STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Post-Acute and Rehabilitation Center	2035 Stonebrook Place Kingsport, TN 37660

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078 Based on facility policy review, medical record review, facility investigation documentation review, and interview, the facility failed to protect the residents' right to be free from sexual abuse for 1 resident (Resident #2) by Resident #3 and physical abuse for 2 residents (Residents #4 and #5) by Resident #1 of 7 residents reviewed for abuse. The abuse resulted in actual harm to residents #4 and #5 when Resident #1 threw a chair at Resident #4 and #5 resulting in Resident #4 receiving a scrape down his left shin and Resident #5 receiving a bruise and swelling on his right knee. The findings include : Review of the facility's policy titled, Abuse .Prevention Program, revised 4/2021, revealed .Residents have the right to be free from abuse .This includes .sexual or physical abuse .The resident abuse .prevention program consists of a facility-wide commitment .to support the following objectives .Protect residents from abuse .by anyone including .other residents . 1. Review of the medical records and facility investigation documentation revealed on 5/12/2024 a resident to residents' altercation occurred between Resident #1, Resident #4, and Resident #5 when Resident #5 punched at Resident #4 and threw a chair at Resident #4 and Resident #5. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Anxiety, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4's Brief Interview for Mental Status (BIMS) score was 15 indicating the resident was cognitively intact. Review of facility incident report dated 5/12/2024 for Resident #4 revealed the resident had a scrape down his left shin approximately (approx.) 8 inches in length due to Resident #1 hitting Resident #4 with a chair no other injuries were noted. Review of a Progress note for Resident #4 dated 5/15/2024 revealed the resident was seen by the Social Services Director (SSD) Resident #4 did not have any concerns following the incident. Review of a psychiatric note for Resident #4 dated 5/15/2024 revealed the resident denied any symptoms of anxiety or depression. The resident reported I am fine. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Dementia, and Depression. Review of the quarterly MDS assessment dated [DATE] revealed Resident #5's BIMS score was 13 indicating the resident was cognitively intact. Review of facility incident report dated 5/12/2024 for Resident #5 revealed the resident had a bruise and swelling on his right knee approx. 2 inches by 2 inches due to Resident #1 hitting Resident #5 with a chair no other injuries were noted. Review of a Progress note for Resident #5 dated 5/15/2024 revealed the resident was seen by SSD. Resident #5 did not have any concerns following the incident. Review of psychiatric notes for Resident #5 dated 5/15/2024 revealed the resident denied any signs or symptoms of anxiety or depression. The resident reported he was doing okay. Review of the medical record revealed Resident #1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Wernicke's Encephalopathy (Neurological Disorder), History of Traumatic Brain Injury, and Schizophrenia, he was discharged to the hospital on 5/12/2024. Review of the quarterly MDS assessment dated [DATE] revealed Resident #1's BIMS score was 6 indicating the resident had severe cognitive impairment. Review of Resident #1's current care plan revealed .The resident is/has potential to be verbally/physically aggressive. He kicks and swats at staff at times .Date initiated 06/19/2022 . Review of a Psychiatric Progress note for Resident #1 dated 5/7/2024 revealed .Patient has been having increased behaviors, agitation, Seroquel increased, and he was sent to the hospital. He was seen today .He was pleasant and talkative . Review of a facility investigation revealed on 5/12/2024 at 4:05 PM, in the smoking area Resident #1 became agitated and began punching at Resident #4 striking him in the face Resident #1 grabbed a chair. The Activities Assistant attempted to remove the chair from the resident who threw the chair at Resident #4 striking him on his lower leg. Resident #1 grabbed the chair again and threw it at Resident #5 striking him on his knee. The facility substantiated abuse for Resident #4 and Resident #5. During an interview on 7/8/2024 at 9:00 AM, Resident #4 stated .he [Resident #1] hit me with a chair in the hand and in the leg .he swung at me and hit me in the face he didn't leave no marks on me or noting .yeah [feels safe at facility] .no [no concerns] .I am okay . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/8/2024 at 1:40 PM the Activities Assistant stated .I was out there [smoking area] before he [Resident #1] got there and when he come out he sat there and he talked to people [other residents] .after a while [Resident #4] come out to smoke and [Resident #1] started talking to him and I couldn't hear what [Resident #4] said but he [Resident #1] just got agitated .