| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345491 | A. Building<br>B. Wing | 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Croatan Ridge Nursing and Rehabilitation Center | 210 Foxhall Road<br>Newport, NC 28570 |

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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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789<br><br>Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to notify the physician when a resident missed a dose of insulin due to the medication being unavailable for administration. This resulted in the nurse not obtaining authorization to administer insulin from the backup supply. This deficient practice affected 1 of 5 residents sampled for Pharmaceutical Services (Resident #28).<br><br>The findings included:<br><br>Resident #28 was admitted to the facility on [DATE] with diagnoses that included diabetes.<br><br>A review of the physician's orders dated 5/23/24 revealed Resident #28 was prescribed Toujeo Solostar Subcutaneous Solution Pen-injector 300 units/milliliter (ml) (insulin glargine)-inject 25 units subcutaneously (under the skin) at bedtime for diabetes.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact and was coded for receiving insulin.<br><br>Resident #28's Medication Administration Record (MAR) dated 2/4/25 signed off by Nurse #3, revealed Resident #28 did not receive the scheduled dose of insulin at 8:00 p.m. because the medication was not available.<br><br>During a telephone interview with Nurse #3 on 2/5/25 at 2:06 p.m. she revealed that Resident #28 did not receive his insulin on 2/4/25 because it was not available. She revealed she should have called the NP, left her a voice message, and sent her a text message for authorization to administer insulin from the backup kit. She further stated she called the NP by phone once on 2/4/25 at 7:41 p.m., but did not receive a response, and did not try to call again, leave a voice message or text the NP. She indicated she should have left a message or texted the NP.<br><br>In an interview with the NP on 2/5/25 at 1:56 p.m. she revealed she was not contacted on 2/4/25 about Resident #28 missing his insulin on 2/4/25. She revealed she was available by phone and via text message during the day and night. She stated she had just been informed about the missed medication today (2/5/25) by Nurse #2. She stated the facility would need authorization from her or the physician to administer any other insulin that was in the backup kit at the facility.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Director of Nursing (DON) on 2/5/25 at 1:46 p.m. she stated Nurse #3 was supposed to have contacted the NP by phone call and a text message to receive authorization to administer insulin in the backup kit. She further stated that all nurses will be retrained on notifying the NP to avoid any lapses in administration of medications.<br><br>In an interview with the Administrator on 2/7/25 at 2:16 p.m. she stated she was unaware that Nurse #3 did not inform the NP of Resident #28 missing a dose of insulin as a result of the medication being unavailable for administration. She further stated that it was the responsibility of nurses to contact the NP via text or phone call to receive authorization to administer medications in the facility's backup kit. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789<br><br>Based on record review, resident interview, and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of property when a staff member (Nurse Aide #1) took a cell phone from the Resident. The deficient practice was reviewed for 1 of 3 residents for misappropriation of residents' property (Resident #12).<br><br>The finding included:<br><br>Resident #12 was admitted to the facility on [DATE].<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] had Resident #12 coded as moderate cognitively impaired.<br><br>During an interview with Resident #12 on 2/4/25 at 2:11 p.m. he stated his phone went missing last year but was later found. Resident #12 further described the perpetrator as Nurse Aide #1 who had taken his cell phone, and he could not remember if he gave it to her or she took it without his permission.<br><br>Attempts made to contact Nurse Aide #1 by phone on 2/6/25 and 2/7/25 were unsuccessful.<br><br>Nurse #4 was not available for the interview.<br><br>During a telephone interview with Nurse #3 on 2/6/25 at 2:16 p.m. she revealed the Resident #12 had complained his phone was missing. She stated she asked Nurse Aide #1 who denied taking the phone. She revealed Nurse Aide #1 helped in looking for the missing phone in and outside the facility. She revealed the family members of Resident #12 were contacted and they determined through a tracker on the phone that the missing phone was in the parking lot on the left side of the building. She further revealed they had searched for the phone for 4 hours and contacted the police at 9:15 p.m. She revealed that the police arrived as they searched for the phone. She revealed Nurse Aide # 1, went to her car, retrieved the missing phone, and handed it to her after insisting that Nurse Aide #1 knew where the phone was because the phone location tracker was leading to her car. She further revealed the phone was returned to Resident #12 and Nurse Aide #1 was sent away after the police stated that she will not be charged because Resident #12 did not want to press charges. Nurse #3 revealed that Resident #12's cell phone was unlocked, and Nurse Aide #1 had made several calls from the phone.