

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Crystal Lake Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 999 South Main Street Pascoag, RI 02859	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's orders for 8 of 8 residents reviewed relative to failing to check blood sugars as ordered, Resident ID #s 1, 4, 6, 7, 8, 9, 10, and 11.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing page 314, states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.</p> <p>1. Record review revealed that Resident ID #1 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, diabetes mellitus.</p> <p>Review of a physician's order dated 9/27/2024 revealed to check his/her blood sugar before meals and at bedtime daily. Additionally, the order revealed to contact the physician if the blood sugar is less than 70 or greater than 300.</p> <p>Review of the November 2024 Medication Administration Record (MAR) revealed that Resident ID #1 did not have his/her blood sugar checked at 4:30 PM or 9:00 PM on 11/1/2024, as ordered.</p> <p>2. Record review revealed that Resident ID #4 was readmitted to the facility in August of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan revealed that s/he is at risk for unstable blood sugars related to a diagnosis of diabetes with an intervention including, but not limited to, check fingerstick blood sugar, as ordered.</p> <p>Review of a physician's order with a start date of 10/24/2024 revealed to administer 5 units of insulin glargine (long-acting insulin to treat diabetes) subcutaneous (below the skin) in the evening. Additionally, the order revealed to check the resident's blood sugar prior to administering the medication.</p> <p>Review of the November 2024 MAR revealed that Resident ID #4's blood sugar was not checked on the evening of 11/1/2024, as ordered.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review revealed that Resident ID #6 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan for Resident ID #6 revealed that s/he is at risk for unstable blood sugars secondary to a diagnosis of diabetes with an intervention including, but not limited to, check fingerstick blood sugar, as ordered.</p> <p>Review of a physician's order dated 8/2/2024 revealed to administer insulin Lispro (fast acting insulin) per a sliding scale based on the residents fingerstick blood sugar 3 times a day.</p> <p>Review of the November 2024 MAR revealed that the resident did not have his/her blood sugar checked on 11/1/2024 at 4:30 PM, as ordered.</p> <p>4. Record review revealed that Resident ID #7 was readmitted to the facility in August of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a physician's order dated 9/25/2024 revealed to administer insulin Lispro per a sliding scale based on the residents fingerstick blood sugar 3 times a day.</p> <p>Review of a physician order dated 9/25/2024 revealed to check the resident's fingerstick blood sugar at bedtime daily. Additionally, it revealed to contact the physician if the fingerstick blood sugar is less than 70 or greater than 400.</p> <p>Review of the November 2024 MAR revealed that the resident did not have his/her fingerstick blood sugar checked on 11/1/2024 at 4:30 PM or at bedtime, as ordered.</p> <p>5. Record review revealed that Resident ID #8 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a physician's order dated 10/9/2024 revealed to check his/her blood sugar twice daily and report to the physician if less than 70 or greater than 300.</p> <p>Review of the November 2024 MAR revealed that the resident did not have his/her blood sugar checked on 11/1/2024 in the evening, as ordered.</p> <p>6. Record review revealed that Resident ID #9 was admitted to the facility in September of 2023 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of the physician's orders revealed the following:</p> <ul style="list-style-type: none"> - An order with a start date of 2/13/2024 to check blood sugar three times a day 15 minutes prior to meals and notify the physician if blood sugar is less than 70 or greater than 400. - An order with a start date of 1/4/2024 to administer insulin Lispro per a sliding scale based on the residents fingerstick blood sugar 3 times a day. <p>Review of the November 2024 MAR revealed that Resident ID #9's blood sugar was not checked on 11/1/2024 at 4:30 PM, as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Record review revealed that Resident ID #10 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a physician order dated 10/18/2024 revealed to administer insulin Lispro per a sliding scale based on the residents fingerstick blood sugar 3 times a day. Additionally, the order instructed to contact the physician if the resident's blood sugar is less than 70 or greater than 400.