STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555247	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Mirage Health and Rehabilitation Center	39950 Vista Del Sol Rancho Mirage, CA 92270

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on interview and record review, the facility failed to ensure the correct insulin (medication use to lower blood sugar levels) dose was administered as prescribed by the physician, for one of three residents (Resident 3). This failure has the potential risk of dangerously low blood sugar level for Resident 3, leading to harm and or death. Findings: On [DATE] at 9:30 a.m., an unannounced visit to the facility was conducted to investigate quality care issues. A review of Resident 3's ADMISSION RECORD, indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar levels). A review of Resident 3's Minimum data Set (an assessment tool), dated [DATE], indicated a Brief Interview for Mental Status (brief cognitive screening measure that focused on orientation and short-term word recall) score of 14 (intact cognition). A review of Resident 3's Order Summary Report, dated [DATE], indicated, .Lantus (a type of Insulin) Subcutaneous (beneath or under, all the layers of the skin) Solution .Inject 10 unit (sic) (unit of measurement) subcutaneously at bedtime . A review of Resident 3's Medication Administration Note, dated February 26, 2024, at 8:00 p.m., indicated, . Realized I had administered the wrong dose of 100u (units) of Lantus into her left arm . A review of Resident 3's eINTERACT Change in Condition Evaluation, dated February 26, 2024, at 8:41 p.m. , indicated, .Wrong dosage of insulin Lantus was given. 100 units .pt (patient) sent to Hospital . Recommendation of Primary Clinician .he ordered to transfer pt to the hospital . A review of Resident 3's Post-Event Review, dated February 27, 2024, at 1:47 p.m., indicated, . IDT (Interdisciplinary Team - team members from different discipline working collaboratively) Review .the IDT met to review the reported incidents of the incorrect dose of insulin that was administered to resident . License nurse .inadvertently administered the incorrect dose of Lantus . (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], at 11:53 a.m., during a concurrent interview and review of Resident 3's Progress Notes, with Licensed Vocational Nurse (LVN) 2, she stated, Resident 3 was transferred to the hospital on February 26, 2024 for blood sugar monitoring. LVN 2 further stated, on February 26, 2024, at 8 p.m. LVN 3 administered the wrong dose of Lantus, 100 units compared to physician order of Lantus 10 units. LVN 2 stated, Lantus 100 units is questionable, uncommon, and a very high dose. LVN 2 further stated, LVN 3 should have cross checked the dose with the physician order and or another nurse to make sure the dosage was correct before administering to Resident 3. LVN 2 stated, if the wrong dose of insulin was administered, Resident 3's blood sugar levels could drop and Resident 3 could be unresponsive and die. On [DATE], at 1:18 p.m., during an interview with the Director of Nursing (DON), she stated, Resident 3 was transferred to the hospital on February 26, 2024, on the evening shift due to LVN 3 administered the incorrect dose of insulin. The DON further stated, LVN 3 administered Lantus 100 units instead of 10 units as ordered by the physician. The DON stated, for any unusually high doses of insulin, the licensed nurse should have questioned the dose. The DON stated, Lantus 100 units was an unusually very high dose and LVN 3 should have cross-checked with another nurse. The DON stated, the licensed nurse should have double or triple check the physician order and the MAR for correct dose before administering the insulin to Resident 3. The DON further stated, due to incorrect insulin dosage, Resident 3 could have become hypoglycemic (low blood sugar level) and died . A review of the facility policy and procedure titled, Administering Medications indicated, .Medications shall be administered in a safe and timely manner and as prescribed .Medication must be administered in accordance with the orders .The individual administering the medication must check .to verify the right resident .right medication .right dosage .before giving the medication . A review of the facility policy and procedure titled, Subcutaneous Injections indicated, .The purpose of this procedure is to provide guideline for the administration of subcutaneous injection .Verify .Physician medication order .Verify dose .