STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Village Care	136 Davis Lane Lafollette, TN 37766

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50407 Based on facility policy review, medical record review and interviews, the facility failed to ensure physician orders were followed for 1 resident (Resident #3) of 5 residents reviewed for elevated fingerstick blood sugar (BS) levels. The findings include: Review of the facility policy titled, Procedure: Fingerstick Glucose Measurement, revised 6/15/2022, revealed .Report .test results to the physician/advanced practice provider .Document .notification and response . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Cerebral Infarction, Hypertension, Diabetes Type 2, Epilepsy, and Non-compliance with Medical Treatment. Review of a Physician's Order for Resident #3 dated 8/21/2024, revealed to administer Humalog (injectable insulin medication used to treat Diabetes) before meals and at bedtime per the sliding scale. Further review revealed for fingerstick BS levels above 401, administer 12 units of Humalog and notify a medical provider. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 13 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. Further review revealed the resident received 3 days of insulin injections when reviewing the past 7 days since readmission. Review of the Medication Administration Record (MAR) for Resident #3 revealed the resident had an elevated BS above 401 on the following days: 9/22/2024 - BS level 410, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. 9/28/2024 - BS level 425, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. 10/2/2024 - BS level 453, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/6/2024 - BS level 402, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. 10/12/2024 - BS level 411, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. 10/13/2024 - BS level 417, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. 10/20/2024 - BS level 435, treated with 12 units of fast acting insulin; further review revealed no documentation the doctor had been notified of the elevated BS. During interview on 10/23/2024 at 11:19 AM, Nurse Practitioner (NP) A and NP B stated it was the expectation for nurses to notify the provider when a resident had a BS level above 401, to determine if additional insulin coverage was needed based on Resident #3's condition and diet for the day. NP A and NP B could not recall being notified of an elevated fingerstick BS level above 401 for Resident #3 on the following dates: 9/22/2024, 9/28/2024, 10/2/2024, 10/6/2024, 10/12/2024, 10/13/2024 and 10/20/2024. NP A and NP B stated Resident #3 frequently refused BS fingersticks and long-acting insulin which contributed to the elevated BS levels. During an interview on 10/23/2024 at 2:30 PM, the Director of Nursing (DON) stated it was the expectation of the facility for nurses to follow physician orders for elevated fingerstick BS levels above 401. Continued interview revealed there was no documentation a medical provider was notified of elevated fingerstick BS levels above 401 for Resident #3 on dates on 9/22/2024, 9/28/2024, 10/2/2024, 10/6/2024, 10/12/2024, 10/13/2024 and 10/20/2024. The DON confirmed the facility failed to follow a physician's order when the provider was not notified of Resident #3's elevated fingerstick BS levels.