

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Pathstone Living		STREET ADDRESS, CITY, STATE, ZIP CODE  718 Mound Avenue Mankato, MN 56001	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</b></p> <p>Based on interview and document review, the facility failed to ensure insulin was administered per physician orders for 1 of 3 residents (R1) reviewed for medication administration.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) indicated R1 was cognitively intact, had a diagnosis of diabetes, and required insulin 7 of 7 days in the lookback period.</p> <p>R1's care plan dated [DATE], indicated R1 would be free of signs or symptoms of hypoglycemia (a condition in which the body's blood sugar level goes below the standard range) and monitor for sweating, tremor, increased heart rate, confusion, slurred speech, lack of coordination, and staggering gait.</p> <p>R1's Physician's orders dated [DATE] directed detemir insulin (Levemir) inject 34 units subcutaneously (under the skin) at bedtime related to diabetes.</p> <p>R1's Physician's orders for insulin glargine dated [DATE] directed inject 40 units subq at bedtime related to diabetes. The order further directed, Start when Levemir is used up.</p> <p>On [DATE] at 11:50 p.m., a progress note indicated R1 received too much insulin on the evening shift. R1 was given 34 units of detemir insulin (a long-acting injection that treats diabetes by increasing insulin levels in the blood, which decreases blood sugar, typically administered once daily at about the same time each day) and 40 units of glargine insulin (a long-acting injection that treats diabetes by increasing insulin levels in the blood, which decreases blood sugar, typically administered once daily at about the same time each day). The progress note indicated R1 was transported to the hospital by ambulance.</p> <p>On [DATE] at 3:24 p.m. a progress note indicated R1 was observed to have increased confusion and agitation the morning on [DATE].</p> <p>R1's [DATE] Medication Administration Record (MAR) indicated R1 received both the detemir insulin and glargine insulin from [DATE] to [DATE].</p> <p>R1's hospital Information Sheet dated [DATE], indicated R1's hospital admission diagnosis was hypoglycemia.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:42 p.m., R1 stated, I was out of it after the insulin overdose on the 12th [of March]. I was really sleepy. I wasn't myself. I knew what was going on but really didn't feel like I gave a darn. Normally I am a worrier, but I was not after all the insulin. Not at all. Actually, I had about a week's worth of overdosing.</p> <p>On [DATE] at 2:58 p.m., licensed practical nurse (LPN)-A stated she was one of the nurses who administered both detemir insulin and glargine insulin over the 6-day period of [DATE] to [DATE]. LPN-A stated the order for glargine insulin was entered with the order to hold glargine insulin until the detemir insulin could be used first, and then the glargine insulin would be utilized after the detemir insulin was gone. LPN-A stated the hold order for the glargine insulin expired, and both insulins showed on the MAR to be administered. LPN-A acknowledged she administered both insulins four nights in a row, and further stated she knew both were long-acting insulins, but did not question the order.</p> <p>On [DATE] at 5:05 p.m., the director of nursing (DON) stated the facility was working on changing from detemir insulin to glargine insulin, and the part of the order to hold the glargine insulin was not visible unless the nurse looked for it under additional information.</p> <p>On [DATE] at 5:11 p.m., registered nurse (RN)-A stated she knew both detemir and glargine insulins were long-acting, and she had not seen an order for both insulins used simultaneously. RN-A acknowledged she did not question the physician's order.</p> <p>On [DATE] at 7:39 a.m., family member (FM)-A stated on the morning of [DATE], R1 was pale, clammy, cranky, irritable, and sleepy. FM-A stated R1 was normally peppy and joked with staff. FM-A stated, They said she was overdosed with insulin.</p> <p>On [DATE] at 9:04 a.m., RN-B stated on the morning of [DATE], R1 was very tired, had increased confusion, and further stated, I wish they [the nurses] had seen something before six days, or asked why there were two long-acting insulins.</p> <p>The Insulin Administration Policy dated [DATE], directed the type of insulin, dosage requirements, strength, and method of administration must be verified before administration.</p>