[Resident #1] picked up a chair and I thought he was going to move the chair but then he hit [Resident #4] with it and I tried to get the chair but before I could get to him he already hit [Resident #5] .when I tried to get the chair he grabbed my arm but he didn't hurt it .they [Resident #4 and #5] are fine I aint seen anything different with them they just got some bruises it wasn't nothing major . During an interview on 7/9/2024 at 11:30 AM, Resident #5 stated he [Resident #1] just got mad for no reason he started arguing .he got the chair and he hit me on the knee it was bruised .it didn't have no cut or nothing like that I've been hit worse than that before that wouldn't nothing .oh yeah [feels safe at facility] .oh yeah I'm doing fine . During an interview on 7/10/2024 at 12:45 PM, the Administrator stated .yes they [Resident #4 and Resident #5] got hit . 2. Review of the medical records and facility investigation documentation revealed on 5/17/2024 a resident-to-resident sexual act occurred when Resident #3 was observed performing a sexual act on Resident #2 . Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Dementia, Anxiety, and Mild Cognitive Impairment Unknown Etiology. Review of the admission MDS assessment dated [DATE] revealed Resident #2's BIMS score was 9 indicating the resident had moderate cognitive impairment, A Social Services (SS) BIMS was completed on 5/17/2024 revealing the residents BIMS was 3, indicating the resident had severe cognitive impairment. The resident required assistance of one or more persons with activities of daily living (ADL's). Medical record review of a current care plan for Resident #2 revealed .Resident has Impaired cognition related to difficulty recalling things short and long term secondary to diagnoses of Dementia .Redirect as needed .Date Initiated 05/15/2024 . Review of psychiatric notes for Resident #2 dated 5/21/2024 and 5/28/2024 revealed the resident was involved in a resident-to-resident event no noted psychosocial harm was noted the resident stated he felt safe at the facility and voiced no concerns staff denied any depression, anxiety, mood, or behavior changes. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Dementia, Depression, and Cerebral Ischemic Attack, the resident was discharged to assisted living on 5/20/2024. Continued review revealed Resident #3 had no prior history of sexual behaviors. Review of the admission MDS assessment dated [DATE] revealed Resident #3's BIMS score was 13 indicating the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #3 came from an assisted living facility he is no longer at the facility no prior history of sexual behaviors, Resident #1 was sent out to the hospital and was still in the hospital, care plans were updated and psych was consulted for all residents safeguards were implemented it was immediately reported investigation was conducted and result was reported, all notifications were made. Review of the facility investigation documentation revealed on 5/17/2024 at 5:15 PM, Certified Nurse Assistant (CNA) H and CNA G witnessed Resident #3 in Resident #2's room on the floor on his knees in front of Resident #2 who was seated in his wheelchair. Resident #2's shirt was up, and his shorts were down exposing his penis. Resident #3's hands were on Resident #2's knees. The facility did not verify or refute the allegation. During an interview with Resident #2 on 7/8/2024 at 11:20 AM, in the dining room the resident stated .no I don't have any [concerns] .no I haven't had any problems with nobody [staff or residents] .yes I do feel safe 100% safe .no [no abuse including sexual abuse] I don't remember anything wrong I don't have no problems with nobody . During an interview on 7/8/2024 at 1:50 PM License Practical Nurse (LPN) C stated .I conducted an interview on [Resident #3] his BIM score turned out to be a 13 or 12 and then I asked him about the incident and I let him know right away this was a safe space and we just had questions .he told me I plead the fifth .I told him I have to make sure that you know what is going on as well as [Resident #2] .he said he gave me a look earlier in the day and I just wanted to repay the favor and when I asked him what does that mean and he said I plead the fifth again .he did say he put the cushion in the floor so his knees don't get banged up .I did talk to [Resident #2's] wife .she said she was shocked her husband was a lady's man and he never gave any kind of inclination to that . During an interview on 7/8/2024 at 2:45 PM Registered Nurse (RN) B stated .I did interview [Resident #2] .I asked him how he was doing he said he was doing fine .I asked him if there was anything going on and he acted like he didn't know what I was talking about .I said I think you had a visitor from one of the other residents and he said yes and I said did you invite him in and he said no he just came in and I