

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Ash Grove Healthcare Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 401 North Medical Drive Ash Grove, MO 65604	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on observation, interview, and record review, the facility failed to ensure all residents received care per the residents' care plans and standards of practice when staff failed to obtain blood sugar parameters for administration of as needed insulin for one resident (Resident #23) and when staff failed to document placement of a physician ordered compression glove or document notification of refusals for one resident (Resident #62). The facility census was 75. Review of the facility policy titled, Physician Orders, last revised November 2024, showed, the following: -If an order is received that is unclear, incomplete, or illegible, clarify the order with the attending physician and document clarification of the order in the medical record; -If the licensed/certified personnel question the appropriateness of an order, the following steps will be taken: Contact the physician for clarification. If unresolved: In long term care: Notify the charge nurse, Director of Nursing (DON), or Administrator. The nurse of DON will contact the physician to discuss the matter. If the matter is not resolved, proceed to the next step. Contact the facility medical director for the final decision. 1. Review of the facility policy titled, Blood Glucose Monitoring, last revised April 2023, showed the following: -A blood glucose level above 400 milligrams (mg)/deciliters (dL) or below 70 mg/dL should be reported to the resident's provider, unless otherwise instructed by the provider; -Notification should be documented in the medical record as well as follow up orders for action; -Out of range blood glucose should be reported to the charge nurses and/or Director of Nursing (DON); -Residents with sliding scale insulin will have notification parameters built into their scale Review of Resident #23's face sheet showed an admitted [DATE]. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/18/24, showed the following: (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 265571
		If continuation sheet Page 1 of 16

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Exhibited moderate cognitive impairment; -Diagnoses included spinal stenosis (narrowing of the spaces inside the backbone can lead to weakness/tingling/pain) and diabetes mellitus; -Staff administered insulin seven out of seven days. Review of the resident's care plan, dated 01/06/22 and reviewed on 01/13/25, showed the following: -Resident had a diagnosis of diabetes mellitus, type II and was insulin dependent; -Staff to monitor for signs/symptoms of altered glucose metabolism as needed; -Staff to assess for increase thirst, increased urination, gradual muscle weakness, weight gain/loss, anorexia, abdominal cramping/pain, nausea, vomiting, blurred vision, lethargy, changed in mental status, pallor (pale skin), and diaphoresis (sweating); -Staff to complete accu-checks (finger stick to obtain blood sugar) as ordered and administer medication as ordered. Review of the resident's nurse note dated 12/09/24, untimed, showed the following: -Morning blood glucose = 359 mg/dL, treated with script of 4 units of Admelog (lispro - a fast-acting insulin) with meals; -Noon blood glucose = 419 mg/dL, treated with 4 units of Admelog; -Staff sent message to physician and staff awaiting orders. Review of a message about the resident sent from the nurse to the nurse practitioner (NP) dated 12/09/24, at 12:24 P.M., showed the following: -Morning blood glucose = 359 mg/dL, treated with script of 4 units of Admelog with meals; -Noon blood glucose = 419, treated with script of 4 units of Admelog; -Resident does not have a sliding scale; -How should we proceed? Review of the NP response dated 12/09/24, at 1:17 P.M., showed continue current care. Anytime they try to adjust his/her meds he/she drops and has issues with hypoglycemia (low blood glucose). Review of a message about the resident sent from the nurse to the NP dated 12/09/24, at 4:08 P.M., showed just an FYI (for your information), 4:00 P.M. blood sugar = 419 mg/dL, 3 units of insulin given. Previous communication noted to continue current plan of care. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a message about the resident sent from the nurse to the NP dated 12/09/24, at 9:21 P.M., showed resident's blood glucose at bedtime was 429 mg/dL. The resident is asymptomatic. Review of the NP response dated 12/10/24, at 7:19 A.M., showed will follow blood sugars over the next few days and adjust as needed. He/she is likely having some dietary indiscretions. Review of a message about the resident sent from the nurse to the NP dated 12/11/24, at 5:25 P.M., showed resident's blood glucose at first check was 459 mg/dL and repeat was 491 mg/dL. Staff gave the resident Admelog 4 units. Please advise. Review of the NP response dated 12/12/24, at 7:17 A.M., showed NP said adjusted his/her insulin. Review of the resident's nurse's note dated 12/12/24, untimed, showed the following: -First Accu-check = 406 mg/dL and repeat = 386 mg/dL; -NP notified; -New order for Admelog (fast-acting insulin) 5 units as needed (PRN). Review of the resident's December 2024 Medication Administration Record (MAR) showed the following: -An order, dated 12/12/24, for staff to administer Admelog Solostar (a fast-acting insulin) 5 units subcutaneous (SQ - into fatty tissue under the skin) injection as needed (PRN) at 6:30 A.M., 11:30 A.M., and at 4:30 P.M. (The order did not provide blood glucose level parameters regarding when to administer the PRN insulin.) Review of the resident's insulin administration record for Lispro (Admelog) pen 5 units PRN SQ at 6:30 A.M., 11:30 A.M., 4:30 P.M. and review of the resident's glucometer blood sugar (BS) results showed the following: -On 12/12/24, at 6:39 A.M., glucometer (an instrument used measure how much sugar is in a person's blood) result = 409 mg/dL; -On 12/12/24, at 6:41 A.M., glucometer result = 386 mg/dL and at 7:43 A.M. staff administered 5 units of PRN insulin; -On 12/12/24, at 11:05 A.M., glucometer result = 418 mg/dL; -On 12/12/24, at 11:07 A.M., glucometer result = 499 mg/dL and at 11:33 A.M. staff administered 5 units of PRN insulin; -On 12/12/24, at 3:32 P.M., glucometer result = 455 mg/dL; -On 12/12/24, at 3:34 P.M., glucometer result = 389 mg/dL and at 4:38 P.M. staff administered 5 units of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/12/24, at 6:21 P.M., glucometer result = 317 mg/dL. Staff did not document administration of PRN insulin; -On 12/13/24, at 6:32 A.M. glucometer result =220 mg/dL. Staff did not document administration of PRN insulin; -On 12/13/24, at 11:17 A.M., glucometer result = 219 mg/dL and at 11:24 A.M. Staff administered 5 units of PRN insulin; -On 12/13/24, at 4:04 P.M., glucometer result = 309 mg/dL and at 4:36 P.M. staff administered 5 units of PRN insulin; -On 12/13/24, at 7:04 P.M., glucometer result = 209 mg/dL. Staff did not document administration of PRN insulin; -On 12/14/24, at 6:32 A.M., glucometer result = 208 mg/dL and at 6:38 A.M. staff administered 5 units of PRN insulin; -On 12/14/24, at 11:14 A.M., glucometer result = 246 mg/dL. Staff did not document administration of PRN insulin; -On 12/14/24, at 4:01 P.M., glucometer result = 249 mg/dL. Staff did not document administration of PRN insulin; -On 12/14/24, at 6:16 P.M., glucometer result = 248 mg/dL. Staff did not document administration of PRN insulin; -On 12/15/24, at 6:31 A.M., glucometer