STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285095	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Rehabilitation and Care Center	111 West 36th Street Scottsbluff, NE 69361

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175 NAC 12-006.05 (E) Based on interviews and record reviews, the facility failed to provide bathing preferences for 1 (Resident 27) of 1 sampled resident. The facility census was 75. Findings are: A. Record review of Resident 27's Admission Record dated 07/29/2024 revealed that Resident 27 originally admitted to the facility on [DATE]. Record review of Resident 27's Minimum Data Set (MDS -a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 05/27/2024 revealed a Brief Interview for Mental Status (BIMS-a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 15, which indicated the resident had no mental status impairment. An interview on 07/29/2024 at 11:15 AM with Resident 27 indicated the staff would not allow a bed bath as a choice. A review of Resident 27's Care Plan revealed no reference for choice about bathing preferences. An interview on 07/31/24 at 07:50 AM with Medication Aide (MA)-N revealed the schedule for all resident baths and/or showers are in a book labeled Hall Bath Book, located at the nurse's station. According to MA-N, staff are to notify the resident they have a scheduled bath for the day and ask when they would like to have a bath or a shower. When the bath is completed, charting is done in Point of Care (POC) (the recording and documenting of patient information directly at the bedside or point of care.) and in the Hall Bath Book. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of 200 Hall Bath Book revealed Resident 27 is scheduled for bathing weekly on Monday and Thursday. The Hall Bath Book revealed charting in POC must be completed when the bath or shower is complete. If the scheduled bath or shower is refused, an alternate day should be offered and documented in the electronic medical record (EMR) (digital collection of medical information about a person that is stored on a computer) on the refusal and an alternate day scheduled. A record review of Resident 27's POC revealed a 30 day look back period, document dated 07/30/2024. The record revealed: -07/01/2024-refused -07/04/2024-shower to be offered on alternate day -07/08/2024-refused -07/11/2024-refused -07/15/2024-refused -07/18/2024-refused -07/22/2024-refused -07/25/2024-refused A review of nursing Progress Notes, dated 06/30/2024 through 07/30/2024 revealed a refusal for baths, and/or showers dated: -07/29/2024 at 6:09 PM stating: resident refused shower this shift. -07/22/2024 at 5:50 PM stating: resident refused to have a skin check and shower done today. -07/15/2024 at 5:52 PM stating: resident refused (gender) shower/bath and skin check. No other dates revealed refusals, reattempts or alternates rescheduled. Interview on 07/31/2024 at 3:22 PM with MA-N revealed if a resident refuses their baths the resident would be asked again within the day. MA-N revealed if the resident had a specific bath type preference, it is honored. Interview on 07/31/2024 at 3:26 PM with Licensed Practical Nurse (LPN)-O revealed Resident 27 refuses their shower and does ask for a bed bath. LPN-O revealed Resident 27 was denied a bed bath and facility staff informed Resident 27 [gender] needed a shower. LPN-O revealed if bed baths are honored the residents would not get clean. A review of policy titled, Bathing/Shower Policy with a revision dated 11/24/2020 revealed: Reporting: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Notify the supervisor if the resident refuses the shower/tub bath. 2. Ask another staff member to attempt to bath/shower resident if the resident refuses, notify the social services as necessary. Ensure documentation is complete. 4. Report other information in accordance with facility policy and professional standards of practice. Preference: 1. Upon admission and at each care plan conference, shower preferences will be reviewed with resident and/or responsible party. Guidance: 1. If a resident refuses a bath because he or she prefers a shower or a different bathing method, such as in-bed bathing, prefers to bathe at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the resident's preferences must be accommodated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49382 Licensure Reference Number 175 NAC 12-006.09(I)(i)(1) Based on observation, record review and interview the facility failed to investigate falls for causative factors and implement interventions by causative factors to prevent falls with injury for 1 Resident, (Resident #24) of 2 sampled residents. Facility stated census of 75. Findings are: Review of a facility policy titled Falls Management dated 05/2017 revealed the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. A review of an Admission Record dated 07/30/2024 revealed the facility admitted Resident #24 on 01/12/2024 with diagnoses that included Multiple Sclerosis (a disease of the central nervous system), generalized muscle weakness, seizure disorder (when nerve cells don't signal properly causing seizures), and dementia (an impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of a facility supplied document titled with the facility name and Incidents by Incident type dated 07/29/2024 revealed Resident #24 had unwitnessed falls on 06/07/2024, 06/13/2024, 06/20/2024, 07/03/2024, 07/11/2024, and 07/21/2024. The Quarterly Minimum Data Set (MDS) (a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) dated 07/19/2024, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 4 indicating the resident was severely cognitively impaired. The resident was independent with eating, needed partial to moderate assistance with bed mobility and was dependent on staff assistance for toilet use and transfers. Resident #24 used a wheelchair for mobility propelled by staff and was frequently incontinent of bladder and continent of bowel. The resident was coded to have had two or more falls without injury in the last 90 days. Review of Resident #24's Care Plan with the following dates revealed the resident was at risk for falls with interventions listed as: -06/07/2024 A scoop mattress was placed on the resident's bed to alert the resident to the edge of their bed for safety. -07/21/2024 A fall mat is to be placed on the floor beside the resident's bed to prevent injuries when the resident places themselves on the floor during seizure and behavior activity episodes. Staff are to follow the provider recommendations and a medication review with medication changes occurred. The residents' room was moved closer to the nurse's station for closer observation. Record review of facility supplied Un-Witnessed Fall report dated revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-06/07/2024 Resident #24 was found sitting on the floor with their back against their bed. The resident confirmed that they had sled off the edge of the bed. There were no documented injuries to the resident. -07/21/2024 Resident #24 was found on the floor next to their bed. The resident received a hematoma and laceration requiring sutures in the local emergency room . In an observation on 07/29/2024 at 3:15 PM revealed Resident #24's bed had a regular flat mattress present. In an interview on 07/30/2024 at 10:15 AM with Medication Aide D (MA-D), MA-D revealed fall prevention interventions for Resident #24 was to keep the resident in close observation and redirect the resident when attempting to get out of their wheelchair. MA-D further reported Resident #24 was recently moved closer to the nurse's station for closer observation while in their room. In an observation on 07/31/2024 at 1:15 PM it was observed that Resident #24's bed was placed with the head of the bed against the wall with a fall mat placed on the floor to the left side of the bed and Resident #24 had a regular flat mattress present. In an interview on 07/31/2024 at 1:30 PM with Licensed Practical Nurse (LPN) B, LPN-B confirmed that Resident #24 mattress was a regular flat mattress. LPN-B denied knowing if the resident was to have a special or scoop mattress. In an interview on 07/31/2024 at 2:45 PM with the Assistant Director of Nursing (ADON), the ADON confirmed that the resident was to have a special scoop mattress to their bed as a fall prevention intervention.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.04(B)(ii)2 Based on observation, record review, and interview the facility failed to ensure that staff received training and assessments of competency for obtaining resident blood glucose (a measurement of the amount of blood sugar in your blood) and for use of the insulin pen (an injection device that allows you to deliver preloaded insulin-a medication used to reduce the amount of blood sugar in the blood of residents with diabetes) for 3 of 3 staff observed. This caused the residents to experience potential inaccurate blood sugar readings and incorrect insulin doses. The facility census was 75. Findings are: A. Record review of the Facility assessment dated [DATE] revealed the purpose is to determine what resources are necessary to care for residents competently. The section labeled Services and Care We Offer Based on our Resident's Needs revealed general care for medications with required specific Cares or Practices including administration of medications that residents need. The section titled Staff training/education and competencies revealed that training topics include infection control and required in-service training for nurse aides. The section revealed that the competencies to consider included medication administration-injectable, oral, subcutaneous (applied by needle under the skin), and topical. Complete competencies for measurements of staff adherence to procedures. Record review of the facility procedure titled Measuring A Blood Glucose Using A Handheld Glucometer (a medical device used to measure and display the amount of sugar in the blood for residents with diabetes) dated 7/11/24 revealed the steps included: wipe the site with an antiseptic wipe. Insert the test strip into the machine (glucometer). Perform a capillary puncture (a skin prick) using a lancet (a small sterile blade used to obtain a small amount of blood for testing). Discard lancet immediately in a sharp's container. Wipe away the first drop of blood. Touch the drop of blood (second drop of blood) to the reagent (test) strip, allowing it to be taken up by the strip. Read the digital result. Provide the patient with a cotton ball or gauze to hold pressure to stop the bleeding. Record review of the Admission Record dated 8/1/24 for Resident 47 revealed that Resident 47 admitted into the facility on [DATE]. Resident 47 had a diagnosis of Diabetes. Observation on 7/30/24 at 3:58 PM at the medication cart on the facility 200 hall revealed that Medication Aide-I (MA-I) performed hand sanitization and put on gloves. MA-I obtained the glucometer, test strip, alcohol antiseptic prep pad, and lancet and went to the room of Resident 47. MA-I wiped the fingertip of the resident's left little finger with the alcohol prep pad. MA-I pricked the finger with the lancet and squeezed the finger to force a drop of blood to appear. MA-I applied the drop to the glucometer test strip. (MA-I did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-I told the resident the blood sugar result of 130. MA-I applied a cotton ball to the fingertip. MA-I returned to the medication cart and revealed it is too early for Resident 47's insulin. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Medication Administration Record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) dated 7/31/24 for Resident 47 revealed that Resident 47 had an order for sliding scale insulin (a progressive increase in the insulin dose based on the resident's blood sugar level that is based on pre-defined blood sugar ranges as ordered by the physician). The MAR revealed that MA-I documented the blood sugar reading of 130 for the 7/30/24 blood sugar ordered for 5:30 PM. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation for obtaining blood sugar using the handheld glucometer is that staff follow the procedure. The DON confirmed that the expectation is that staff wipe away the first drop of blood and obtain a second drop of blood to be applied to the test strip. The DON confirmed that an inaccurate blood sugar reading may be obtained when the first drop of blood is tested . The DON confirmed that using the second drop of blood for testing ensures an accurate blood sugar reading. Record review of the undated facility Insulin Administration for Qualified Medication Aide (QMA) (a Medication Aide) Competency Checklist revealed that the QMA must perform the procedure with 100% accuracy for competency. The steps for preparing an insulin pen and administering insulin revealed the staff is to check the Medication Administration Record (MAR) for the insulin order. Remove the (insulin) pen cap. Wipe the pen tip with an alcohol wipe. Remove the protective seal from a new needle and screw the needle in place. Dial a dose of 2 units to prime the pen. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in and check to see that the insulin comes out of the needle (If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle.) Check the order for the correct dose. Make sure the window shows 0 and then select the dose. Select the correct dose and dial until the number shows in the window. Take the medication and supplies to the resident. Record review of the Admission Record dated 7/31/24 for Resident 40 revealed that Resident 40 admitted into the facility on [DATE]. Resident 40 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:02 PM at the medication cart on the 200 hall revealed that MA-I obtained supplies and went to the room of Resident 40. MA-I wiped the pad of the resident's left little finger with the alcohol prep pad. MA-I used the lancet to prick the finger pad. MA-I squeezed the finger and a drop of blood appeared. MA-I applied the drop of blood to the glucometer test strip. (MA-I did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-I revealed a blood sugar result of 277. MA-I returned to the medication cart. MA-I entered the blood sugar result and verified Resident 40 was to receive 6 units of Lispro insulin (a type of fast acting insulin). MA-I obtained the insulin pen and set the dial to 2 units. MA-I pushed the plunger as MA-I held the top of the pen downward and a drop of insulin appeared at the tip of the pen. (MA-I had not applied the needle and held the pen upward to prime the pen as required). MA-I applied the needle and dialed the pen to a dose of 6 units. MA-I wiped the stomach of Resident 40 with an alcohol prep pad. MA-I tried to inject the insulin into the stomach of Resident 40, but the pen/needle would not click. MA-I returned to the medication cart and removed the needle and discarded it into the sharp's container. MA-I applied a new needle. MA-I dialed the pen to 6 units and returned to the resident room. (MA-I did not prime the new needle). MA-I wiped a different area on the resident's stomach and injected the insulin and held the needle in place for 20 seconds at 4:08 PM. MA-I returned to the medication cart and documented the administration. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MAR dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for sliding scale insulin. The MAR revealed that MA-I documented the blood sugar reading of 277 for the 7/30/24 blood sugar ordered for 4:30 PM. The MAR revealed that MA-I documented that 6 units of insulin were administered to Resident 40 for the 7/30/24 4:30 PM sliding scale insulin order. Observation on 7/31/24 at 11:32 AM on the facility 200 hall revealed that Medication Aide-I (MA-I) revealed a blood sugar of 161 for Resident 16 meant that Resident 16 was to receive 2 units of insulin. MA-I removed the insulin pen from the medication cart and removed the cap from the Lispro insulin pen. MA-I applied a needle to the insulin pen. MA-I dialed the insulin pen to 2 units. MA-I held the tip of the insulin pen downward and pushed the plunger to prime the pen. (MA-I did not hold the tip of the pen/needle upward to prime the pen/needle as required). MA-I dialed the pen to the dose of 2 units and went to the room of Resident 16. MA-I wiped an area on the resident's stomach with an alcohol prep pad. MA-I placed the needle against the