said so were you talking and he said yeah we were talking .I said did anything else happen and he said no .I talked to him a little bit more and asked him again before I left if he was okay and he said everything was fine .he looked the same he had a smile on his face he was his normal self he wasn't upset in any way or nervous or anything .I went back a little bit later to check on him and to do a BIMS and I think it was about a 3 or a 4 .he was his same self he did not seem upset at all . During a telephone interview on 7/9/2024 at 11:55 AM, CNA G stated .me and [CNA H] were doing our round .it was around 5:00 [5:00 PM] .when we walked up there the door [Resident #2's room door] was closed so she [CNA H] knocked on the door and opened the door the door bumped [Resident #3s] wheelchair .she stuck her head in the room to see what she bumped .she looked back .give me a look and I knew something wasn't right .she asked [Resident #3] did you fall he was on his knees in front of [Resident #2's] wheelchair . and [Resident #2] had his shirt pulled up and his shorts pulled down in the front and had his penis out . [Resident #3] said no I didn't fall .she [CNA H] went to get the nurse and I stayed there with them [Resident #2 and #3] .I don't know if he [Resident #2] understood what was going on .[Resident #3] had a pad in the floor and he had his knees on it when he was in front of the chair .he got the pad and put it back in his chair and got back up in his chair. [Resident #2] still did not pull his pants up or pull his shirt down he just sat there . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/9/2024 at 12:45 PM, CNA H stated .I went to the door and I knocked on the door and I pushed the door open a little bit and when I got through the door [Resident #3] was on his knees on a pad in the floor in front of [Resident #2s] wheelchair with his hands on [Resident #2's] knees and his head was between [Resident #2's legs] and I saw [Resident #2's] privates were pulled out and his t shirt was pulled up .I did not see him doing the physical part .I said are you okay and he [Resident #3] said your rude and I said I'm sorry and I asked him if he fell and he said no and then [Resident #2] kind of laughed he was laughing he wasn't upset at all it was like he thought it was funny .he [Resident #3] did not ever say I was doing this or that and [Resident #2] didn't say anything happened or seemed upset he was just laughing . they were separated I didn't leave them in the room alone .[Resident #2] is just the same person he always has been he's not sad at all .I have him during the day when I work he seems fine and he didn't act like he was upset that [Resident #3] was in there and they were both talking in the hallway just before that happened .I don't know whether [Resident #2] could consent to something like that .based on what I did see there is no doubt what was happening he [Resident #3] was doing the dirty to [Resident #2] he was giving him a blow job he was doing a sexual act with him .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, and interview the facility failed to revise a comprehensive person-centered care plan related to falls for 1 resident (Resident #12) of 16 residents reviewed for comprehensive care plans. The findings include: Review of the facility's undated policy titled, Fall Prevention & Management Program, revealed .When any resident experiences a fall, the facility will .review the resident's care plan and update as indicated . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, revealed, . Care plan interventions are chosen .after data gathering, proper sequencing of events .careful consideration of .resident's problem areas and their causes .interventions address the underlying source(s) of the problem area(s) .not just symptoms or triggers .care plans are revised as .residents conditions change .The interdisciplinary team reviews and updates the care plan .when the desired outcome is not met . Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Need for Assistance with Personal Care, Muscle Weakness, and Dysarthria (difficulty walking). Review of a 5-Day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 had severe cognitive impairment. Review of the facility's documentation for Resident #12 dated 3/18/2024, revealed .Incident location . Reception/Lobby .pt [patient] was discovered in floor by staff .pt wanted to get out of chair but did not ask for assist [assistance] .Action Taken .assisted back into wheelchair .Injuries Observed .Skin Tear .Left elbow . Further review revealed a new fall intervention was not implemented by the facility following Resident #12's fall on 3/18/2024. Review of the facility's documentation for Resident #12 dated 3/24/2024, revealed .Incident Location . Resident's Room .Resident was noted to be in the floor when nurse walked by .Immediate Action Taken . Resident sent to hospital for evaluation .Injuries Observed at Time of Incident .Injury Type .Hematoma .Injury Location .Left eye/eyebrow . Further review revealed a new fall intervention was not implemented by the facility following Resident #12's fall on 3/24/2024. During an interview on 5/8/2024 at 11:47 AM, the MDS Nurse stated she was responsible for updating resident care plans. The MDS Nurse confirmed the comprehensive care plan for Resident #12 was not revised to reflect new fall interventions after the resident fell on [DATE] and 3/24/2024.