result = 86 mg/dL and at 6:47 A.M. staff administered 5 units of PRN insulin; -On 12/15/24, at 11:12 A.M., glucometer result = 97 mg/dL. Staff did not document administration of PRN insulin; -On 12/15/24, at 4:06 P.M., glucometer result = 132 mg/dL. Staff did not document administration of PRN insulin; -On 12/15/24, at 6:41 P.M., glucometer result = 250 mg/dL. Staff did not document administration of PRN insulin; -On 12/16/24, at 6:29 A.M., glucometer result = 224 mg/dL and at 6:30 A.M. staff administered 5 units of PRN insulin; -On 12/16/24, at 11:18 A.M., glucometer result = 346 mg/dL and at 11:16 A.M. staff administered 5 units of PRN insulin; -On 12/16/24, at 3:40 P.M., glucometer result = 358 mg/dL and at 3:41 P.M. staff administered 5 units of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/16/24, at 8:13 P.M glucometer result = 186 mg/dL. Staff did not document administration of PRN insulin; -On 12//17/24, at 6:45 A.M., glucometer result = 133 mg/dL and at 6:49 A.M. staff administered 5 units of PRN insulin; -On 12/17/24, at 3:53 P.M., glucometer result = 296 mg/dL and at 3:55 P.M. staff administered 5 units of PRN insulin; -On 12/17/24, at 6:42 P.M., glucometer result = 194 mg/dL. Staff did not document administration of PRN insulin; -On 12/18/24, at 6:21 A.M., glucometer result = 163 mg/dL. Staff did not document administration of PRN insulin; -On 12/18/24, at 11:08 A.M. glucometer result = 298 mg/dL and at 11:10 A.M. staff administered 5 units of PRN insulin; -On 12/18/24, at 4:22 P.M., glucometer result = 260 mg/dL and at 4:28 P.M. staff administered 5 units of PRN insulin; -On 12/18/24, at 6:29 P.M., glucometer result = 181 mg/dL. Staff did not document administration of PRN insulin; -On 12/19/24, at 7:08 A.M., glucometer result = 116 mg/dL. Staff did not document administration of PRN insulin; -On 12/19/24, at 11:25 A.M., glucometer result = 131 mg/dL and at 11:27 A.M. staff administered 5 units of PRN insulin; -On 12/19/24, at 4:03 P.M., glucometer result = 126 mg/dL. Staff did not document administration of PRN insulin; -On 12/19/24, at 6:31 P.M., glucometer result = 178 mg/dL. Staff did not document administration of PRN insulin; -On 12/20/24, at 6:46 A.M., glucometer result = 114 mg/dL. Staff did not document administration of PRN insulin; -On 12/20/24, at 11:35 A.M., glucometer result = 159 mg/dL. Staff did not document administration of PRN insulin; -On 12/20/24, at 4:47 P.M., glucometer result = 202 mg/dL and at 4:50 P.M. staff administered 5 units of PRN insulin; -On 12/20/24, at 6:01 P.M., glucometer result = 267 mg/dL. Staff did not document administration of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/21/24, at 6:54 A.M., glucometer result = 73 mg/dL. Staff did not document administration of PRN insulin; -On 12/21/24, at 11:00 A.M., glucometer result = 160 mg/dL. Staff did not document administration of PRN insulin; -On 12/21/24, at 4:24 P.M., glucometer result = 259 mg/dL and at 4:25 P.M. staff administered 5 units of PRN insulin; -On 12/21/24, at 6:15 P.M., glucometer result = 214 mg/dL. Staff did not document administration of PRN insulin; -On 12/22/24, at 6:42 A.M., glucometer result = 70 mg/dL. Staff did not document administration of PRN insulin; -On 12/22/24, at 10:59 A.M., glucometer result = 201 mg/dL. Staff did not document administration of PRN insulin; -On 12/22/24, at 3:59 P.M., glucometer result = 259 mg/dL and at 4:01 P.M. staff administered 5 units of PRN insulin; -On 12/22/24, at 6:12 P.M., glucometer result = 117 mg/dL. Staff did not document administration of PRN insulin; -On 12/23/24, at 7:08 A.M., glucometer result = 72 mg/dL and at 7:10 A.M., staff administered 5 units of PRN insulin; -On 12/23/24, at 11:14 A.M., glucometer result = 151 mg/dL. Staff did not document administration of PRN insulin; -On 