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Director of Nursing (DON) on 2/5/25 at 12:28 p.m. she stated that on the evening of 6/19/24, a Nurse #3 called her on phone saying Resident #12's was missing his cell phone. She stated that Nurse #3 had told her that Resident #12 had stated that Nurse Aide #1 had asked to use his cell phone. She revealed she directed the nurse and all staff to do a search in the building and no trash should be thrown out until the phone was located. She stated she proceeded to the building at about 9:50 p.m. after the police and Resident #12's granddaughter and son had arrived at the facility. She further revealed that Resident #12's granddaughter was able to locate the phone in the parking lot of the facility using a tracker she had on her phone. She revealed that Nurse Aide #1 went to her car, retrieved her pocketbook bag, and took the phone out and gave it to Nurse #3. She revealed Resident #12 was alert and oriented and declined to press charges. The DON stated it was against company policy to use residents' property. The DON stated that she asked Nurse Aide #1 to leave and not come back to the facility and she was terminated. The DON revealed that Inservice training on misappropriation of property was done for all staff and an audit completed for all alert and oriented residents for any missing property.<br><br>In an interview with the Administrator on 2/5/25 at 12:43 p.m. she revealed that Resident #12's phone went missing on 6/19/24 at about 7:15 p.m., and Nurse Aide #1 had it in her car. She stated that the family of Resident #12 were able to track the location of the phone to Nurse Aide #1's car. She revealed that Nurse Aide #1 told her that Resident #12 allowed her to use the phone but Resident #12 had denied giving her the phone. The Administrator stated Nurse Aide #1 was terminated immediately after establishing she borrowed and took Resident #12 phone and used it. She stated it was a violation of the company policy. She revealed that all staff received Inservice training on misappropriation of property.<br><br>The facility provided the following corrective action plan with a completion date of 6/23/24.<br><br>Address what measures were put in place to ensure the deficient practice will not recur:<br><br>-The police department was contacted by Nurse #3 on 6/19/24 at 9:15 p.m.<br><br>-Incident reported to Adult Protective Services by the Administrator on 6/20/24.<br><br>-The Administrator filed a report with NCDHHS on 6/20/24<br><br>-NC Healthcare Registry was made aware of the incident on 6/20/24 by the Administrator.<br><br>-The DON terminated Nurse Aide #1 on 6/19/24.<br><br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>include:<br><br>-Employee suspended/terminated<br><br>-100% of interviews by the DON of alert and oriented residents regarding any missing items.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -100% in-service of all employees in all departments regarding misappropriation pf resident property completed by the DON.<br><br>-Time stamps per resident's cell phone documented the Nurse Aides use of the resident's phone during company time which is a violation of company policy regarding unauthorized borrowing of resident's property.<br><br>-Audits of private property for non-alert and oriented residents<br><br>Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained.<br><br>Include:<br><br>-From 6/20/24 through 9/20/24, the DON/Designee to monitor 5 residents with questionnaire every week x 4 weeks then every month x1 then review at Quality Assurance Performance Improvement (QAPI).<br><br>-An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the interdisciplinary on 6/20/24, concerning employee borrowing residents cell phone and this plan of correction that was developed and implemented.<br><br>-The facility's QAPI committee will review this POC for the next 3 months.<br><br>-The Administrator stated she was responsible for this POC.<br><br>Corrective action completion date: 6/23/24.<br><br>Validation:<br><br>Onsite validation of the corrective action plan was completed on 2/7/25. Interviews with staff in all departments in the facility confirmed they received in-service training on Misappropriation of resident property and exploitation policy. A review of the audit tool was conducted including a review of the resident questionnaires for all alert and oriented residents completed on 8/19/24.<br><br>The compliance date of 6/23/24 for the corrective action plan was validated. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38702<br><br>Based on record review and Pharmacy Consultant and staff interviews, the Pharmacy Consultant failed to report a irregularity related to a physicians order for an as needed (PRN) psychotropic medication, Ativan, (a medication used to treat anxiety) to ensure it included a rationale for extended use and was time limited in duration for 2 of 5 residents reviewed for unnecessary medications<br><br>(Resident #22 and Resident #47).<br><br>The findings included:<br><br>1. Resident #22 was admitted to the facility on [DATE] with diagnoses including dementia with anxiety.