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, and interview the facility failed to implement new fall interventions for 1 resident (Resident #12) of 4 residents reviewed for falls. The findings include: Review of the facility's policy titled, Accidents and Incidents- Investigating and Reporting, revised 6/2017, revealed .The following data .shall be included on the Report of Incident/Accident form .The disposition of the injured .Any corrective action taken .Follow-up information .Other pertinent data . Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Need for Assistance with Personal Care, Muscle Weakness, and Dysarthria (difficulty walking). Review of a 5-Day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 had severe cognitive impairment. Review of the facility's documentation for Resident #12 dated 3/18/2024, revealed .Incident location . Reception/Lobby .pt [patient] was discovered in floor by staff .pt wanted to get out of chair but did not ask for assist [assistance] .Action Taken .assisted back into wheelchair .Injuries Observed .Skin Tear .Left elbow . Further review revealed a new fall intervention was not implemented for Resident #12's fall on 3/18/2024. Review of the facility's documentation for Resident #12 dated 3/24/2024, revealed .Incident Location . Resident's Room .Resident was noted to be in the floor when nurse walked by .Immediate Action Taken . Resident sent to hospital for evaluation .Injuries Observed at Time of Incident .Injury Type .Hematoma .Injury Location .Left eye/eyebrow . Further review revealed a new fall intervention was not implemented for Resident #12's fall on 3/24/2024. During an interview on 5/8/2024 at 11:47 AM, the Assistant Director of Nursing and MDS Nurse confirmed the facility failed to implement new fall interventions after Resident #12 fell on [DATE] and 3/24/2024.

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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** 40640 Based on facility policy review, medical record review, and interview, the facility failed to ensure 1 resident (Resident #1) of 5 residents reviewed for medication administration was free of a significant medication error after receiving another resident (Resident #2's) prescribed medication which resulted in actual harm to Resident #1. The findings include: Review of the facility's policy titled, Administering Medications, revised 4/2019, revealed .Medications are administered in a safe and timely manner .as prescribed .Medication errors are documented, reported, and reviewed by the QAPI [Quality Assurance Performance Improvement] committee to inform process changes and or need for additional staff training .The individual administering medications verifies the resident's identity before giving the resident his/her medications . Review of the facility's undated policy titled, Medication Error guidelines, revealed .The licensed nurses shall ensure medications will be administered .According to physician's orders . Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Cerebral Palsy, Diabetes Mellitus, Hypertension, Obstructive Sleep Apnea, Other Disorders of the Lungs, Chronic Obstructive Pulmonary Disorder (COPD) and Pickwickian Syndrome (also called obesity hypoventilation syndrome, throws off the balance of oxygen and carbon dioxide in your lungs). Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had moderate cognitive impairment and received antianxiety, antidepressants, diuretic, and opioid medications. Review of a comprehensive care plan dated 11/27/2023, revealed Resident #1 had .risk for adverse side effects related to anti-anxiety medication, ineffective breathing patterns r/t [related to] COPD, OSA [Obstructive Sleep Apnea], and Pickwickian Syndrome-she is dependent on CPAP [Continuous Positive Airway Pressure/a machine to keep breathing airways open while asleep] at HS [night] .chronic pain d/t [due to] osteoarthritis, cerebral palsy, thoracic spondylosis [the natural wearing down in the mid-back] . Review of the Physician's Orders for Resident #1 dated 4/2024, revealed Resident #1 had the following orders: oxygen 2-4 liters via (by) nasal cannula, Hydrocodone-Acetaminophen tablet (medication used to treat pain) 5-325 milligram (mg) every 6 hours, and Lorazepam (medication used to treat anxiety) 0.5 mg as needed. Further review revealed the resident had a physician's order to wear the CPAP device at night. The nurse was to assist the resident in placing the CPAP device on . Review of the Nurse's Note for Resident #1 dated 4/6/2024, revealed .