STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda	901 Southeast Willmar Avenue Willmar, MN 56201

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 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** 47083 Based on interview and document review, the facility failed to administer insulin according to the physician's orders for 1 of 3 residents (R1) reviewed for insulin administration. Findings include: R1's Medicare 5 day Minimum Data Set (MDS) dated [DATE], indicated R1 had a diagnosis of Type 1 Diabetes Mellitus and received daily insulin injections. R1's Physician Orders dated 4/23/24 directed to administer: 1 unit of Novolog insulin per gram (carbohydrate): Breakfast 1 unit/10gram Lunch 1 unit/10gram Supper 1 unit/10gram Sliding scale insulin (SSI)/Correction: (Novolog insulin) For blood sugar of 151-200, give 1 unit For blood sugar of 201 - 250 = 2 units For blood sugar of 251 - 300 = 3 units For blood sugar of 301 - 350 = 4 units For blood sugar of 351- 400 = 5 units For blood sugar of Over 400 = 6 units Diet & Dosing Carbohydrates (carbs) per meal (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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Do not use correction scale if your blood sugar was taken after you have eaten or received correction scale within the last 3 hours. Can use carb coverage. 2. If calculated dose includes a half amt, round down to the nearest whole number. R1's insulin administration record indicated R1 received 2 units of Novolog insulin at 5:30 p.m., for a blood sugar of 204. Additionally, R1 received 30 units Novolog insulin for carbohydrate intake at supper meal, for a total of 32 units Novolog insulin. R1's record of blood sugar readings indicated her blood sugar indicated: 204 at 6:27 p.m. on 4/25/24 63 at 11:36 p.m. on 4/25/24 61 at 11:40 p.m., on 4/25/24 52 at 11:58 p.m., on 4/25/24 57 at 12:33 a.m., on 4/26/24 62 at 12:45 a.m., on 4/26/24 On 4/25/24, at 11:52 p.m. a progress note indicated R1's blood sugar was 204 before supper. Insulin was self-administered by the resident with the staff present. Blood sugar 70 and dropped to 61. Resident given 120 milliliters (ml) of orange juice. It was passed on to the night nurse to monitor the resident's blood sugar. On 4/26/24, at 2:28 a.m. a progress note indicated R1 was fighting low blood sugar episode. R1 was found to be sitting on the floor in front of her wheelchair just outside her bathroom door. No injuries were noted and she denied pain. Medical doctor (MD) notified. On 5/3/24, at 9:38 a.m. the director of nursing (DON) stated the insulin dosing was ordered to be based off the carbohydrate grams. R1 should have had 3 units regular insulin on 4/25/24 with her supper meal. She stated this was a significant medication error. On 5/3/24, at 11:03 a.m. licensed practical nurse (LPN)-A stated she discovered the medication error on 4/26/24 as she was documenting R1's medication administration at 7:30 a.m. She informed registered nurse (RN)-A of the error immediately. On 5/3/24, at 11:13 a.m. RN-A stated LPN-A brought the medication error to her attention on 4/26/24. The directions for determining the amount of insulin to administer were made clear following the discovery of the error involving insulin. She reviewed the menu for the supper meal on 4/25/24, determining R1 should have received a total of 5 units of Novolog insulin on 4/25/24 at 5:30 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/24, at 12:16 p.m. the assistant director of nursing (ADON) stated R1 should have received 2 units of Novolog insulin for her blood sugar of 204, plus 3 units Novolog insulin for her carbohydrates she ate for supper, for a total of 5 units Novolog insulin. The nursing staff was familiar with carb counting, but not counting the grams of carbohydrates. The directions for the order were clarified following the medication error. On 5/3/24, at 12:48 p.m. pharmacist (P)-A stated when R1 received 32 units of Novolog insulin, instead of 5 units, this was considered a significant medication error. On 5/3/24, at 1:18 p.m. LPN-B stated she dosed the Novolog insulin pen to 32 units on 4/25/24 at suppertime for R1 to self-administer. she misread the directions for dosing as they related to counting carbohydrate grams. On 5/3/24, at 2:13 p.m. the DON stated R1's insulin dose of 32 units on 4/25/24 was a major medication error. The facility Administration of Medications Policy dated 2/2024 directed all medication is to be given as prescribed by the doctor/nurse practitioner. The facility Treatment for Diabetic Residents Policy and Procedure dated 2023 directed always follow physician standing orders.