<br><br>A review of the physician's order revealed Ativan 0.5 milligrams (mg) every 6 hours as needed for anxiety dated 08/09/2024 to 08/23/2024 and a dated 08/23/2024 to 09/22/2024 for Ativan 0.5 mg every 6 hours as needed for anxiety for 30 days. The medical record did not contain a documented rationale for the extended use of the medication.<br><br>A review of the summary of Medication Regimen Review by the Pharmacy Consultant dated 09/06/2024 revealed medication regimen review completed. No recommendations.<br><br>The admission Minimum Data Set (MDS) dated [DATE] coded as severely cognitively impaired and on an antianxiety medication seven out of seven days of the look back period.<br><br>An interview was conducted with the Pharmacy Consultant on 02/06/2025 at 09:48 AM. The Consultant stated she performed monthly medication reviews on Resident #22 and was aware of the Ativan 0.5 mg PRN order for increased anxiety. She also stated she did not send a recommendation questioning the rationale of the PRN Ativan medications extension because she was not aware a physician needed to assess the Resident for the rationale prior to the extended order.<br><br>An interview was conducted with the Director of Nursing (DON) on 02/06/2025 at 12:47 PM. The DON stated the Pharmacy Consultant was supposed to report any irregularities from the monthly medication reviews. She did not receive a report from her concerning the PRN medication Ativan for Resident #22. The DON also stated she expected her to accurately report all irregularities from her monthly during her reviews.<br><br>An interview with the Administrator was conducted on 02/06/2025 at 12:53 PM. The Administrator stated she expected the Pharmacy Consultant to accurately report irregularities from the monthly medication reviews.<br><br>2. Resident #47 was admitted to the facility on [DATE] with diagnoses including dementia with mood disturbances.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The admission Minimum Data Set (MDS) dated [DATE] had Resident #47 coded as severely cognitively impaired.<br><br>A review of the hospice physicians order (PO) dated 12/27/2024 revealed Ativan 1 milligrams (mg) as needed every 4 hours for anxiety/agitation for 90 days end of life care. The medical record did not contain a 14-day stop date for the medication.<br><br>A review of the summary of Medication Regimen Review by the Pharmacy Consultant dated 01/02/2025 lacked a recommendation for the Ativan.<br><br>An interview was conducted with the Pharmacy Consultant on 02/06/2025 at 09:48 AM. She stated she performed monthly medication reviews on Resident #47 but did not send a recommendation for the Ativan PRN medication because it was for a hospice resident and did not know they could not have an extended order.<br><br>An interview was conducted with the Director of Nursing (DON) on 02/06/2025 at 12:47 PM. The DON stated the Pharmacy Consultant was supposed to report any irregularities from the monthly medication reviews. She did not receive a report from the Consultant concerning the PRN medication Ativan for Resident #47. The DON also stated she expected the Pharmacy Consultant to accurately report all irregularities from her monthly during her reviews.<br><br>An interview with the Administrator was conducted on 02/06/2025 at 12:53 PM. The Administrator stated she expected the Pharmacy Consultant to accurately report irregularities from the monthly medication reviews. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38702<br><br>Based on record review, and staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to ensure the physicians order for an as needed (PRN) psychotropic medication, Ativan, (a medication used to treat anxiety) included a rationale for extended use and was time limited in duration for 2 of 5 residents reviewed for unnecessary medications (Resident #22 and Resident #47).<br><br>The findings included:<br><br>1. Resident #22 was admitted to the facility on [DATE] with diagnoses including dementia with anxiety.<br><br>The admission Minimum Data Set (MDS) dated [DATE] coded as severely cognitively impaired and on an antianxiety medication seven out of seven days of the look back period.<br><br>A review of the physician's order revealed Ativan 0.5 milligrams (mg) every 6 hours as needed for anxiety dated 08/09/2024 to 08/23/2024 and a physician's order dated 08/23/2024 to 09/22/2024 for Ativan 0.5 milligrams (mg) every 6 hours as needed for anxiety for 30 days. The medical record did not contain a documented rationale for the extended use of the medication.<br><br>The August 2024 Medication Administration Record (MAR) review revealed an order for Ativan 0.5 mg every 6 hours as needed for anxiety for 30 days 08/23/2024 and discontinue 09/22/2024. The medication was administered on 08/25/2024, 08/26/2024, 08/28/2024, 08/29/2024 and 08/30/2024.<br><br>The September 2024 MAR review revealed an order for Ativan 0.5 mg every 6 hours as needed for anxiety for 30 days. 08/23/2024 and discontinue 09/22/2024. The medication was administered on 09/01/2024, 09/02/2024, 09/03/2024, 09/10/2024, 09/14/2024, 09/16/2024 and 09/19/2024.<br><br>The care plan dated 01/27/2025 included interventions to evaluate and effectiveness of psychotropics.<br><br>An interview was conducted with the Director of Nursing (DON) on 02/06/2025 at 10:49 AM. The DON stated there was no rationale for the new order of Ativan 0.5 mg PRN on 08/23/2024 and thought it could be extended automatically after the initial 14-day order.