[Resident #1] was given wrong medication buprenorphine 8-2mg [buprenorphine 8mg-a medication used to opioid use disorder and naloxone 2 mg-an opioid antagonist to treat opioid overdose] .Resident was lethargic .V/S [vital signs] decreased .Resident [Resident #1] became responsive and refused to go to ER [emergency room]. Resident was sent to ED [Emergency Department] for Eval [Evaluation]. Resident family and medical director notified of incident . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Rheumatoid Arthritis, Osteoporosis, Crohn's Disease, and Opioid Dependence. Review of a quarterly MDS assessment dated [DATE], revealed Resident #2 was cognitively intact, received antianxiety, antidepressant, and opioid medications. Review of the comprehensive care plan dated 4/1/2024, revealed Resident #2 .received Suboxone for opioid abuse treatment, at risk for adverse side effects .administer medications as ordered .has chronic pain r/t rheumatoid arthritis and osteoporosis . Review of the Physician's Orders for Resident #2 dated 4/2024, revealed Narcan Nasal Liquid (medication used to treat narcotic overdose) 4 MG/0.1ML (milliliter) and Buprenorphine HCl (hydrochloride)-Naloxone HCl (Suboxone) Sublingual (under the tongue) Tablet 8-2 MG (buprenorphine 8mg-a medication used to opioid use disorder and naloxone 2 mg-an opioid antagonist to treat opioid overdose). Review of the Individual Resident's Controlled Substance Record for Resident #2 dated 4/6/2024 at 6:00 AM, revealed .med [medication] error . Review of the emergency room documentation for Resident #1 dated 4/6/2024, revealed the resident presented with altered mental status after receiving another resident's medications (Resident #2's). The resident was believed to have received Suboxone.She received Narcan . no change [in condition] .hypoxic [low oxygen] requiring a non-rebreather [mask] .rhonchi [movement of fluids and secretions in larger airways in asthma and respiratory infections] .hypercarbia [an increase in carbon dioxide in the blood stream] .CPAP was not on last night . Review of a Medication Error Incident/Investigation report for Resident #1 dated 4/6/2024, revealed the time of the incident 5:00 AM-5:45 AM, .Nurse supervisor [Registered Nurse/RN B] was advised by agency nurse [Licensed Practical Nurse /LPN A] she gave [Resident #1] .suboxone 8-2ml [milliliter] that was intended for [Resident #2] . Review of the hospital documentation for Resident #1 dated 4/6/2024-4/19/2024 revealed during the course of the hospital stay the resident was admitted to the hospital with hypercarbic respiratory failure and was intubated after arrival on 4/6/2024. A hospital ICU stay from 4/6/2024-4/19/2024 occurred and the patient was discharged on [DATE] to a higher level of care. During an interview on 5/6/2024 at 10:10 AM, Resident #2 stated an agency nurse (unable to recall the nurse's name) handed her a cup of medications and Resident #2 informed the nurse the medication was not her medication and told the nurse .go get me my .suboxone . Resident #2 stated she knew it was not suboxone because suboxone was a strip that goes under the tongue and the medication given to her was pills. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 5/8/2024 at 8:38 AM, LPN A stated she was able to recall the medication error regarding Resident #1 which occurred on 4/6/2024. LPN A stated Resident #1 and Resident #2's names were similar, the rooms were close together, and thought this was the reason she made the error. LPN A stated Resident #1 was awake until 4:00 AM and had refused to wear her (Resident #1) CPAP and at 6:00 AM the nurse went in and administered Resident #1 her medication wrong medication). LPN A stated she went into Resident #2's room to administer medications and resident [#2] refused the medications and stated those medications did not belong to her (Resident #2). LPN A stated she went to assess Resident #1, took the resident's blood pressure, attempted to arouse the resident, and notified the RN Supervisor of the medication error. The RN supervisor and LPN A notified EMS (Emergency Medical Service), physician, and the Resident #1's family of the medication error. LPN A stated she cooperated with the facility staff to investigate the medication error and had not been reassigned to the facility. During an interview on 5/9/2024 at 1:50 PM, the Director of Nursing confirmed LPN A had not followed the five rights of medication administration and Resident #1 received the wrong medication which belonged to Resident #2 on 4/6/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Post-Acute and Rehabilitation Center	2035 Stonebrook Place Kingsport, TN 37660

