STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Milbank	1103 South Second Street Milbank, SD 57252

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41088 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to follow their grievance policy regarding a complaint filed by a family member on behalf of resident 2 who had received services from the facility. Findings revealed: 1. Review of the provider's 8/14/24 SD DOH FRI revealed: *On 8/14/24 the daughter of resident 2 had voiced concerns regarding services provided to her mother (resident 2) which included the following: -Potential staff improper use of mechanical lifts with resident transfers which may have resulted in resident 2 having a dislocated hip that was later discovered while she was hospitalized . -Short staffing. -Long call light wait times. -A COVID-19 positive resident wandering the facility and possibly infecting others. -Resident 2 had symptoms of black/tarry bowel movements. *The report had not indicated nursing followed-up with the physician in response to resident 2's black/tarry bowel movement symptoms. Review of resident 2's electronic medical record revealed: *On 7/7/24 at 8:37 p.m. there was a nurse progress note that indicated: -Resident continued to complain of stomach pain. -She had a poor appetite and ate very little at meals. -She had needed more assistance from staff with transfers. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She was noted to have dark/tarry bowel movement. -When the on-call physician was notified, the nurse was advised to continue to monitor resident 2, to call with any changes of resident's condition, and set up an appointment with resident 2's primary physician for the next morning. *There had been no documentation resident 2 had been seen by her primary physician on 7/8/24. *On 7/9/24 at 6:13 p.m. there was a nurse progress note that indicated resident 2 had been transferred to the emergency room due to a suspected gastrointestinal bleed. Interview on 12/18/24 at 3:54 p.m. with administrator C regarding resident 2 and review of the provider's 8/14/24 SD DOH FRI regarding resident 2 revealed: *The surveyor requested a copy of the grievance investigation and response to the family of resident 2 that was filed with the facility. *The requested grievance and investigation was not available. *They had no documentation that indicated an investigation had been conducted regarding resident 2's daughter's concerns. *Administrator C had filed an incident report with the SD DOH after the daughter's concerns were brought to her attention. -The daughter felt there had been poor communication between the facility nurses and a lack of follow through from facility nursing with resident 2's physician. -Resident 2 had continued stomach discomfort leading up to her transfer to the emergency department on 7/9/24 where she was diagnosed with a gastrointestinal bleed. *Administrator C could not remember if she had spoken with resident 2's family about their concerns. *The former director of nursing (DON) and administrator C had been responsible for following their grievance process for any grievances filed with the facility. *That DON had left their employment recently and had been replaced about a month ago by DON B who previously had been the assistant DON. *The facility's human resources representative had been recently appointed to address resident grievances and was following through with their grievance policy. *She thought the former DON had been addressing the grievances but there was no documentation to prove investigations had been completed and their grievance process had been followed. *They had not been following their grievance policy. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Administrator C confirmed she was responsible for ensuring any facility grievances were addressed in a timely manner and that had not happened for resident 2. Review of the provider's revised September 30, 2024 Grievances policy revealed: *It is the policy of this facility to investigate all grievances registered by, or on behalf of a resident, without the threat of reprisal in any form. Residents are encouraged to express grievances on behalf of themselves or others to the facility's Administrator, the Resident Council, State or Government Agencies, or other persons. The Administrator shall provide all residents or their representatives with the name, address and telephone number of the appropriate state government office where complaints may be lodged. Procedure: 1. The facility will establish a Grievance Policy that will be made available to the resident upon request. 2. The facility Administrator has been designated to receive all grievances. 