12/23/24, at 4:36 P.M., glucometer result = 220 mg/dL and at 4:38 P.M. staff administered 5 units of PRN insulin; -On 12/23/24, at 7:33 P.M., glucometer result = 159 mg/dL. Staff did not document administration of PRN insulin; -On 12/24/24, at 6:36 A.M., glucometer result = 120 mg/dL. Staff did not document administration of PRN insulin; -On 12/24/24, at 11:07 A.M., glucometer result = 198 mg/dL and at 11:10 A.M. staff administered 5 units of PRN insulin; -On 12/24/24, at 4:16 P.M., glucometer result = 183 mg/dL. Staff did not document administration of PRN insulin; -On 12/24/24, at 7:47 P.M., glucometer result = 199 mg/dL. Staff did not document administration of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/25/24, at 6:47 A.M., glucometer result = 152 mg/dL. Staff did not document administration of PRN insulin; -On 12/25/24, at 11:21 A .M. glucometer result = 363 mg/dL and at 11:22 A.M. staff administered 5 units of PRN insulin; -On 12/25/24, at 3:48 P.M., glucometer result = 270 mg/dL and a 3:51 P.M. staff administered 5 units of PRN insulin; -On 12/25/24, at 6:14 P.M., glucometer result = 187 mg/dL. Staff did not document administration of PRN insulin; -On 12/26/24, at 6:54 A.M., glucometer result = 288 mg/dL and at 6:58 A.M. staff administered 5 units of PRN insulin; -On 12/26/24, at 11:16 A.M., glucometer result = 367 mg/dL and at 11:20 A.M. staff administered 5 units of PRN insulin; -On 12/26/24, at 3:45 P.M., glucometer result = 271 mg/dL and at 3:55 P.M. staff administered 5 units of PRN insulin; -On 12/26/24, at 7:02 P.M., glucometer result = 144 mg/dL. Staff did not document administration of PRN insulin; -On 12/27/24, at 6:42 A.M., glucometer result = 189 mg/dL and at 6:45 A.M. staff administered 5 units of PRN insulin; -On 12/27/24 at 11:14 A.M., glucometer result =236 mg/dL and at 11:28 A.M. staff administered 5 units insulin; -On 12/27/24, at 3:52 P.M., glucometer result = 262 mg/dL and at 3:54 P.M. staff administered 5 units of PRN insulin; -On 12/27/24, at 5:49 P.M. glucometer result = 289 mg/dL. Staff did not document administration of PRN insulin; -On 12/28/24, at 6:46 A.M., glucometer result = 255 mg/dL and at 6:43 A .M. staff administered 5 units of PRN insulin; -On 12/28/24, at 11:25 A.M., glucometer result = 180 mg/dL. Staff did not document administration of PRN insulin; -On 12/28/24, at 4:15 P.M., glucometer result = 244 mg/dL and at 4:19 P.M. staff administered 5 units of PRN insulin; -On 12/28/24, at 5:44 P.M., glucometer result = 257 mg/dL. Staff did not document administration of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a message about the resident sent from the nurse to the NP dated 12/30/24, at 2:46 A.M., showed: -Resident came to the nurses' station at 1:45 A.M., stating he/she felt he/she needed a snack due to low blood sugar. First check was 55 mg/dL, gave the resident a cookie and juice. Rechecked the resident's blood sugar at 2:09 A.M. was 54 mg/dL. Gave the resident crackers and more juice. Rechecked the resident's blood sugar at 2:36 A.M., and the result was 104 mg/dL. Resident felt comfortable going back to bed. Staff will continue to monitor. Review of the NP response, dated 12/30/24, at 3:02 P.M., showed Noted. Review of the resident's insulin administration record for Lispro (Admelog) pen 5 units as needed (PRN) SQ at 6:30 A.M., 11:30 A.M., 4:30 P.M. and review of the resident's glucometer blood sugar (BS) results showed the following: -On 12/30/24, at 6:33 A.M. glucometer result = 186 mg/dL and at 6:36 A.M. staff administered 5 units of PRN insulin; -On 12/30/24, at 11:09 A.M., glucometer result = 138 mg/dL. Staff did not document administration of PRN insulin; -On 12/30/24 at 3:52 P.M. glucometer result = 218 mg/dL and at 3:55 P.M. staff administered 5 units of PRN insulin; -On 12/30/24, at 