resident's stomach and injected the insulin and held the needle in place for 20 seconds. Record review of the MAR dated 8/1/24 for Resident 16 revealed that Resident had an order for sliding scale insulin. The MAR revealed that MA-I documented that 2 units of insulin were administered to Resident 16 for the 7/31/24 11:30 AM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered. This surveyor requested copies of all training and competency assessments for MA-I that the facility completed in the last year from the DON. The DON provided a Clinical Skills Observation for Licensed Nurse/Medication Aide for MA-I and a Medication Pass Evaluation for MA-I. Record review of the Clinical Skills Observation for Licensed Nurse/Medication Aide for MA-I dated 7/29/24 revealed that the skills checklist outlines the steps expected of you in order to properly administer tablets, pills, and capsules. The checklist did not contain required steps for performing blood glucose checks with the handheld glucometer. The checklist did not contain the required steps for administering insulin using an insulin pen. Neither of the check boxes were checked to identify that MA-I either met the requirements Medication Administration-Tablets, Pills, and Capsules Requirements Met or did not meet the requirements Medication Administration-Tablets, Pills, and Capsules Requirements NOT Met. The checklist was signed by MA-I and Unit Manager-M (UM-M). The checklist documented an observation date of 7/29/24. Record review of the Medication Pass Evaluation for MA-I dated 7/29/24 revealed that it contained no evaluation of performing blood glucose checks with the handheld glucometer. The evaluation contained no evaluation of using an insulin pen. The evaluation was signed by UM-M. The form had a completed date of 7/29/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/1/24 at 2:18 PM with the DON confirmed that staff to are to receive training on use of the handheld glucometer and the insulin pen. The DON confirmed that staff competency should be assessed periodically on use of the handheld glucometer and the insulin pen to ensure staff are following procedure. The DON confirmed that the facility was unable to locate any additional training or competency documents for MA-I. The DON was unsure of a timeframe for how often competency assessments should be completed. B. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:12 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) put on gloves and prepared supplies to check the blood sugar for Resident 48. MA-J went to the room of Resident 48 and wiped the pad of the resident's left little finger with the alcohol prep pad. MA-J pricked the finger with the lancet and squeezed until a drop of blood appeared. MA applied the drop to the glucometer test strip. (MA-J did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-J revealed a blood sugar result of 153. MA-J returned to the medication cart and documented the blood sugar of 153. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented the blood sugar reading of 153 for the 7/30/24 blood sugar ordered for 5:30 PM. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was provided training on using the handheld glucometer last winter. MA-J revealed that the steps MA-J uses for obtaining a blood sugar are to identify which finger will be used and to wipe the finger with an alcohol wipe. MA-J revealed that they then poke the finger and apply the drop of blood to the test strip. MA-J revealed it is okay to use the first drop of blood. Record review of the Admission Record dated 8/1/24 for Resident 21 revealed that Resident 21 admitted into the facility on [DATE]. Resident 21 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:15 PM at a medication cart on the 200 hall revealed that MA-J gathered supplies to check the blood sugar for Resident 21. MA-J put on gloves and wiped the resident's right ring finger. MA-J wiped the pad of the resident's finger with an alcohol prep pad. MA-J pricked the pad of the finger with the lancet and squeezed the finger to produce a drop of blood. MA-J applied the drop of blood to the glucometer test strip. (MA-J did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-J placed a cotton ball on the resident's finger. MA-J revealed a blood sugar result of 141. Record review of the MAR dated 7/31/24 for Resident 21 revealed that Resident 21 had an order for blood glucose check before meals. The MAR revealed that MA-J documented the blood sugar reading of 141 for the 7/30/24 blood sugar check ordered for 5:30 PM. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/30/24 at 4:35 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) reviewed the insulin order for Resident 48. MA-J revealed the order for Resident 48 to receive 2 units of Lispro insulin. MA-J removed the cap from the insulin pen. MA-J applied a needle to the insulin pen and dialed the pen to 2 units. MA-J held the tip of the pen slightly downward and pushed the plunger to prime the needle. (MA-J did not hold the tip of the pen/needle upward to prime the pen/needle as required). MA-J dialed the insulin pen to the ordered dose of 2 units and went to the resident's room. MA-J wiped an area on the resident's upper right arm with an alcohol prep pad. MA-J and injected the insulin. MA-J held the needle in place for several seconds. MA-J returned to the medication cart and documented the administration. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented the blood sugar reading of 153 for the 7/30/24 blood sugar ordered for 5:30 PM. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was trained on use of insulin pens in December or January of last year (2023). MA-J revealed the steps for administering insulin with the insulin pen begin with removing the cap from the insulin pen. MA-J then places a needle on the pen and dials the pen to 2 units to prime. MA-J revealed that the insulin pen is held with the tip of the needle held down towards the trash can and the plunger is pushed so you can see insulin drip. MA-J revealed that MA-J then dials the ordered dose of insulin to administer to the resident. This surveyor requested copies of all training and competency assessments for MA-J that the facility completed in the last year from the DON. The DON provided an Insulin Administration Competency for MA-J dated 3/15/24. Record review of the Insulin Administration Competency for MA-J dated 3/15/24 revealed that it did not include assessment of steps to use an insulin pen. The first step of the competency was to confirm the physician's order and draw accurate insulin amount and type. The staff then perform hand sanitization and put on gloves. Select an appropriate injection site. Clean the site with an alcohol swab. Remove the needle cap. Hold syringe between thumb and forefinger as if grasping a dart. Inject needle quickly and firmly at a 45 degree to 90 degree angle. This was the only training/competency documentation for MA-J that was provided. Interview on 8/1/24 at 2:18 PM with the DON confirmed that staff to are to receive training on use of the handheld glucometer and the insulin pen. The DON confirmed that staff competency should be assessed periodically on use of the handheld glucometer and the insulin pen to ensure staff are following procedure. The DON confirmed that the facility was unable to locate any additional training or competency documents for MA-J. C. Record review of the Admission Record dated 8/1/24 for Resident 1 revealed that Resident 1 admitted into the facility on [DATE]. Resident 1 had a diagnosis of Diabetes. (continued on next page)

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Monument Rehabilitation and Care Center	111 West 36th Street Scottsbluff, NE 69361

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/31/24 at 4:21 PM in the room of Resident 1 revealed that Medication Aide-K (MA-K) put on gloves and placed a glucometer test strip in the glucometer. MA-K wiped the pad of the resident's right middle finger with an alcohol prep pad. MA-K pricked the finger with a lancet. A drop of blood appeared. MA-K applied the drop of blood to the test strip. (MA-K did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-K revealed a blood sugar result of 163. Record review of the MAR dated 8/1/24 for Resident 1 revealed that Resident 1 had an order for sliding scale insulin. The MAR revealed that MA-K documented the blood sugar reading of 163 for the 7/31/24 blood sugar check ordered for 4:30 PM. Interview on 8/1/24 at 1:32 PM with MA-K revealed that the facility provided training on use of the handheld glucometer and thinks it was last fall. MA-K revealed that the process for obtaining a blood sugar using the glucometer included wiping the finger with the alcohol prep pad and poking the finger. MA-K revealed they apply the drop of blood to the glucometer test strip. MA-K confirmed that MA-K was not aware that the first drop of blood was to be wiped away and the second drop of blood was to be applied to the test strip. This surveyor requested copies of all training and competency assessments for MA-K that the facility completed in the last year from the DON. The DON provided two Clinical Skills Observations for Licensed Nurse/Medication Aide for MA-K and two Medication Pass Evaluations for MA-K. Record review of the Clinical Skills Observation for Licensed Nurse/Medication Aide for MA-K revealed that it was undated and to see attached. A Medication Pass Evaluation for MA-K was attached with a date of 4/13/23. The Clinical Skills Observation for Licensed Nurse/Medication Aide for MA-K revealed that the skills checklist outlines the steps expected of you in order to properly administer tablets, pills, and capsules. The checklist did not contain required steps for performing blood glucose checks with the handheld glucometer. The checklist did not contain the required steps for administering insulin using an insulin pen. The check box Medication Administration-Tablets, Pills, and Capsules Requirements Met was checked. The form did not contain the learner's signature. The form did not contain the Observer's signature. Record review of the attached Medication Pass Evaluation for MA-K dated 4/13/23 revealed that it contained no evaluation of performing blood glucose checks with the handheld glucometer. The evaluation contained no evaluation of using an insulin pen. The signature for Review Completed By on the evaluation was illegible. Record review of the undated Clinical Skills Observation for Licensed Nurse/Medication Aide for MA-K revealed that the skills checklist outlines the steps expected of you in order to properly administer tablets, pills, and capsules. The checklist did not contain required steps for performing blood glucose checks with the handheld glucometer. The checklist did not contain the required steps for administering insulin using an insulin pen. Neither of the check boxes were checked to identify that MA-K either met the requirements Medication Administration-Tablets, Pills, and Capsules Requirements Met or did not meet the requirements Medication Administration-Tablets, Pills, and Capsules Requirements NOT Met. The checklist was signed by MA-K. The line for the Observer's name and Observer's signature were blank. The line for Observation Date was blank. The form was stapled to a Medication Pass Evaluation for MA-K that was dated 7/29/24. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Medication Pass Evaluation for MA-K dated 7/29/24 revealed that it contained no evaluation of performing blood glucose checks with the handheld glucometer. The evaluation contained no evaluation of using an insulin pen. The evaluation was signed by UM-M. The documented completed date was 7/29/24.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, record review, and interview the facility failed to maintain a medication error rate of less than 5% with an observed medication error rate of 16% (25 medications administered with 4 errors). The facility census was 75. Findings are: A. Record review of the undated facility Insulin Administration for Qualified Medication Aide (QMA) (a Medication Aide) Competency Checklist revealed that the QMA must perform the procedure with 100% accuracy for competency. The steps for preparing an insulin pen and administering insulin revealed the staff is to check the Medication Administration Record (MAR) for the insulin order. Remove the (insulin) pen cap. Wipe the pen tip with an alcohol wipe. Remove the protective seal from a new needle and screw the needle in place. Dial a dose of 2 units to prime the pen. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in and check to see that the insulin comes out of the needle (If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle.) Check the order for the correct dose. Make sure the window shows 0 and then select the dose. Select the correct dose and dial until the number shows in the window. Take the medication and supplies to the resident. Record review of the Admission Record dated 7/31/24 for Resident 40 revealed that Resident 40 admitted into the facility on [DATE]. Resident 40 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:02 PM at the medication cart on the 200 hall revealed that MA-I obtained supplies and went to the room of Resident 40. MA-I wiped the pad of the resident's left little finger with the alcohol prep pad. MA-I used the lancet to prick the finger pad. MA-I squeezed the finger and a drop of blood appeared. MA-I applied the drop of blood to the glucometer test strip. (MA-I did not wipe away the first drop of blood and obtain a second drop of blood to test as required). MA-I revealed a blood sugar result of 277. MA-I returned to the medication cart. MA-I entered the blood sugar result and verified Resident 40 was to receive 6 units of Lispro insulin (a type of fast acting insulin). MA-I obtained the insulin pen and set the dial to 2 units. MA-I pushed the plunger as MA-I held the tip of the pen downward and a drop of insulin appeared at the tip of the pen. (MA-I had not applied the needle and had not held the pen tip upward to prime the pen as required- a medication error). MA-I applied the needle and dialed the pen to a dose of 6 units. MA-I wiped the stomach of Resident 40 with an alcohol prep pad. MA-I tried to inject the insulin into the stomach of Resident 40, but the pen/needle would not click. MA-I returned to the medication cart and removed the needle and discarded it into the sharps container. MA-I applied a new needle. MA-I dialed the pen to 6 units and returned to the resident room. (MA-I did not prime the new needle). MA-I wiped a different area on the resident's stomach and injected the insulin and held the needle in place for 20 seconds at 4:08 PM. MA-I returned to the medication cart and documented the administration. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MAR (a legal record of the medications administered to a patient at a facility by a health care professional) dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for sliding scale insulin. The MAR revealed that MA-I documented that 6 units of insulin were administered to Resident 40 for the 7/30/24 4:30 PM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered. B. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:35 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) reviewed the insulin order for Resident 48. MA-J revealed the order for Resident 48 to receive 2 units of Lispro insulin. MA-J removed the cap from the insulin pen. MA-J applied a needle to the insulin pen and dialed the pen to 2 units. MA-J held the tip of the pen downward and pushed the plunger to prime the needle. (MA-J did not hold the tip of the pen/needle upward to prime the pen/needle as required-a medication error). MA-J dialed the insulin pen to the ordered dose of 2 units and went to the resident's room. MA-J wiped an area on the resident's upper right arm with an alcohol prep pad. MA-J and injected the insulin. MA-J held the needle in place for several seconds. MA-J returned to the medication cart and documented the administration. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented the blood sugar reading of 153 for the 7/30/24 blood sugar ordered for 5:30 PM. