10 p.m., with consulting pharmacist identified no one should be taking insulin more than 30 minutes prior to eating in general. Diabetics even if sick still need to take their insulin however, if the resident was not eating the facility should have reached out to the provider to make sure the insulin dose did not need to be adjusted. Fiasp insulin was a rapid acting insulin and should be given just before eating and staff should follow the manufacturer's instruction for any insulin they are administering. The dispensing pharmacy confirmed that the facility emergency kit (E-kit) contained both glucagon gel and glucagon injections 2 doses of each at the time of the incident. Once the facility used an item out of the E-kit the facility would send a fax and they would replace the item the next delivery day. Interview on 4/15/25 at 2:43 p.m., with director of nursing (DON) identified that fast acting insulin should never be given more than 15 minutes prior to eating. On 1/26/25, LPN-A had attempted to give R15 sugar packets with orange juice prior to breaking into the emergency kit (E-kit). She agreed that R15 should have been given his insulin with his meal and the nurse should have made sure he started to eat. She revealed that insulin was an issue with R15 because if he did not like his insulin order he would seek out another provider and make an appointment and set up a ride independently to have his insulin order changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. Building B. Wing	04/16/2025

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further interview on 4/16/25 at 2:30 p.m., director of nursing (DON) revealed that R15's progress note on 1/26/25, indicated that R15 had been given his insulin 45 minutes prior to being served his meal, resulting in a low blood sugar. R15 took Fiasp insulin which was a rapid acting insulin and should have been given with food confirming that LPN-A did not follow the manufacture instruction and gave R15 the insulin before he ate his meal. She further confirmed that LPN-A did not follow the facility standing order protocol for low blood sugar to administer either glucagon gel or glucagon injection according to standing orders. She reported at the time of the incident, LPN-A stated she had given juice or sugar to R15 related to his low blood sugar instead of the correct procedure outlined in the standing orders. She had re-educated LPN-A at that time and had planned to re-educate all the licensed nurses on using the facility standing order protocol for low blood sugars. She had performed a new competency for LPN-A on 1/27/25, however she could not recall if all nursing staff had received competencies yearly. Review of LPN-A's employee file identified education on insulin administration occurred on 3/10/23, 3/13/23, and 3/20/23. On 4/1/23, LPN-A met the requirements for competency of medication pass. There were no competencies listed for 2024 related to insulin adminisistration or identifying potential complications. On 1/27/25, LPN-A had re-education and met the requirements for competency of insulin administration including checking times insulin should be administered. Interview on 4/16/25 at 3:52 p.m., with the emergency department provider who had who treated R15 on 1/26/25 and treated him previously in the past also identified R15 had received his mealtime insulin before he was given his meal. R15 had not been eating well and when she spoke to the facility nurse, she reported that she re-educated the nurse for R15 who had previous concerns with low blood sugars, that the facility should have used critical thinking and brought him out to dining area to ensure he ate his meal after administering his insulin. She confirmed R15 should not be administered his rapid acting Fiasp insulin without eating his meal, his order was insulin at mealtime which means he gets it with a meal and the facility needs to watch that better. She reported the facility was doing the best they can, but they needed to work on critical thinking skills as some nurses just follow orders and do not question anything. If R15 had not been feeling well and had been eating poorly, the nurse should R15 ate within the required timeframe. Review of the 2/17/25, Blood Glucose Monitoring policy identified the policy notes after checking a resident's blood sugar level, staff were to report critical results and test results outside parameters timely. There was no mention on what staff should look for with diabetic complications, if they should follow insulin manufacturer's guidelines, or what to do if those complications should arise. Review of 8/1/24, Facility Assessment identified 9 licensed nurses were employed at the facility. The facility was to ensure nursing staff were to maintain competencies required to meet the residents needs including pharmacological. Staff were to be trained on procedures and policies consistent with their roles. There was no mention staff should be deemed competent at least yearly, or more often as necessary, according to the roles and duties they provide in order to ensure those competencies were maintained.