<br><br>A telephone interview with Nurse Practitioner (NP) was conducted on 02/07/2025 at 11:42 AM. The NP stated she did write the PRN Ativan order for the extension of 30 days and was not aware that there needed to be a rationale after the initial 14-day order and in the future, it will include the rationale prior to an extended order.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Administrator was conducted on 02/06/2025 at 12:53 PM. The Administrator stated she was made aware that Resident #22 had a PRN medication without a rationale for use after the initial 14-day order and wanted her staff to follow the regulations and make sure the PRN medication had a rationale prior to extension of the medication.<br><br>2. Resident #47 was admitted to the facility on [DATE] with diagnoses including dementia with mood disturbances.<br><br>The admission Minimum Data Set (MDS) dated [DATE] had Resident #47 coded as severely cognitively impaired<br><br>The care plan 12/31/2024 had focus of use of psychotropic drugs with the potential for side effects.<br><br>A review of the hospice physicians order dated 12/27/2024 revealed Ativan 1 milligrams (mg) as needed for anxiety/agitation for 90 days end of life care. The medical record did not contain a 14-day stop date for the medication.<br><br>The December 2024 Medication Administration Record (MAR) review revealed an order for Ativan 1 mg as needed. Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 90 days end of life care. The medication was administered on 12/28/2024, 12/29/2024 and 12/31/2024.<br><br>The January 2025 MAR review revealed an order for Ativan 1 mg as needed. Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 90 days end of life care. The medication was administered 23 out of 31 days in January.<br><br>An interview was conducted with the Director of Nursing (DON) on 02/06/2025 at 10:49 AM. The DON stated there was an order for Ativan 1 mg PRN for Resident #47 on 12/27/2024 and it was for 90 days and should have been an initial order for 14 days.<br><br>An interview with the Medical Director (MD) was conducted on 02/06/2025 at 12:04 PM. The MD stated she wrote the order for the PRN Ativan and thought she could extend an order for psychotropic for more than 14 days. She now understands that it must have an initial 14 days and assessment of the resident with rationale and duration to extend order. The MD also stated she will make sure it will be implemented going forward.<br><br>An interview with the Administrator was conducted on 02/06/2025 at 12:53 PM. The Administrator stated he was made aware that Resident #47 had a PRN medication without the initial 14-day stop date and wanted her staff to follow the regulations and make sure the PRN medication had an initial 14-day stop date and rationale and duration prior to extension of the medication. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38702<br><br>Based on observations, record reviews, and staff interviews, the facility failed to ensure it was free of a medication error rate less than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of the 5 sampled residents observed during medication administration (Resident #44 and Resident #45).<br><br>The findings included:<br><br>1. Resident #44 was admitted to the facility on [DATE] with diagnoses including Parkinsons disease.<br><br>A review of Resident #44s physician's orders dated 02/07/2025 revealed Voltaren external Gel 1% Diclofenac Sodium Topical (helps with pain). Apply to the left ankle two times a day for pain/inflammation for 10 days. Apply 2 grams or 2.25 inches to site twice daily.<br><br>An observation of Resident #44s medication administration on 300 halls was conducted on 02/07/2025 at 9:31 AM. Nurse #2 gathered medications for Resident #44 including Voltaren external gel 1%. She took medications in the Residents room and sat the medications on the bedside table on an opened tissue. She measured approximately a nickel amount of gel on her finger and applied it to the Residents left ankle. The nurse did not use the dosing card to measure the exact amount ordered.<br><br>An interview with Resident #44 was conducted on 02/07/2025 at 10:41 AM. The Resident stated the gel was working and there were no issues.<br><br>An interview with Nurse #2 was conducted on 02/07/2025 at 10:47 AM. The nurse stated the medication does come with a card to measure out the dosage, but it was missing. She would usually report it to the Quality Improvement (QI) Nurse but used her nursing judgement and applied a nickel size amount to Residents #44's ankle.<br><br>A telephone interview with the Pharmacist was conducted on 02/07/2025 at 11:35 AM. The Pharmacist stated the Voltaren topical medication comes with a dosing card with every order that is dispensed and the dosing card needed to be used every time the medication was administered. The Pharmacist also stated there were no adverse effects from the nickel size amount of the medication that was administered.<br><br>An interview with the Director of Nursing (DON) was conducted on 02/07/2025 at 12:47 PM. The DON stated Nurse #2 should have used the dosing card and measured out the correct amount prior to administration. The DON also stated she expected the nursing staff to follow the orders and if there were any concerns, then they should have reported it to her.<br><br>An interview with the QI Nurse was conducted on 02/07/2025 at 3:37 PM. The QI Nurse stated the nurses were educated and have checkoff skills yearly and know they were supposed to use the dosing card to measure the medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345491 | A. Building<br>B. Wing | 02/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Croatan Ridge Nursing and Rehabilitation Center | 210 Foxhall Road<br>Newport, NC 28570 |