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was trained on use of insulin pens in December or January of last year (2023). MA-J revealed the steps for administering insulin with the insulin pen begin with removing the cap from the insulin pen. MA-J then places a needle on the pen and dials the pen to 2 units to prime. MA-J revealed that the insulin pen is held with the tip of the needle held down towards the trash can and the plunger is pushed so you can see insulin drip. MA-J revealed that MA-J then dials the ordered dose of insulin to administer to the resident. C. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/31/24 at 11:32 AM on the facility 200 hall revealed that Medication Aide-I (MA-I) revealed a blood sugar of 161 for Resident 16 meant Resident 16 was to receive 2 units of insulin. MA-I removed the insulin pen from the medication cart and removed the cap from the Lispro insulin pen. MA-I applied a needle to the insulin pen. MA-I dialed the insulin pen to 2 units. MA-I held the tip of the insulin pen downward and pushed the plunger to prime the pen. (MA-I did not hold the tip of the pen/needle upward to prime the pen/needle as required-a medication error). MA-I dialed the pen to the dose of 2 units and went to the room of Resident 16. MA-I wiped an area on the resident's stomach with an alcohol prep pad. MA-I placed the needle against the resident's stomach and injected the insulin and held the needle in place for 20 seconds. Record review of the MAR dated 8/1/24 for Resident 16 revealed that Resident 16 had an order for sliding scale insulin. The MAR revealed that MA-I documented that 2 units of insulin were administered to Resident 16 for the 7/31/24 11:30 AM sliding scale insulin order. D. Record review of the facility policy titled Installation of Eye Drops dated January 2014 revealed that the steps for the procedure included: Gently pull the lower eyelid down. Instruct the resident to look up. Drop the medication into the mid lower eyelid. Observation on 7/31/24 at 11:41 AM at the medication cart on the 200 hall revealed that Medication Aide-I (MA-I) performed med set up for Resident 40. MA-I reviewed the order for Resident 40 to receive Systane eye drop (a liquid medication used to treat dry eyes) one drop in each eye. MA-I entered the room of Resident 40. MA-I washed the hands and then applied gloves. Resident 40 sat in a wheelchair in the room. MA-I opened the bottle of Systane eye drops. MA-I squeezed the eye drop bottle and dropped 1 drop on the top of the right eyelid. (MA-I did not pull down on the lower eyelid to apply the drop into the lower eyelid as required) MA-I then pulled up on the top eyelid of the right eye and squeezed the eye drop bottle. A drop fell from the bottle onto the top of the closed bottom eyelid. The eye drop did not go into the eye (a medication error as the eye drop was not received in the eye). MA-I then moved their hands to the left eye of Resident 40. MA-I pulled up the top eyelid of the resident's left eye and applied a drop to the left eye. The drop landed on the eyeball. Record review of the MAR dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for Systane eye drops to give 1 drop in each eye four times a day. The MAR revealed that MA-I documented that 1 drop was administered to each eye of Resident 40 for the 7/31/24 12:00 PM order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation for administering eye drops is that staff pull down on the lower eyelid and place the eye drop in the lower eyelid pocket for proper administration. The DON confirmed that staff should not pull up on the upper eyelid. The DON confirmed that the eye drop was not administered if it did not go into the eye.

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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 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** 41938 Licensure Reference Number 175 NAC 12-006.10D Based on observation, record review, and interview the facility failed to ensure that staff provided the ordered dose of insulin (a medication used to reduce the amount of blood sugar in the blood of residents with diabetes) to residents to prevent significant medication errors for 3 of 4 residents observed (Residents 40, 48, and 16). The facility census was 75. Findings are: A. Record review of the undated facility Insulin Administration for Qualified Medication Aide (QMA) (a Medication Aide) Competency Checklist revealed that the QMA must perform the procedure with 100% accuracy for competency. The steps for preparing an insulin pen and administering insulin revealed the staff is to check the Medication Administration Record (MAR) for the insulin order. Remove the (insulin) pen cap. Wipe the pen tip with an alcohol wipe. Remove the protective seal from a new needle and screw the needle in place. Dial a dose of 2 units to prime the pen. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. Press the injection button all the way in and check to see that the insulin comes out of the needle (If no insulin comes out, repeat the test. If insulin still does not come out, get a new needle.) Check the order for the correct dose. Make sure the window shows 0 and then select the dose. Select the correct dose and dial until the number shows in the window. Take the medication and supplies to the resident. Record review of the Admission Record dated 7/31/24 for Resident 40 revealed that Resident 40 admitted into the facility on [DATE] and had a diagnosis of Diabetes. Observation on 7/30/24 at 4:02 PM at the medication cart on the 200 hall revealed that MA-I obtained supplies and went to the room of Resident 40. MA-I wiped the pad of the resident's left little finger