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47497 Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas identified thorough and appropriate data collection and analysis and evaluation of the identified concern(s) during QAPI. This had the potential to affect all 43 residents. Review of the facilities QAPI minutes from June of 2024 through March of 2025 identified the following: 1. June 2024 minutes identified the facility chose a PIP of pain. The minutes did not include any data collection, analysis, evaluation of the identified concern, or an action plan. 2. July, August, September, October, November, December of 2024 and January, February, March of 2025 QAPI minutes identified the facility chose a PIP of pain but lacked any data collection, analysis or evaluation of the identified concern or an action plan. Interview on 4/15/25 at 4:30 p.m., with the administrator identified the QAPI committee had chosen pain from the facilities CMS Quality measures as their PIP project back in June. He reported they had not developed an action plan. He would expect the committee to follow the PIP process to bring the data to QAPI, discuss the problem, set a measurable goal, developed an action plan, and revisit and adjust the plan as needed until completion. Review of the facility provided October 2024, QAPI Plan identified at least annually, a project that focuses on high risk or problem-prone areas will be addressed thought he QAPI program including PIP development. A minimum of one PIP and a maximum of four PIP's will occur simultaneously. A PIP worksheet which establishes the goals, scope, timing, milestones, and team's roles and responsibilities will be developed for each PIP. The PIP team will be assembled by the QAPI committee. The team will be interdisciplinary with employees representing each job role affected by the project and may include resident and/or family representation, when appropriate. A project lead will be selected and will be responsible for coordinating, organizing and directing the activities of that specific PIP team. The PIP team will identify the information needed to evaluate the problem at hand, supplies required, staff participation, and any equipment needs. The project lead will communicate any identified resources needed. The team will utilize root cause analysis to identify the cause of the problem and any contributing factors. The PIP team will develop an action plan with identified problem statement, causes, goals, interventions, employees responsible, and due dates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39988 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 medication room was not used for resident insulin administration and/or blood glucose checks, in order to prevent potential cross-contamination. Observation and interview on 4/16/25 at 8:24 a.m. of licensed practical nurse (LPN)-A wheeled R8 into the medication storage room adjacent to the dining room. LPN-A donned gloves and primed Humulin Kwik pen with 2 units. LPN-A identified R8's blood sugar was 171 and then dialed up 20 units of insulin for administration. LPN-A administered the insulin in R8's left abdomen and discarded the insulin needle in the sharp's container and removed her gloves. LPN-A then wheeled R8 back out to the dining room table. LPN-A reported that typically she did not give insulin in the medication room however R8 had gotten out the dining room before she caught her to give her insulin. She also revealed that there were typically 2 licensed nurses on duty during the daytime hours and today she was the only licensed nurse on duty with a trained medication aide (TMA) so she had to give all the insulins in the facility so that was why she gave the insulin in the medication room. Interview on 4/16/25 at 8:30 a.m., with the assistant director of nursing (ADON)/infection control nurse identified that if a resident needed insulin that she had taken them into the medication room to provide privacy before. Interview on 4/16/25 at 2:30 p.m., with the director of nursing (DON) identified that she was unaware nurses had been taking residents into the medication room to administer insulin. She agreed that would be an infection control concern and posed a likelihood of cross-contamination. The DON was surprised to hear more than one nurse had brought a resident into the medication room to administer insulin. Review of 6/21/21, General guild lines for infection control identified facility would maintain a sanitary environment by adhering to infection control practices. The infection preventionist and/or the director of nurses would be responsible for the facility infection control procedures. The charge nurse would be responsible to carry out functions of infection control. Infection control practices are necessary to prevent or control the spread of infections. Review of 2/1/25, Medication Storage in the Facility policy identified the medication storage areas are to be kept clean and only authorized personnel should be in the medication storage area.