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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Administrator was conducted on 02/07/2025 at 3:55 PM. The Administrator stated she expected the nursing staff to follow the orders and measure the topical medications using the dosing card that is included with the medication.<br><br>2. Resident #45 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD).<br><br>A review of Resident #45's physician's orders revealed 02/12/2024 Advair 2 inhalation orally two times a day for COPD. Rinse the mouth with water after dose.<br><br>An observation of Resident #45's medication administration was conducted on 02/06/2025 at 9:36 AM. Nurse #1 gathered medications and supplies including the Advair and went into Resident #45's room. The Nurse administered the medications to the Resident and then assisted with the 2 inhalations of Advair. The Resident received the medications without any signs or symptoms of distress and the nurse left the room without assisting the resident with rinsing her mouth with water.<br><br>An interview with Nurse#1 was conducted on 02/06/2025 at 9:39 AM. The Nurse stated she did not assist the Resident with rinsing her mouth with water because there was no need to rinse mouth out with Advair.<br><br>An interview with the Director of Nursing (DON) was conducted on 02/07/2025 at 12:47 PM. The DON stated Nurse #1 should have assisted Resident #45 with rinsing her mouth with water after the use of Advair and could not explain why she did not. The DON also stated she expected the nursing staff to follow the physicians' orders and if there were any concerns, then they should report it to her.<br><br>An interview with the QI nurse was conducted on 02/07/2025 at 3:37 PM. The Nurse stated the nurses were educated and have checkoff skills yearly and the nurses were trained to assist with rinsing the Residents mouths out after using Advair.<br><br>An interview with the Administrator was conducted on 02/07/2025 at 3:55 PM. The Administrator stated she expected the nursing staff to follow the physicians' orders. |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789<br><br>Based on record review, resident, facility and pharmacy staff interviews, the facility failed to administer medication as ordered by the physician to meet resident's need of 1 of 5 sampled residents reviewed for pharmacy services (Resident #28).<br><br>The findings included:<br><br>Resident #28 was admitted to the facility on [DATE] with a diagnosis including diabetes mellitus.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact and coded for Insulin use.<br><br>A review of the physician's orders dated 5/23/24 revealed Resident #28 was prescribed Toujeo Solostar Subcutaneous Solution Pen-injector 300 units/milliliter (Insulin Glargine) Inject 25 units subcutaneously at bedtime for diabetes.<br><br>Review of Resident #28s Medication Administration Record (MAR) dated 2/4/25, revealed Resident #28 did not receive insulin because the medication was not available.<br><br>In an interview with Resident #28 on 2/5/25 at 11:55 a.m. he revealed he was concerned that he did not get his insulin on 2/4/25 at 8:00 p.m. Resident #28 stated he was told by the nurse that the medication was not available.<br><br>In an interview with Nurse #2 on 2/5/25 at 11:57 a.m. she stated she had just re-ordered Resident #28s insulin and was not sure why the backup insulin was not administered on 2/4/25.<br><br>During a telephone interview with Nurse #3 on 2/5/25 at 2:06 p.m. she revealed that Resident #28's insulin pen was empty when she was administering medications on 2/4/25. She revealed she re-ordered the medication 2 nights prior but it had not been delivered by the pharmacy. She further stated she did not know she could use the backup kit medication because the medication was a different brand from prescribed, Toujeo Solostar Pen-injector.<br><br>In an interview with the Pharmacy Consultant on 2/6/25 at 9:23 a.m. she revealed the facility made a resupply request to the pharmacy on 2/4/25 at 7:41 p.m. and that the order was filled on 2/5/25 and sent to the facility on the same day in the evening.<br><br>During an interview with the Director of Nursing (DON) on 2/5/25 at 1:46 p.m. she revealed Resident #28's insulin had been re-ordered 2 days prior to 2/4/25 and that the pharmacy was on back order. She stated she was not aware that Resident #28 missed his insulin. She further stated the facility had back up insulin available that the nurse could access to ensure there was no lapse. She further stated that all nurses will be retrained on re-ordering medications timely.<br><br>In an interview with the Administrator on 2/7/25 at 2:16 p.m. she stated she was unaware that Resident #28 did not receive his insulin on 2/4/25. She further stated that it was the responsibility of nurses to alert the DON if a resident has a lapse in medication administration. |