7:02 P.M., glucometer result = 160 mg/dL. Staff did not document administration of PRN insulin; -On 12/31/24, at 6:46 A.M., glucometer result = 129 mg/dL. Staff did not document administration of PRN insulin; -On 12/31/24, at 10:59 A.M., glucometer result = 195 mg/dL and at 11:02 A.M. staff administered 5 units of PRN insulin; -On 12/31/24, at 4:49 P.M., glucometer result = 265 mg/dL and at 5:09 P.M. staff administered 5 units of PRN insulin; -On 12/31/24, at 7:25 P.M., glucometer result = 212 mg/dL. Staff did not document administration of PRN insulin; -On 01/01/25, at 7:38 A.M., glucometer result =144 mg/dL. Staff did not document administration of PRN insulin; -On 01/01/25, at 11:31 A.M., glucometer result = 275 mg/dL and at 11:33 A.M. staff administered 5 units of PRN insulin; -On 01/01/25, at 3:50 P.M., glucometer result = 260 mg/dL and at 3:52 P.M. staff administered 5 units of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/01/25, at 6:47 P.M., glucometer result = 307 mg/dL. Staff did not document administration of PRN insulin; -On 01/02/25, at 11:01 A.M., glucometer result = 195 mg/dL and at 11:04 A.M. staff administered 5 units of PRN insulin; -On 01/02/25, at 4:23 P.M., glucometer result = 232 mg/dL and at 4:28 P.M. staff administered 5 units of PRN insulin; -On 01/02/25, at 7:00 P.M., glucometer result = 205 mg/dL and at 7:01 P.M. staff administered 5 units of PRN insulin; -On 01/03/25, at 7:10 A.M., glucometer result = 93 mg/dL. Staff did not document administration of PRN insulin; -On 01/03/25, at 11:36 A.M., glucometer result = 256 mg/dL and at 11:40 A.M. staff administered 5 units of PRN insulin; -On 01/03/25, at 4:53 P.M., glucometer result = 218 mg/dL and at 4:57 P.M. staff administered 5 units of PRN insulin; -On 01/03/25, at 6:14 P.M., glucometer result = 246 mg/dL. Staff did not document administration of PRN insulin; -On 01/04/25, at 7:00 A.M., glucometer result = 65 mg/dL. Staff did not document administration of PRN insulin; -On 01/04/25, at 7:02 A.M., glucometer result = 66 mg/dL. Staff did not document administration of PRN insulin; -On 01/04/25, at 8:09 A.M., glucometer result = 102 mg/dL. Staff did not document administration of PRN insulin. Review of the resident's nurse's note dated 01/04/25, untimed, showed the following: -Notified the resident's physician of blood glucose of 65 mg/dL, repeat check 66 mg/dL; -The nurse took the resident to the dining room and got the resident his/her breakfast and a glass of orange juice; -No symptoms of low blood glucose; -After breakfast, blood glucose 102 mg/dL. Review of the resident's insulin administration record for Lispro (Admelog) pen 5 units as needed (PRN) SQ at 6:30 A.M., 11:30 A.M., 4:30 P.M. and review of the resident's glucometer blood sugar (BS) results showed the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Ash Grove Healthcare Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 401 North Medical Drive Ash Grove, MO 65604	
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/04/25, at 11:35 A.M., glucometer result = 239 mg/dL and at 11:39 A.M. staff administered 5 units of PRN insulin; -On 01/04/25, at 4:19 P.M., glucometer result = 202 mg/dL and at 4:21 P.M., staff administered 4 units of PRN insulin. (Staff did not have an order to administer 4 units.); -On 01/04/25, at 5:51 P.M., glucometer result = 266 mg/dL. Staff did not document administration of PRN insulin; -On 01/05/25, at 7:19 A.M., glucometer result = 68 mg/dL. Staff did not document administration of PRN insulin; -On 01/05/25, at 7:21 A.M., glucometer result = 67 mg/dL. Staff did not document administration of PRN insulin; -On 01/05/25, at 7:46 A.M., glucometer result = 88 mg/dL. Staff did not document administration of PRN insulin; -On 01/05/25, at 10:58 A.M., glucometer result = 226 mg/dL. Staff did