3. The facility will notify the resident individually or through postings in prominent location of the facility the right to file grievance orally, in writing or anonymously. a. The notification will include the name, address, and phone number of the grievance official, a reasonable time frame to investigate the grievance, and the resident's right to obtain a written copy of the grievance investigation if requested. b. The notification will also include the contact information for agencies where the grievance can also be reported to appropriate state agencies. 4. Any resident or representative or member of the resident's family or the resident council may present a grievance to the Administrator or designee orally or in writing. 5. The Administrator or designee shall confer with persons involved in the incident and other relevant persons and within three [3] days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal representative, if any. Where appropriate, due to the mental or physical condition of the complainant or aggrieved party, an oral explanation shall accompany the written one. 6. During the investigation, the facility will put in place immediate action to prevent potential violation of resident's rights. 7. If the grievance involves suspected abuse, neglect, injury of unknown source, or misappropriation of property, abuse protocol will be followed. [See Abuse and Neglect Policy] (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings, or conclusions regarding the resident's concerns [s], a statement as to whether the grievance was confirmed or not confirmed, any corrective action to be taken by the facility as a result of the grievance, and the date the written decision was issued. 9. If grievance is confirmed, the facility will take appropriate corrective action. 10. The facility will maintain results for 3 years.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32355 Based on South Dakota Department of Health (SD DOH) complaint online report, document review, interview, and policy review, the provider failed to provide report to the SD DOH for one of one sampled resident (1) who was given two long-acting insulins at the same time for four days, had episodes of hypoglycemia (low blood sugars), and required evaluation at the emergency department (ED). Findings include: 1. Review of the SD DOH 12/12/24 intake information revealed: *I am writing to file a complaint regarding [long-term care provider's name]. There was a sentinel event [not anticipated] that could have ended a resident's life. *[Resident 1] (4/5/1956) was transported to [name of hospital] on 12/12/24 for complaints of hypoglycemia and altered mental status. It was reported by [registered nurse (RN) K] (nursing home staff) that the patient's blood sugar was 24 at their facility. No interventions were completed by the nursing home staff at that time, only waiting for [ambulance name] to arrive. [RN K] reported that the patient has been having hypoglycemic episodes for the past 5 days. *Upon inspection of the MAR [medication administration record] sent with the patient to our facility, it was discovered that the patient was getting dosed with two different types of long-acting insulin types. The insulins that were administered were Touje [Toujeo] SoloStar 44 IU [international units] daily and Tresiba Flex INJ [injection] 40 IU daily. *The pharmacist at [hospital's name], [pharmacist's name], spoke with [provider's pharmacy name] regarding the two prescriptions for long-acting insulin. It was made to light that the brand of insulin was changed due to insurance funding issues. The patient was to change from Touje [Toujeo] to Tresiba because his insurance did not cover Touje [Toujeo]. There was a delay from when the Tresiba order was signed and when the medication arrived at the facility. Per [provider's pharmacy name], the facility was supposed to non-administer the Tresiba until the entirety of the Touje [Toujeo] insulin pen was administered. On 12/6/24 and 12/7/24 the Tresiba was non-administered by their pharmacy's directions. However, on 12/8/24 the patient started to receive both the Tresiba and Touje [Toujeo] every day until 12/12/24 when the Touje [Toujeo] order was discontinued per the estimated length of time for the pen to run out per [provider's pharmacy name]. Patient received both the insulins from 12/8-12/11/24. *The facility was updated when the patient was admitted for his hypoglycemia and blood sugar monitoring. A nursing report was given to [RN K] at [provider's name] and she stated she had no idea the patient was receiving two types of long-acting insulin. However, upon inspection of their MAR it seems that she potentially gave the does on 12/9/24 and 12/10/24 per their MAR user abbreviations. Review of resident 1's 12/12/24 ED note revealed: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[AGE] year-old male with type 2 diabetes on insulin presented to [hospital's ED name] via EMS [emergency medical services] due to being unresponsive secondary to hypoglycemia. Blood sugar was initially reported by nursing home staff to be 24. Blood sugar increased to 73 after receiving D10 [dextrose] by EMS. Patient was responsive and answering questions. He ate toast without difficulty. Serum blood sugar reading was 41. Suspected that patient may be receiving multiple long-acting insulin medications unintentionally which occurred related to insurance requesting changing insulin options and having to re-order new medication, apparently both Toujeo and Tresiba were administered for 4 days. *He last received double coverage of insulin yesterday morning. Concerned that he may have persistent hypoglycemia until insulin wears off. Recommended admission to [hospital's name] for observation to ensure his blood sugar levels return to baseline and adjust his diabetes medication. Review of resident 1's electronic medical record (EMR) from 12/6/24 through 12/12/24 revealed: *On 12/6/24 at 2:57 p.m. there was a nurse progress note (PN) that indicated the resident to be given Tresiba Flex [insulin] 40 units once a day starting the next morning. -There was no documentation that supported the Tresiba should not have been given until the Toujeo insulin supply was all gone. *On 12/7/24 at 8:36 a.m. RN E documented that she had administered only the Toujeo. -There was no documentation that supported why she only administered the Toujeo. -There was no documentation that she had contacted the physician or the pharmacy department for clarification of the two long-acting insulin orders. *On 12/9/24 at 7:49 a.m. RN K gave the resident 6 ounces (oz) of orange juice. -There was no documentation that supported why she had given him orange juice. -The MAR documentation indicated that: --His blood sugar level had been checked and was low at 62. --She administered both the Toujeo and Tresiba insulins shortly after she had given him orange juice for a low blood sugar level. *On 12/10/24 the physician had seen the resident and decreased the Toujeo by 2 units. -There was no documentation that those two long-acting insulins had been clarified with the physician. *On 12/12/24 at 3:30 a.m. a certified nursing assistant (CNA) had observed the resident in the doorway of a shared bathroom. Another resident had been attempting to hold him up and telling him to hang on. The CNA attempted to direct the resident to sit down on the toilet but he could not follow directions. He was alert but unable to speak. The nurse and CNA were able to assist him to sit down in the wheelchair (w/c). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-His blood sugar level had been checked and was low at 45. -The nurse administered a glucose injection into his abdomen per physician orders. -His blood sugar continued to drop to 40 and remained low at 44. -The nurse administered another glucose injection. He was able to drink a glass of orange juice and eat 1/2 a cup of ice cream. -His blood sugar level continued to rise from 49, 57, and 73. By 4:45 a.m. his blood sugar level had risen to 101. -A note regarding the resident's hypoglycemic episode was sent to the physician. *On 12/12/24 at 8:51 a.m. social services designee L had written a PN that the wife of the resident was called and informed he was sent to the ED due to being nonresponsive and a low blood sugar. *On 12/12/24 at 9:03 a.m. RN K documented: -This RN went into this resident room after being notified by [nurse consultant A], [director of nursing (DON) B] instructed me to call the ED to give report, this RN left the room to call the [local ED] to give report on this resident being sent to ER for hypoglycemia, this RN updated this resident's name, birthdate, & is having hypoglycemia episodes to the ER nurse, [DON B] was in the room with this resident until the ambulance arrived, this resident's blood sugar was taking [taken] by the [DON B], [DON B] stated this resident blood sugar was 24, the blood sugar was stated to the ER nurse that it was 24, the ER nurse state you need to recheck the blood sugar & if it is still low give him some honey or glucose, or something, you can't send him here with a low blood sugar, so they need to recheck the blood sugar, this RN let the ER nurse know that a call back will be given, resident is in & out of consciousness & is not able to swallow at this time, the ambulance is here for transport, resident left by ambulance, resident's spouse was phone called, no answer left a voice mail on her phone message to call facility for update & this resident is being transferred to the [hospital's ED]. -At 12:40 p.m. the ED had called to inform RN K that the resident was admitted for observation due to hypoglycemia and a urinary tract infection. Review of resident 1's 12/6/24 through 12/12/24 MAR revealed he had been given both the Tresiba and Toujeo insulins everyday at the same time on 12/8/24, 12/9/24, 12/10/24, and 12/11/24. There was no documentation that supported those nurses had contacted the physician or the provider's pharmacy for clarification of the insulin orders. Interview on 12/18/24 at 8:00 a.m. with resident 1 regarding the incident on 12/12/24 revealed he: *Was alert and oriented to self and place. *Remembered being sent to the hospital and that his insulin had to be adjusted. *Was not able to recall why he had been hospitalized . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Stated: My memory is poor. Review of resident 1's 12/12/24 medication variance report revealed: *An internal report had been completed because he had a hypoglycemic episode and required the activation of the EMS system. *He was found cool, clammy, unresponsive, eyes open, and he was grunting. *His blood sugar was tested and had been below the typical range of 80 to 130 milligrams (mg)/deciliter (dl). -The blood sugar level was 24. *There was no documentation that a facility reported incident (FRI) report had been completed and submitted to the SD DOH. Interview on 12/18/24 at 5:10 p.m. with nurse consultant A, DON B, and administrator C regarding resident 1 revealed: *They had been aware of the SD DOH facility reported incident guidelines. *The had not reported the incident involving resident 1 because the nursing staff had been following physician orders. *RN E had found the discrepancy and should have clarified the orders with the pharmacy department and the physician. -She would have been expected to report the discrepancy to leadership and ensure the other nursing staff had been aware of the discrepancy. She had not communicated the discrepancy to anyone. *They agreed the incident should have been reported to the SD DOH when the resident's blood sugar was critically low and required EMS, evaluations at the ED, and hospitalization . Review of the provider's 2/20/24 revised Abuse and Neglect policy revealed: *Reporting/Response: -All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received. -A final investigation report will be submitted to your state agency within 5 days.*The administrator clarified on 12/27/24 at 11:01 a.m. through email communication with the surveyor that this was the policy they utilized for all incident reporting to SD DOH.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32355 Based on South Dakota Department of Health (SD DOH) complaint online report, interviews, records review, and policy review, the provider failed to ensure one of one resident (1) had been free from a significant medication error when he was administered two long-action insulins at the same time for four consecutive days. Findings include: 1. Review of the SD DOH 12/12/24 intake information revealed: *I am writing to file a complaint regarding [long-term care provider's name]. There was a sentinel event [not anticipated] that could have ended a resident's life. *[Resident 1] (4/5/1956) was transported to [name of hospital] on 12/12/24 for complaints of hypoglycemia and altered mental status. It was reported by [registered nurse (RN) K] (nursing home staff) that the patient's blood sugar was 24 at their facility. No interventions were completed by the nursing home staff at that time, only waiting for [ambulance name] to arrive. [RN K] reported that the patient has been having hypoglycemic episodes for the past 5 days. *Upon inspection of the MAR [medication administration record] sent with the patient to our facility, it was discovered that the patient was getting dosed with two different types of long-acting insulin types. The insulins that were administered were Touje [Toujeo] SoloStar 44 IU [international units] daily and Tresiba Flex INJ [injection] 40 IU daily. *The pharmacist at [hospital's name], [pharmacist's name], spoke with [provider's pharmacy name] regarding the two prescriptions for long-acting insulin. It was made to light that the brand of insulin was changed due to insurance funding issues. The patient was to change from Touje [Toujeo] to Tresiba because his insurance did not cover Touje [Toujeo]. There was a delay from when the Tresiba order was signed and when the medication arrived at the facility. Per [provider's pharmacy name], the facility was supposed to non-administer the Tresiba until the entirety of the Touje [Toujeo] insulin pen was administered. On 12/6/24 and 12/7/24 the Tresiba was non-administered by their pharmacy's directions. However, on 12/8/24 the patient started to receive both the Tresiba and Touje [Toujeo] every day until 12/12/24 when the Touje [Toujeo] order was discontinued per the estimated length of time for the pen to run out per [provider's pharmacy name]. Patient received both the