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, and interviews the facility failed to ensure the medical record was accurate and complete for 4 residents (Resident #7, #17, #3, and #12) of 8 residents reviewed for blood glucose monitoring and insulin administration. The findings include: Review of the facility's policy titled, Guidelines for Charting and Documentation, dated 4/2012, revealed .the purpose of charting and documentation is to provide .complete account of the resident's care .response to care .be concise .accurate .and complete .do not leave blank lines . Review of the facility's policy titled, Administering Medications, dated 4/2019, revealed .the individual administering the medication initials [documents administration] the resident's MAR [Medication Administration Record] .after giving each medication . Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, and Bipolar Disorder. Review of the Physician's Orders for Resident #7 dated 11/2023, revealed . Novolin R [fast-acting insulin] Injection Solution 100 UNIT/ML [milliliter] .if [blood sugar level] 151 - 200 = 2 units .201 - 250 = 4 units .251 - 300 = 6 units .301 - 350 = 8 units .351 - 400 = 10 units .before meals and at bedtime . Review of the MAR for Resident #7 dated 4/2024, revealed the Novolin R insulin administration and the blood sugar check had a missed entry on 11/15/2023 at 8:00 AM. Review of a 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 was cognitively intact and had an active diagnosis of Diabetes. Further review revealed the resident received insulin. Review of a comprehensive care plan dated 4/23/2024, revealed Resident #7 .has Diabetes .Diabetes medication as ordered .Blood Sugar as ordered by doctor . During an interview on 5/9/2024 at 10:45 AM, Registered Nurse (RN) Supervisor A stated she was assigned to Resident #7 on 11/15/2023 (shift and date of the missed entry). RN Supervisor A stated she omitted the documentation of Resident #7's blood sugar level and/or insulin administration on the MAR by accident but followed the physician's orders. RN Supervisor A stated after she conducted the blood sugar check, if insulin was indicated she administered it per physician's orders. RN Supervisor A stated she was aware of the requirement to document blood sugar checks and insulin administration on Resident #7 ' s MAR. RN Supervisor A stated she failed to ensure the information was recorded appropriately in the documentation system. Medical record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Diabetes, Morbid Obesity, and Hypertension. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #17 dated 11/2023, revealed .NovoLog [fast acting insulin] .if [blood sugar level] 151 - 200 = 2 units .201 - 250 = 5 units .251 - 300 = 7 units .301 - 350 = 10 units .351 - 400 = 12 unit .Notify provider id [if] BS [blood sugar] over 400 . Review of the MAR for Resident #17 dated 11/2023, revealed the Novolog insulin administration and the blood sugar check had a missed entry on 11/13/2023 at 4:30 PM. Review of a quarterly MDS assessment dated [DATE], revealed Resident #17 had severe cognitive impairment and had an active diagnosis of Diabetes. Further review revealed the resident received insulin. Review of a comprehensive care plan dated 4/3/2024, revealed Resident #17 .has DM [Diabetes Mellitus] . Accuchecks [blood sugar checks] as ordered by doctor .Administer medication as ordered by doctor . Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Chronic Myeloid Leukemia, Diabetes, and Chronic Kidney Disease. Review of the Physician's Orders for Resident #3 dated 11/2023, revealed .Humalog [fast-acting insulin] .if [blood sugar level] 151 - 200 = 2 units .201 - 250 = 4 units .251 - 300 = 6 units .301 - 350 = 8 units .351 - 400 = 10 units .401 - 999 = 15 units .Notify provider id [if] BS over 400 . Review of the MAR for Resident #3 dated 11/2023, revealed the Humalog insulin administration and the blood sugar check had multiple missed entries on 11/13/2023 at 5:00 PM, 11/16/2023 at 5:00 PM, and 11/17/2023 at 5:00 PM. Review of an admission MDS assessment dated [DATE], revealed Resident #3 was cognitively intact and had an active diagnosis of Diabetes. Further review revealed the resident received insulin. Review of a comprehensive care plan dated 11/17/2023, revealed Resident #3 .Diabetes .blood sugar as ordered .diabetes medication as ordered . During an interview on 5/8/2024 at 3:45 PM, RN Supervisor A stated she was assigned to Resident #3 on 11/13/2023, 11/16/2023, and 11/17/2023 (shift and days of missed entries). RN Supervisor A stated she failed to document Resident #3's blood sugar levels and/or insulin administration on Resident #12 ' s MAR by accident but followed the physician's orders. RN Supervisor A stated after she conducted the blood sugar check, if insulin was indicated she administered it per physician's orders. RN Supervisor A stated she was aware of the requirement to document blood sugar checks and insulin administration on Resident #3 ' s MAR. RN Supervisor A failed to ensure the information was recorded appropriately in the documentation system. Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Need for Assistance with Personal Care, Dysarthria (difficulty walking), and Diabetes. Review of a comprehensive care plan dated 2/22/2024, revealed Resident #12 .has Diabetes .blood sugar as ordered . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 5-Day MDS assessment dated [DATE], revealed Resident #12 had severe cognitive impairment and had an active diagnosis of Diabetes. Further review revealed the resident received insulin. Review of the Physician's Orders for Resident #12 dated 4/2024, revealed .Insulin Lispro .if [blood sugar level] 151 - 200 = 2 units .201 - 250 = 5 units .251 - 300 = 7 units .301 - 350 = 10 units .351 - 400 = 12 units . Review of the MAR for Resident #12 dated 4/2024, revealed Insulin Lispro administration with a blood sugar check had multiple missed entries on 4/19/2024 at 9:00 PM, 4/24/2024 at 9:00 PM, 4/27/2024 at 9:00 PM, 4/28/2024 at 9:00 PM, 4/29/2024 at 4:30 PM, and 4/29/2024 at 9:00 PM. Review of the MAR for Resident #12 dated 5/2024, revealed Insulin Lispro administration with the blood sugar check had a missed entry on 5/3/2024 at 9:00 PM. During an interview on 5/9/2024 at 8:01 AM, Family Nurse Practitioner (FNP) A stated she had not observed any missed documentation on the MARs but stated the omissions were an oversight regarding documentation. FNP A stated there had been no adverse resident outcomes from the omissions on the MARs and had no concerns with Diabetes management at the facility. During a telephone interview on 5/9/2024 at 8:42 AM, FNP B stated the facility notified her of any abnormal blood sugar values to include high and low readings and had not noticed any missed entries on the MARs. FNP B stated any missed entries on the MARs are related to the failure to ensure documentation is complete and accurate. FNP B stated the facility conducted blood sugar readings and administered insulin appropriately. FNP B stated there had been no adverse resident outcomes from the omissions on the MARs and had no concerns with Diabetes management at the facility. During an interview on 5/9/2024 at 9:47 AM, RN Account Manager for the pharmacy stated she visited the facility monthly and as needed to complete medication administration observations. RN Account Manager stated the omissions observed on the MAR is related to a documentation issue. During a telephone interview on 5/9/2024 at 10:08 AM, Licensed Practical Nurse (LPN) B stated she was assigned to Resident #12 on 4/27/2024 and 4/28/2024 (the shift and dates of missed entries). LPN B stated she omitted the documentation of Resident #12's blood sugar levels and/or insulin administration on the MAR as an oversight but followed the physician's orders. LPN B stated after she conducted the blood sugar check, if insulin was indicated she administered it per physician's orders. LPN B stated she was aware of the requirement to document blood sugar checks and insulin administration on the MAR, but failed to ensure the information was recorded appropriately in the documentation system. During a telephone interview on 5/9/2024 at 10:12 AM, LPN E stated she was assigned to Resident #12 on 4/19/2024, 4/24/2024, and 5/3/2024 (the shift and dates of the missed entries). LPN E stated she omitted the documentation of Resident #12's blood sugar levels and/or insulin administration on the MAR but followed the physician's orders. LPN E stated after she conducted the blood sugar checks and if insulin was indicated she administered it per physician's orders. LPN E stated she was aware of the requirement to document blood sugar checks and insulin administration on Resident #12 ' s MAR. LPN E stated she failed to ensure the information was recorded appropriately in the documentation system for Resident #12. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/9/2024 at 10:16 AM, LPN C stated she was assigned to Resident #12 on 4/29/2024 (the shift and date of the missed entry). LPN C stated she omitted the documentation of Resident #12's blood sugar levels and/or insulin administration on the MAR but followed the physician's orders. LPN C stated after she conducted the blood sugar check, if insulin was indicated she administered it per physician's orders. LPN C stated she was aware of the requirement to document blood sugar checks and insulin administration on the MAR for Resident #12. During a telephone interview on 5/9/2024 at 10:33 AM, the Pharmacy Consultant stated during his monthly regimen reviews for the residents, he had not identified any concerns with insulin administration. During an interview on 5/9/2024 at 12:25 PM, the Medical Director stated the omissions (related to insulin administration and blood sugar checks) observed for Residents #7, #17, #3, and #12 were related to incomplete documentation on the residents ' MAR. During an interview on 5/9/2024 at 1:40 PM, the Director of Nursing (DON) confirmed the medical records for Residents #7, #17, #3, and #12 were not considered complete or accurate when the blood glucose levels, and insulin administration were not documented appropriately (omitted) on the MAR.