not document administration of PRN insulin; -On 01/05/25, at 3:59 P.M., glucometer result = 253 mg/dL and at 4:00 P.M. staff administered 5 units of PRN insulin; -On 01/05/25, at 7:03 P.M., glucometer result = 197 mg/dL. Staff did not document administration of PRN insulin; -On 01/06/25, at 7:05 A.M., glucometer result = 49 mg/dL. Staff did not document administration of PRN insulin; -On 01/06/25, at 8:50 A.M., glucometer result = 104 mg/dL. Staff did not document administration of PRN insulin. Review of a message sent from the nurse to the NP dated 01/06/25, at 8:57 A.M., showed: -Resident's initial blood glucose this A.M. = 47 mg/dL. Resident taken to breakfast immediately and allowed to eat. Follow-up blood glucose = 104 mg/dL. Will monitor throughout shift. Anything further? Review of the NP's response dated 01/06/25, at 9:08 A.M., showed continue to monitor. Provider decreased the resident's long-acting insulin. Review of the resident's insulin administration record for Lispro (Admelog) pen 5 units as needed (PRN) SQ at 6:30 A.M., 11:30 A.M., 4:30 P.M. and review of the resident's glucometer blood sugar (BS) results showed: -On 01/06/25, at 11:42 A.M. glucometer result = 197 mg/dL. Staff did not document administration of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/06/25, at 4:35 P.M., glucometer result = 282 mg/dL. Staff did not document administration of PRN insulin; -On 01/06/25, at 8:54 P.M., glucometer result = 292 mg/dL. Staff did not document administration of PRN insulin; -On 01/07/25, at 6:30 A.M., glucometer result = 222 mg/dL and at 6:36 A.M. staff administered 5 units of PRN insulin; -On 01/07/25, at 11:26 A.M., glucometer result = 204 mg/dL. Staff did not document administration of PRN insulin; -On 01/07/25, at 8:40 P.M., glucometer result = 317 mg/dL. Staff did not document administration of PRN insulin; -On 01/08/25, at 6:49 A.M., glucometer result = 264 mg/dL and at 7:27 A.M. staff administered 5 units of PRN insulin; -On 01/08/25, at 11:31 A.M., glucometer result = 256 mg/dL and at 11 34 A.M. staff administered 5 units of PRN insulin; -On 01/08/25, at 5:16 P.M., glucometer result = 248 mg/dL and at 5:18 .M. staff administered 4 units of PRN insulin. (Staff did not have an order to administer 4 units); -On 01/08/25, at 7:11 P.M., glucometer result = 286 mg/dL. Staff did not document administration of PRN insulin; -On 01/09/25, at 6:42 A.M., glucometer result = 178 mg/dL and at 7:14 A.M. staff administered 4 units of PRN insulin. (Staff did not have an order to administer 4 units); -On 01/09/25, at 11:15 A.M., glucometer result = 246 mg/dL and at 11:19 A.M. staff administered 5 units of PRN insulin; -On 01/09/25, at 4:33 P.M., glucometer result = 227 mg/dL and at 4:35 P.M. staff administered 4 units of PRN insulin. (Staff did not have an order to administer 4 units.); -On 01/09/25, at 7:19 P.M., glucometer result = 235 mg/dL. Staff did not document administration of PRN insulin; -On 01/10/25, at 7:22 A.M., glucometer result = 214 mg/dL and at 7:38 A.M. staff administered 5 units of PRN insulin; -On 01/10/25, at 10:52 A.M., glucometer result = 245 mg/dL and at 11:27 A.M. staff administered 5 units of PRN insulin; -On 01/10/25, at 3:55 P.M., glucometer result = 249 mg/dL and at 4:01 P.M. staff administered 5 units of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/10/25, at 6:05 A.M., glucometer result = 132 mg/dL. Staff did not document administration of PRN insulin; -On 01/11/25, at 6:30 A.M., glucometer result = 102 mg/dL. Staff did not document administration of PRN insulin; -On 01/11/25, at 11:06 A.M., glucometer result = 279 mg/dL and at 11:10 P.M. staff administered 5 units of PRN insulin; -On 01/11/25, at 3:42 P.M., glucometer result = 172 mg/dL and at 3:45 P.M. staff administered 5 units of PRN insulin; -On 01/11/25, at 