insulins from 12/8-12/11/24. *The facility was updated when the patient was admitted for his hypoglycemia and blood sugar monitoring. A nursing report was given to [RN K] at [provider's name] and she stated she had no idea the patient was receiving two types of long-acting insulin. However, upon inspection of their MAR it seems that she potentially gave the does on 12/9/24 and 12/10/24 per their MAR user abbreviations. Review of resident 1's 12/12/24 ED note revealed: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*[AGE] year-old male with type 2 diabetes on insulin presented to [hospital's ED name] via EMS [emergency medical services] due to being unresponsive secondary to hypoglycemia. Blood sugar was initially reported by nursing home staff to be 24. Blood sugar increased to 73 after receiving D10 [dextrose] by EMS. Patient was responsive and answering questions. He ate toast without difficulty. Serum blood sugar reading was 41. Suspected that patient may be receiving multiple long-acting insulin medications unintentionally which occurred related to insurance requesting changing insulin options and having to re-order new medication, apparently both Toujeo and Tresiba were administered for 4 days. *He last received double coverage of insulin yesterday morning. Concerned that he may have persistent hypoglycemia until insulin wears off. Recommended admission to [hospital's name] for observation to ensure his blood sugar levels return to baseline and adjust his diabetes medication. Review of resident 1's electronic medical record (EMR) revealed he: *Had an admitted [DATE]. *Had a diagnosis of Type 2 diabetes and was dependent upon the use of insulin to maintain his blood sugar levels. *Had a Brief Interview for Mental Status (BIMS) score of 11 that indicated he had mild cognitive impairment. *Was dependent upon the staff to: -Assist him with medication administration and ensure he received the right medication and the right dose. -Ensure they followed-up with the physician and pharmacy department regarding any medication order discrepancies and clarification of those orders. -Communicate with each other on order changes received from the pharmacy department or physician to ensure his safety from medication administration errors. Continued review of resident 1's electronic medical record (EMR) from 12/6/24 through 12/12/24 revealed: *On 12/6/24 at 2:57 p.m. there was a nurse progress note (PN) that indicated the resident to be given Tresiba Flex [insulin] 40 units once a day starting the next morning. -There was no documentation that supported the Tresiba should not have been given until the Toujeo insulin supply was all gone. *On 12/7/24 at 8:36 a.m. RN E documented that she had administered only the Toujeo. -There was no documentation that supported why she only administered the Toujeo. -There was no documentation that she had contacted the physician or the pharmacy department for clarification of the two long-acting insulin orders. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*On 12/9/24 at 7:49 a.m. RN K gave the resident 6 ounces (oz) of orange juice. -There was no documentation that supported why she had given him orange juice. -The MAR documentation indicated that: --His blood sugar level had been checked and was low at 62. --She administered both the Toujeo and Tresiba insulins shortly after she had given him orange juice for a low blood sugar level. *On 12/10/24 the physician had seen the resident and decreased the Toujeo by 2 units. -There was no documentation that those two long-acting insulins had been clarified with the physician. *On 12/12/24 at 3:30 a.m. a certified nursing assistant (CNA) had observed the resident in the doorway of a shared bathroom. Another resident had been attempting to hold him up and telling him to hang on. The CNA attempted to direct the resident to sit down on the toilet but he could not follow directions. He was alert but unable to speak. The nurse and CNA were able to assist him to sit down in the wheelchair (w/c). -His blood sugar level had been checked and was low at 45. -The nurse administered a glucose injection into his abdomen per physician orders. -His blood sugar continued to drop to 40 and remained low at 44. -The nurse administered another glucose injection. He was able to drink a glass of orange juice and eat 1/2 a cup of ice cream. -His blood sugar level continued to rise from 49, 57, and 73. By 4:45 a.m. his blood sugar level had risen to 101. -A note regarding the resident's hypoglycemic episode was sent to the physician. *On 12/12/24 at 8:51 a.m. social services designee L had written a PN that the wife of the resident was called and informed he was sent to the ED due to being nonresponsive and a low blood sugar. *On 12/12/24 at 9:03 a.m. RN K documented: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-This