STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	06/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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** 41093 44637 Based on observation, interview, and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 5 (Resident #1) residents reviewed for medication errors. The facility failed to ensure on 6/2/24 Resident #1 received 55 units of Lantus (long-acting insulin for diabetes) as ordered and instead was administered 55 units of Humalog (short-acting insulin for diabetes). The noncompliance was identified as PNC. The noncompliance began on 6/2/24 and ended on 6/3/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for receiving the incorrect medication and dosage resulting in adverse reactions. Findings Include: Record review of the face sheet dated 6/5/24 indicated Resident #1 was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including diabetes, aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language), stroke, hypertension (elevated blood pressure), and COPD. Record review of Resident #1 active physician order summary dated 6/2/24 indicated Resident #1 was to be administered Novolog (short-acting insulin for diabetes) 100 UNIT/ML as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 -400 = 10 units; 401+ = 10 units and call the physician, subcutaneously (Subcutaneous administration is the insertion of medications beneath the skin either by injection or infusion) before meals and at bedtime. Record review of Resident #1 active physician order summary dated 6/2/24 indicated Resident #1was to be administered Lantus (long-acting insulin) 55 units subcutaneously at bedtime. (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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(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	Record review of the physician orders dated 6/5/24 indicated Resident #1 had an order for Lantus 55 units at bedtime for diabetes, Lantus 60 units in the morning for diabetes, and Novolog (short-acting insulin for diabetes) 100 UNIT/ML as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 -400 = 10 units; 401+ = 10 units and call the physician. Record review of the MDS assessment dated [DATE] indicated Resident #1 had unclear speech, was usually understood by others, and usually understood others. The MDS indicated Resident #1 had a BIMS of 08 and was moderately cognitively impaired. The MDS indicated Resident #1 had received insulin injections 7 out of 7 days in the 7-day look back. Record review of the care plan last revised 2/6/24 indicated Resident #1 was at risk for unstable blood sugar readings related to diabetes with interventions including administer diabetes medication as ordered by doctor and monitor/document for side effects and effectiveness. Record review of the nurse progress note dated 6/2/24 at 11:42 p.m. indicated at 8:20 p.m. Resident #1's blood sugar was 336 (normal range 70-100) at this time. Interchangeable formula Humalog 55 units was given mistakenly instead of the ordered Lantus 55 units . The physician was immediately notified of error, new orders to send to the emergency room for glucose monitoring and notify DON. The progress note indicated 911 was notified. The progress note indicated Resident #1 remained with nurse and was monitored closely until emergency medical services arrived. The progress noted indicated Resident #1's blood sugar results were as follows: 8:25 p.m.-349 8:35 p.m.- 310 8:45 p.m.- 319 8:55 p.m.- 305 The progress note indicated Resident #1 asked for snack from snack tray which was provided to her by the nurse. Record review of the hospital records dated 6/3/24 indicated Resident #1 presented to the emergency department on 6/2/24 due to accidental insulin overdose. The hospital records indicated the emergency department workup glucose results were 265. The hospital records indicated Resident #1 was treated with glucagon (medication to treat severe low blood sugar) and D5 1/2NS (5% dextrose (glucose) in half normal saline (often used to treat diabetic patients for a patient whose blood glucose less than 250)). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Med Error report dated 6/3/24 indicated on 6/2/24 at 8:20 p.m. LVN A drew up short-acting insulin (Humalog) 55 units and administered to Resident #1. The Med Error report indicated Resident #1's order was for 55 units of Lantus (long-acting insulin). The Med Error report indicated the error was discovered by LVN A. The Med Error report indicated LVN A realized after she gave the injection of insulin she had mistakenly given the wrong insulin. The Med Error Report indicated LVN A immediately called the physician and was given an order to send Resident #1 to the ER and to call the DON. The Med Error Report indicated LVN A said she got distracted due to Resident #1 joking with her and picked up the vial of Humalog instead of Lantus, drew up 55 units, and administered it. The Med Error Report indicated Resident #1 was sent to the ER for glucose monitoring. The Med Error Report indicated LVN A was immediately in-serviced regarding the 5 Right of Medication Administration. The Med Error Report indicated a portion of the med pass will be monitored 5 times a week to ensure all nurses and MAs are following the medication administration policy. During an interview on 6/5/24 at 10:55 a.m. Resident #1 was noted to be non-verbal but able to answer yes and no questions by nodding or shaking her head. Resident #1 indicated by nodding she knew the reason she was sent to the hospital. Resident #1 indicated by shaking her head she was not shaky, sweating, or felt bad in any way after she had been administered 55 units of short-acting insulin. During an observation and interview on 6/5/24 at 11:16 a.m. the DON performed finger stick blood sugar sample and insulin administration on Resident #1. The