5:35 P.M., glucometer result = 114 mg/dL. Staff did not document administration of PRN insulin; -On 01/12/25, at 6:38 A.M., glucometer result = 168 mg/dL. Staff did not document administration of PRN insulin; -On 01/12/25, at 11:09 A.M., glucometer result = 322 mg/dL and at 11:12. A.M. staff administered 5 units of PRN insulin; -On 01/12/25, at 3:39 P.M., glucometer result = 292 mg/dL and at 3:41. P.M. staff administered 5 units of PRN insulin; -On 01/12/25, at 6:50 P.M., glucometer result = 226 mg/dL. Staff did not document administration of PRN insulin; -On 01/13/25, at 7:23 A.M., glucometer result = 123 mg/dL and at 7:32 A.M. staff administered 4 units of PRN insulin (Staff did not have an order to administer 4 units); -On 01/13/25, at 10:57 A.M., glucometer result = 123 mg/dL. Staff did not document administration of PRN insulin; -On 01/13/25, at 3:55 P.M., glucometer result = 283 mg/dL and at 4:06 P.M. staff administered 4 units of PRN insulin (Staff did not have an order to administer 4 units); -On 01/13/25, at 7:43 P.M., glucometer result = 327 mg/dL. Staff did not document administration of PRN insulin; -On 01/14/25, at 6:34 A.M., glucometer result = 268 mg/dL and at 6:37 A.M. staff administered 4 units of PRN insulin. (Staff did not have an order to administer 4 units.); -On 01/14/25, at 10:57 A.M., glucometer result =255 mg/dL and at 11:25 A.M. staff administered 5 units of PRN insulin; -On 01/14/25, at 3:59 P.M., glucometer result = 236 mg/dL and at 4:26 P.M. staff administered 5 units of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/14/25, at 7:46 P.M., glucometer result = 196 mg/dL. Staff did not document administration of PRN insulin; -On 01/15/25, at 6:25 A.M., glucometer result = 165 mg/dL. Staff did not document administration of PRN insulin; -On 01/15/25, at 11:10 A.M., glucometer result = 338 mg/dL and at 11:11 A. M. staff administered 5 units of PRN insulin; -On 01/15/25, at 5:42 P.M., glucometer result = 241 mg/dL and at 5:43 P.M. staff administered 5 units of PRN insulin; -On 01/15/25, at 7:08 P.M., glucometer result = 299 mg/dL. Staff did not document administration of PRN insulin; -On 01/16/25, at 6:35 A.M., glucometer result = 194 mg/dL and at 6:37 A.M. staff administered 5 units of PRN insulin; -On 01/16/25, at 10:59 A.M., glucometer result = 183 mg/dL. Staff did not document administration of PRN insulin; -On 01/16/25, at 3:52 P.M., glucometer result = 364 mg/dL and at 3:56 P.M. staff administered 5 units of PRN insulin; -On 01/16/25, at 6:43 P.M., glucometer result = 418 mg/dL. Staff did not document administration of PRN insulin; -On 01/16/25, at 9:12 P.M., glucometer result = 356 mg/dL. Staff did not document administration of PRN insulin; -On 01/17/25, at 7:01 A.M., glucometer result = 179 mg/dL. Staff did not document administration of PRN insulin; -On 01/17/25, at 11:11 A.M., glucometer result = 291 mg/dL. Staff did not document administration of PRN insulin; -On 01/17/25, at 4:55 P.M., glucometer result = 211 mg/dL and at 5:10 P.M., staff administered 5 units of PRN insulin; -On 01/17/25, at 5:47 P.M., glucometer result = 190 mg/dL; -On 01/18/25, at 6:42 A.M., glucometer result = 103 mg/dL; -On 01/18/25, at 11:07 A.M., glucometer result = 270 mg/dL and at 11:27 A.M. staff administered 5 units of PRN insulin; -On 01/18/25, at 4:32 P.M., glucometer result = 364 mg/dL and at 4:54 P.M. staff administered 5 units of PRN insulin; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/18/25, at 5:42 P.M., glucometer result = 432 mg/dL. Staff did not document administration of PRN insulin; -On 01/18/25, at 5:45 P.M., glucometer result = 390 mg/dL. Staff did not document administration of PRN insulin; -On 01/19/25, at 6:57 A.M., glucometer result = 169 mg/dL and at 7:04 A.M. staff administered 5 units of PRN insulin; -On 