RN went into this resident room after being notified by [nurse consultant A], [director of nursing (DON) B] instructed me to call the ED to give report, this RN left the room to call the [local ED] to give report on this resident being sent to ER for hypoglycemia, this RN updated this resident's name, birthdate, & is having hypoglycemia episodes to the ER nurse, [DON B] was in the room with this resident until the ambulance arrived, this resident's blood sugar was taking [taken] by the [DON B], [DON B] stated this resident blood sugar was 24, the blood sugar was stated to the ER nurse that it was 24, the ER nurse state you need to recheck the blood sugar & if it is still low give him some honey or glucose, or something, you can't send him here with a low blood sugar, so they need to recheck the blood sugar, this RN let the ER nurse know that a call back will be given, resident is in & out of consciousness & is not able to swallow at this time, the ambulance is here for transport, resident left by ambulance, resident's spouse was phone called, no answer left a voice mail on her phone message to call facility for update & this resident is being transferred to the [hospital's ED]. -At 12:40 p.m. the ED had called to inform RN K that the resident was admitted for observation due to hypoglycemia and a urinary tract infection. Review of resident 1's 12/6/24 through 12/12/24 MAR revealed he had been given both the Tresiba and Toujeo insulins every day at the same time on 12/8/24, 12/9/24, 12/10/24, and 12/11/24. There was no documentation that supported those nurses had contacted the physician or the provider's pharmacy for clarification of the insulin orders. Review of resident 1's 12/12/24 medication variance report revealed: *An internal report had been completed he had an hypoglycemic episode and required the activation of the EMS system. *He was found cool, clammy, unresponsive, eyes open, and he was grunting. *His blood sugar was tested and had been below the typical range of 80 to 130 milligrams (mg)/deciliter (dl). -The blood sugar level was 24. Review of the provider's 12/13/24 Safety Huddle meeting notes revealed that there was to be education on insulin administration and pharmacy training. 3. Interview on 12/17/24 at 4:10 p.m. with RN E revealed: *She was aware of the insulin medication errors that had been found the prior week regarding the resident 1. *She had worked during that time frame that he had two orders on his MAR for both of the long-acting insulins. *She only administered the Toujeo insulin to the resident and did not administer the Tresiba insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Milbank	1103 South Second Street Milbank, SD 57252

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*She stated: -I thought it was strange that he had two long-acting insulins and just gave the one that we always had. -I charted that too. -The Tresiba was there, I just didn't remove it and give it to him. *The provider had a new pharmacy and a new process for entering the medication orders onto the resident's MAR. -The staff faxed the medication orders to the pharmacy and they would update the resident's MAR with the new or changed orders. *The Toujeo was not going to be covered by the resident's insurance and it was going to be replaced with Tresiba. *The pharmacy had expected there to be a delay with the delivery of the new insulin and the staff were to continue giving resident 1 the Toujeo until it was gone. -That information had not been communicated amongst the staff or from shift-to-shift. -The pharmacy had entered the new order on the resident's MAR but had not added to hold it until the Toujeo was completed. -There were two orders on the resident's MAR to administer both of those long-acting insulins at the same time every day. -The Tresiba had been delivered to the facility the next day and was available to be administered. *She had not: -Contacted the pharmacy or the physician to clarify those orders that were entered in the MAR for resident 1 to receive two long-acting insulins at the same time. -Communicated that discrepancy to the next nurse coming on shift. *She stated: -I got busy and forgot about it. -Besides common sense would tell you not to give two long-acting insulins. *The nursing staff had been educated to: -Not assume that another nurse would have known not to administer two long-acting insulins at the same time. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Make sure to report off to the next nurse coming on shift. Interview on 12/18/24 at 8:00 a.m. with resident 1 regarding the incident on 12/12/24 revealed he: *Was alert and oriented to self. *Remembered being sent to the hospital and that his insulin had to be adjusted. *Was not able to recall why he had been hospitalized . *Stated: My memory is poor. Interview on 12/18/24 at 9:25 a.m. with RN H revealed she: *Had been employed with the facility approximately three weeks. *Had been educated that morning on: -Not administering two long-acting insulins. -The importance of clarifying with the doctor if there were two orders to administer long-acting insulins. *Had worked the morning of 12/11/24 but could not recall if she had administered both of the insulins to resident 1. Interview on 12/18/24 at 9:45 a.m. with DON B revealed: *She had been the DON since November 2024. *Prior to November she had been the assistant DON from April 2024. *She did not recall if the prior DON had completed medication administration competencies for the nursing staff. *She was not able to find any medication administration competencies for the nursing staff. *They should have completed medication administration competencies yearly. -She knew that because they had just been placed on her desk. *They had not completed any recent medication administration competencies. Interview on 12/18/24 at 9:50 a.m. and again at 2:35 p.m. with licensed practical nurse (LPN) D revealed: *She filled-in as needed at this facility. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*She had received education yesterday on: -The importance of contacting the physician or pharmacy on any orders that do not look correct. -An overview for insulin administration. -There was a double check verification process for new orders to make sure they were entered correctly. *To her knowledge there was no other education or competencies on medication administration initiated since this incident to ensure residents safety. Interview on 12/18/24 at 5:10 p.m. with administrator C, DON B, and nurse consultant A revealed: *They had recently changed pharmacies and the new process was implemented on 12/2/24. *The pharmacy was in charge of changing and updating all the physician orders in the residents' MARs. *The staff would have faxed any order changes to the pharmacy and they would make the changes. *The staff should have checked to make sure the orders had been implemented correctly. *The order change for resident 1 regarding the two long-acting insulins had come from the pharmacy because insurance was no longer going to pay for the Toujeo. *The pharmacy had called to speak with the nurse in charge on 12/6/24 regarding the insulin medication change. -The staff were to continue giving the Toujeo until it was completed and the new Tresiba insulin arrived. -The Tresiba had come in right away and was placed in the medication compartment with the Toujeo for resident 1. -The charge nurse who had spoken with the pharmacy had failed to pass on the process to the on-coming nurse. *The pharmacy had put the order for resident 1's new insulin in the MAR to be started right away and did not delete the old insulin order. *RN E had caught the discrepancy with the duplicate order the next day but she had not: -Called the pharmacy or the physician to clarify the order. -Communicated this discrepancy with the other nurses to ensure a significant medication error had not occurred. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*They would have expected RN E to have completed the above process and RN E was re-educated on that. *They initiated education with the nursing staff on 12/13/24. -They had educated the staff when they worked their next shift. -The education included recognizing duplicate orders and contacting the pharmacy and the physician to clarify the orders. -The 5 rights of medication administration. -Pharmacy training on the new process of verifying the orders in the resident's MAR had been entered correctly. *They could not locate or recall the last time medication administration competencies had been completed on the staff who administered residents' medications. *The only audit they had initiated to ensure the residents were safe from significant medication errors was a daily audit to compare the new orders with the resident's MAR to ensure the pharmacy had entered it correctly. *They had not initiated any other audits or medication administration competencies since the occurrence with resident 1 to ensure: -The staff had understood the process changes and implemented them correctly. -All residents who were dependent upon the staff to administer their medications had done so safely, correctly, and according to the 5 rights of medication administration. *They had not considered implementing those audits on medication administration for the safety of the residents. Review of the provider's December 2019 Medication Administration - General Guidelines policy revealed: *Medications are administered as prescribed in accordance with good nursing principles and practices *FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.