with the alcohol prep pad. MA-I used the lancet to prick the finger pad. MA-I squeezed the finger and a drop of blood appeared. MA-I applied the drop of blood to the glucometer test strip. MA-I revealed a blood sugar result of 277. MA-I returned to the medication cart. MA-I entered the blood sugar result and verified Resident 40 was to receive 6 units of Lispro insulin (a type of fast acting insulin). MA-I obtained the insulin pen and set the dial to 2 units. MA-I pushed the plunger as MA-I held the top of the pen downward and a drop of insulin appeared at the top of the pen. (MA-I had not applied the needle and held the pen upward to prime the pen as required). MA-I applied the needle and dialed the pen to a dose of 6 units. MA-I wiped the stomach of Resident 40 with an alcohol prep pad. MA-I tried to inject the insulin into the stomach of Resident 40, but the pen/needle would not click. MA-I returned to the medication cart and removed the needle and discarded it into the sharps container. MA-I applied a new needle. MA-I dialed the pen to 6 units and returned to the resident room. (MA-I did not prime the new needle). MA-I wiped a different area on the resident's stomach and injected the insulin and held the needle in place for 20 seconds at 4:08 PM. MA-I returned to the medication cart and documented the administration. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR (a legal record of the medications administered to a patient at a facility by a health care professional) dated 7/31/24 for Resident 40 revealed that Resident 40 had an order for sliding scale insulin. The MAR revealed that MA-I documented that 6 units of insulin were administered to Resident 40 for the 7/30/24 4:30 PM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered. B. Record review of the Admission Record dated 8/1/24 for Resident 48 revealed that Resident 48 admitted into the facility on [DATE]. Resident 48 had a diagnosis of Diabetes. Observation on 7/30/24 at 4:35 PM at a medication cart on the 200 hall revealed that Medication Aide-J (MA-J) reviewed the insulin order for Resident 48. MA-J revealed the order for Resident 48 to receive 2 units of Lispro insulin. MA-J removed the cap from the insulin pen. MA-J applied a needle to the insulin pen and dialed the pen to 2 units. MA-J held the tip of the pen downward and pushed the plunger to prime the needle. (MA-J did not hold the tip of the pen/needle upward to prime the pen/needle as required). MA-J dialed the insulin pen to the ordered dose of 2 units and went to the resident's room. MA-J wiped an area on the resident's upper right arm with an alcohol prep pad. MA-J injected the insulin. MA-J held the needle in place for several seconds. MA-J returned to the medication cart and documented the administration. Record review of the MAR dated 7/31/24 for Resident 48 revealed that Resident 48 had an order for sliding scale insulin. The MAR revealed that MA-J documented that 2 units of insulin were administered to Resident 48 for the 7/30/24 5:30 PM sliding scale insulin order. Interview on 8/1/24 at 2:12 PM with MA-J revealed that MA-J was trained on use of insulin pens in December or January of last year (2023). MA-J revealed the steps for administering insulin with the insulin pen begin with removing the cap from the insulin pen. MA-J then places a needle on the pen and dials the pen to 2 units to prime. MA-J revealed that the insulin pen is held with the tip of the needle held down towards the trash can and the plunger is pushed so you can see insulin drip. MA-J revealed that MA-J then dials the ordered dose of insulin to administer to the resident. C. Record review of the Admission Record dated 7/29/24 for Resident 16 revealed that Resident 16 admitted into the facility on [DATE]. Resident 16 had a diagnosis of Diabetes. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/31/24 at 11:32 AM on the facility 200 hall revealed that Medication Aide-I (MA-I) revealed a blood sugar of 161 for Resident 16 meant Resident 16 was to receive 2 units of insulin. MA-I removed the insulin pen from the medication cart and removed the cap from the Lispro insulin pen. MA-I applied a needle to the insulin pen. MA-I dialed the insulin pen to 2 units. MA-I held the tip of the insulin pen downward and pushed the plunger to prime the pen. (MA-I did not hold the tip of the pen/needle upward to prime the pen/needle as required). MA-I dialed the pen to the dose of 2 units and went to the room of Resident 16. MA-I wiped an area on the resident's stomach with an alcohol prep pad. MA-I placed the needle against the resident's stomach and injected the insulin and held the needle in place for 20 seconds. Record review of the MAR dated 8/1/24 for Resident 16 revealed that Resident had an order for sliding scale insulin. The MAR revealed that MA-I documented that 2 units of insulin were administered to Resident 16 for the 7/31/24 11:30 AM sliding scale insulin order. Interview on 8/1/24 at 9:14 AM with the facility Director of Nursing (DON) confirmed that the expectation is that staff follow the facility procedure for insulin administration. The DON confirmed that the needle is to be applied to the insulin pen prior to priming the pen. The DON confirmed that once the needle is applied to the insulin pen the insulin pen is dialed to 2 units. The DON confirmed the insulin pen is then held with the tip of the needle up when priming the pen to remove any air and ensure the correct insulin dose will be administered.