01/19/25, at 11:04 A.M., glucometer result = 117 mg/dL. Staff did not document administration of PRN insulin; -On 01/19/25, at 3:42. P.M., glucometer result = 336 mg/dL and at 4:24 P.M. staff administered 5 units of PRN insulin; -On 01/19/25, at 6:50 P.M., glucometer result = 340 mg/dL. Staff did not document administration of PRN insulin; -On 01/20/25, at 6:52 A.M., glucometer result = 199 mg/dL and at 6:56 A.M. staff administered 5 units of PRN insulin; -On 01/20/25, at 11:02 A.M., glucometer result = 199 mg/dL and at 11:06 A.M. staff administered 5 units of PRN insulin; -On 01/20/25, at 4:02 P.M., glucometer result = 301 mg/dL and at 4:04 P.M., staff administered 5 units of PRN insulin; -On 01/20/25, at 7:05 P.M., glucometer result = 216 mg/dL. Staff did not document administration of PRN insulin; -On 01/21/25, at 6:26 A.M., glucometer result = 116 mg/dL. Staff did not document administration of PRN insulin; -On 01/21/25, at 10:55. A.M., glucometer result = 241 mg/dL. Staff did not document administration of PRN insulin; -On 01/21/25, at 4:11 P.M., glucometer result = 303 mg/dL and at 4:12 P.M. staff administered 5 units of PRN insulin; -On 01/21/25, at 7:01 P.M. glucometer result =171 mg/dL. Staff did not document administration of PRN insulin; -On 01/22/25, at 7:01 A.M., glucometer result = 146 mg/dL and at 7:06 A.M., staff administered 5 units insulin; -On 01/22/25 at 11:23 A.M. glucometer result = 275 mg/dL and at 12:06 P.M., staff administered 5 units of PRN insulin; (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/22/25, at 3:59 P.M., glucometer result = 305 mg/dL and at 3:57 P.M. staff administered 5 units of PRN insulin; -On 01/22/25, at 9:20 P.M., glucometer result = 379 mg/dL. Staff did not document administration of PRN insulin; -On 01/23/25, at 7:00 A.M., glucometer result = 178 mg/dL and at 7:04 A.M. staff administered 5 units of PRN insulin. Observation on 01/23/25, at 11:10 A.M of Licensed Practical Nurse (LPN) A showed the following: -He/she checked the resident's blood sugar as per the physician's order with a glucometer, and the glucometer showed a result of 197 mg/dL; -The nurse administered 5 units of PRN Admelog Solostar insulin via SQ injection. During an interview on 01/23/25, at 11:10 A.M., LPN A said the following: -The NP changed the resident's Admelog Solostar insulin order to as needed before meals due to the resident being a brittle diabetic (diabetes that is difficult to manage and causes extreme fluctuations in blood sugar levels); -The NP did not give parameters for administration versus holding of the resident's insulin; -The nurse said he/she questioned the NP about the lack of parameters for administration of the insulin and the NP told the nurse to decide whether to administer or not; -The nurse said he/she typically held (did not administer) the resident's Admelog Solostar insulin if his/her blood sugar result was 120 mg/dL or lower. During an interview on 01/24/25, at 9:37 A.M., Registered Nurse (RN) B said the following: -The physician or nurse practitioner gave an order for nursing to administer the resident's Admelog (lispro) insulin 3 times per day PRN; -RN B said if he/she would have obtained the physician's order, he/she would have asked the physician or NP for blood sugar parameters to know when to give the medication or he/she would have asked the physician or NP, if the order was meant to be routinely scheduled instead of PRN. During an interview on 01/24/25, at 10:20 A.M., LPN A said the following: -The physician or NP generally give orders to administer insulin on a routine basis or the orders have parameters, such us as a scale of how much insulin to give based on the blood sugar results; -He/she would prefer the physician or NP to order a resident's insulin as scheduled routinely; -He/she generally a		