</p> <p>Review of the November 2024 MAR revealed that Resident ID #10's blood sugar was not checked on 11/1/2024 at 4:30 PM, as ordered.</p> <p>8. Record review revealed that Resident ID #11 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan revealed that s/he is at risk for unstable blood sugars related to a diagnosis of diabetes with an intervention including, but not limited to, check fingerstick blood sugar, as ordered.</p> <p>Review of a physician's order dated 9/3/2024 revealed to administer insulin Aspart (fast acting insulin) per a sliding scale based on the residents fingerstick blood sugar 3 times a day. Additionally, the order instructed to contact the physician if the resident's blood sugar is less than 70 or greater than 400.</p> <p>Review of the November 2024 MAR revealed that Resident ID #11 did not have his/her blood sugar checked on 11/1/2024 at 4:30 PM, as ordered.</p> <p>During a surveyor interview on 11/4/2024 at approximately 1:30 PM with the Director of Nursing Services and the Clinical Consultant they acknowledged that Resident ID #s 1, 4, 6, 7, 8, 9, 10, and 11 did not have their blood sugar checked, as ordered on 11/1/2024.</p> <p>Cross Reference- F839</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to keep all residents free from significant medication errors for 5 of 6 residents reviewed relative to failing to administer insulin as ordered, Resident ID #s 1, 4, 5, 6 and 7.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Medication Administration dated 10/11/2017 states in part, It is the policy to ensure that resident medication administration is managed to ensure for resident quality of life, timeliness and safety .Medications are administered within one hour of the time noted on MAR [Medication Administration Record].</p> <p>1. Record review revealed that Resident ID #1 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, diabetes mellitus.</p> <p>Review of a care plan for Resident ID #1 revealed that s/he is at nutritional risk related to a diagnosis of diabetes with an intervention including, but not limited to, offer diabetic medications as ordered.</p> <p>Review of the physician's orders revealed the following:</p> <ul style="list-style-type: none"> - An order dated 10/23/2024 to administer 8 units of Humalog insulin (fast acting insulin) between 4:00 PM and 6:00 PM daily. - An order dated 9/18/2024 to administer 20 units of Lantus insulin (long acting insulin) between 7:00 PM and 11:00 PM daily. <p>Review of the November 2024 MAR revealed that Resident ID #1 did not receive his/her scheduled insulin as ordered on 11/1/2024.</p> <p>Record review failed to reveal evidence that the physician was made aware of the missed doses of insulin on 11/1/2024.</p> <p>2. Record review revealed that Resident ID #4 was readmitted to the facility in August of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan for Resident ID #4 revealed that s/he is at risk for unstable blood sugars secondary to a diagnosis of diabetes with an intervention including, but not limited to, administer medication as ordered.</p> <p>Review of a physician's order with a start date of 10/24/2024 revealed to administer 5 units of insulin glargine (long acting insulin to treat diabetes) subcutaneous (below the skin) in the evening.</p> <p>Review of the November 2024 MAR revealed that Resident ID #4 did not receive his/her scheduled insulin as ordered on 11/1/2024.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review failed to reveal evidence that the physician was made aware of the missed dose of insulin on 11/1/2024.</p> <p>3. Record review revealed that Resident ID #5 was readmitted to the facility in May of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan for Resident ID #5 revealed that s/he is at risk for unstable blood sugars secondary to a diagnosis of diabetes with an intervention including, but not limited to, administer medication as ordered.</p> <p>Review of a physician's order with a start date of 10/21/2024 revealed to administer 5 units of Lantus insulin subcutaneous every evening.</p> <p>Review of the November 2024 MAR revealed that Resident ID #5 did not receive his/her scheduled insulin as ordered on 11/1/2024.</p> <p>Record review failed to reveal evidence that the physician was made aware of the missed dose of insulin on 11/1/2024.</p> <p>4. Record review revealed that Resident ID #6 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan for Resident ID #6 revealed that s/he is at risk for unstable blood sugars secondary to a diagnosis of diabetes with an intervention including, but not limited to, administer medication as ordered.</p> <p>Review of a physician's order dated 8/11/2024 revealed to administer 10 units of insulin glargine subcutaneous every evening.</p> <p>Review of the November 2024 MAR revealed that Resident ID #6 did not receive his/her scheduled insulin as ordered on 11/1/2024.</p> <p>Record review failed to reveal evidence that the physician was made aware of the missed dose of insulin on 11/1/2024.</p> <p>5. Record review revealed that Resident ID #7 was readmitted to the facility in August 2024 with a diagnosis including, but not limited to, type 2 diabetes mellitus.</p> <p>Review of a care plan for Resident ID #7 revealed that s/he is at nutritional risk related to a diagnosis of diabetes with an intervention including, but not limited to, offer diabetic medications as ordered.</p> <p>Review of a physician order dated 10/21/2024 revealed to administer 20 units of insulin glargine subcutaneous every evening.</p> <p>Review of the November 2024 MAR revealed that Resident ID #7 did not receive his/her scheduled insulin as ordered on 11/1/2024.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review failed to reveal evidence that the physician was made aware of the missed dose of insulin on 11/1/2024.</p> <p>During a surveyor interview on 11/4/2024 at approximately 1:30 PM with the Director of Nursing Services and the Clinical Consultant, they acknowledged that the above-mentioned insulin doses were not administered for Resident ID #s 1, 4, 5, 6 and 7.</p> <p>Cross Reference- F839</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that staff are licensed, certified, or registered in accordance with applicable State laws for 1 of 1 staff reviewed, Staff A.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health on 11/3/2024 revealed that a Certified Medication Technician (CMT), Staff A, worked in the facility on 11/1/2024 and impersonated a licensed nurse. Additionally, it revealed that Staff A attempted to do this a second time on 11/3/2024 but was discovered to not have the proper credentials and was sent home.</p> <p>Review of the Rhode Island Department of Health licensing website revealed Staff A is licensed as a CMT.</p> <p>During a surveyor interview on 11/4/2024 at approximately 10:50 AM with the Director of Nursing Services (DNS) she revealed that Staff A, was scheduled to work as a CMT on 11/1/2024 and 11/3/2024. Additionally, she revealed that on 11/3/2024 Staff A, attempted to conduct the narcotic count and obtain the keys for the licensed nurse medication cart and was stopped by Nursing Supervisor, Staff B. Per the DNS, Staff B discovered that Staff A was a CMT and not a licensed nurse. Additionally, the DNS acknowledged that Staff A did work in the capacity of a licensed nurse on 11/1/2024 during the 3:00 PM to 11:00 PM shift and had completed the narcotic count and obtained the keys for the licensed nurse medication cart.</p> <p>During a surveyor interview on 11/4/2024 at 11:50 AM via the telephone with Licensed Practical Nurse, Staff C, she revealed that she conducted the narcotic count with Staff A on 11/1/2024. Additionally, Staff C revealed that Staff A was unsure how to complete a narcotic count and she instructed her how to do so. Staff C revealed that she felt unsure of Staff A competence but did not speak to the Director of Nursing Services about her concerns.</p> <p>A surveyor interview was attempted with Staff A on 11/4/2024 at 12:02 PM but she did not return the surveyor's call.</p> <p>During a surveyor interview on 11/4/2024 at 12:06 PM with Registered Nurse (RN), Staff D, she revealed that on 11/1/2024 Staff A told her she was a nurse. Per Staff D, Staff A completed the narcotic count and said that she would pass the narcotics and insulins for all of the residents.</p> <p>During a surveyor interview on 11/4/2024 at 12:20 PM via telephone with RN, Staff E, she revealed that she worked on 11/1/2024 with Staff A from 3:00 PM to 11:00 PM. Additionally, Staff E revealed that Staff A completed the narcotic count and was supposed to administer the narcotics and insulin to all of the residents. Staff E revealed that she was unaware that Staff A was not a nurse, however, she did acknowledge that Staff A appeared to be unsure about what she was doing while completing the narcotic count at the end of the night.</p> <p>(continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the November 2024 Medication Administration Record (MAR) for Resident ID #12 revealed oxycodone 5 milligrams (mg, a schedule 2 narcotic) was signed off as administered by CMT, Staff A on 11/1/2024.</p> <p>Review of the November 2024 MAR for Resident ID #13 revealed oxycodone 5 mg was signed off as administered by Staff A on 11/1/2024.</p> <p>During a surveyor interview on 11/4/2024 at approximately 1:30 PM with the DNS and the Clinical Consultant, they acknowledged that Staff A worked on 11/1/2024 and inaccurately portrayed herself as a nurse. Additionally, the DNS and Clinical Consultant acknowledged that administering schedule 2 narcotics is outside of the scope of practice for a CMT.</p>		