DON explained procedure to the resident, disinfected equipment prior to use, and performed proper hand hygiene. Resident #1's blood sugar was 237. DON administered per the physician order 4 units of Novolog per sliding scale. The DON said LVN A said she could not find Resident #1's Novolog on 6/2/24 when administering insulin and that was why she administered Humalog. The DON said when she arrived at the facility the morning of 6/3/24 at 7:30 a.m. Resident #1's Novolog was in the nursing cart. The DON said she had to work the floor as a charge nurse this week due to another nurse having a family emergency. The DON said she did not know where the LVN A obtained the Humalog she used for Resident #1's insulin injection. During an interview on 6/5/24 at 1:54 p.m. The physician said he was notified of the incident with Resident #1 receiving 55 units of short-acting insulin instead of 55 units of long-acting insulin. The Physician said he gave an order to have Resident #1 sent to the emergency department for evaluation. The physician said if a resident had a blood sugar of 300 and they were administered 10 units of short-acting insulin within an hour or two the blood sugar normally would come down to the 100s. The physician said he had never had a resident receive 55 units of short-acting insulin by mistake. The physician said receiving 55 units of short-acting insulin with a blood sugar in the 300s could possibly drop the blood sugar into the double digits as low as the 30s or 40s. The physician said he wanted Resident #1 sent out to the emergency department for evaluation due to her being non-verbal and was worried if she had an adverse reaction, she would not be able to verbally call out for help. During an interview on 6/6/24 at 8:56 a.m. LVN C was able to name the 5 rights of medication administration. LVN C said if the wrong dose of medication was administered the resident should be assessed and notification made to the physician and DON. LVN C said that if a medication needed to be interchanged the physician should be notified prior to doing so and a verbal order should be written after speaking with the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/24 at 9:10 a.m. LVN B was able to name the 5 rights of medication administration. LVN B said if a resident received the wrong dose of medication, she would notify the physician immediately. LVN B said if a medication needed to be interchanged, she would notify the physician to verify interchanging the medication was acceptable, write the verbal order to interchange the medication, and discontinue the previous order. During an interview on 6/6/24 at 9:16 a.m. the ADON was able to name the 5 rights of medication administration. The ADON said if a resident received the wrong dose of medication, she would notify the physician immediately. The ADON said if a medication needed to be interchanged, she would notify the physician to verify interchanging the medication was acceptable, write the verbal order to interchange the medication, and notify the family and DON. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 6/22/24 at 9:16 a.m., she said Resident #1 was to receive both 55 units of Lantus and her sliding scale dose of Novolog. LVN A said she could not recall what the dose of the Novolog was to be and would have to check the order. LVN A explained the sliding scale is based on whatever the resident's FSBS (fingerstick blood sugar) result was. She said the number of units of the NovoLog the resident receives is determined by the FSBS result. LVN A said she had performed the FSBS and Resident #1's blood sugar was three hundred something. LVN A said she could not recall the exact FSBS result. LVN A said because the blood sugar was over 300 she knew Resident #1 would receive Novolog and her Lantus. LVN A said she saw the vial of Lantus on the cart but could not fine the Novolog. LVN A said she went to the fridge in the med room to see if there was any Novolog insulin for Resident #1. LVN A said there was not Novolog but was Humalog. She explained the Novolog and Humalog were interchangeable. She said the vial of Humalog was unopened and unlabeled. LVN A said she remembered thinking it was lucky the Humalog was there and she did not have to get into the EKIT to pull it. LVN A said she labeled the bottle with the date and Resident #1's name and returned to the cart. LVN A said while she was preparing to administer Resident #1's Lantus of 55 units the Resident was cutting up with her. LVN A said she drew up 55 units and administered the medication to Resident #1. LVN A said when she returned to her cart and had both the vial of the Lantus and the vial of the Humalog sitting out. LVN A said she was terrified she had given 55 units of the Humalog instead of the 55 units of Lantus she intended to give. LVN A said she could not say for sure she had actually administered 55 units of Humalog instead of the intended 55 units of Lantus but because both vials were out she could not be sure and immediately called the physician and called 911. LVN A said she then checked blood sugars on Resident #1 every 10 minutes until EMS arrived. LVN A said she was in-serviced over the five medication rights. LVN A said she had been back to work and was observed checking FSBS and administering insulin as ordered by the DON and ADON. LVN A said she was also in-serviced over substituting the Humalog for the Novolog. LVN A said if we can't find the medication and need to substitute or insurance changes and it needs to be changed and we do not yet have the new insulin from the pharmacy, we are to first call the physician and obtain and order and put that order into the EMR system so the medication cand be checked against the MAR before administration. LVN A said she had not given the additional insulin based on the sliding scale because she was scared she had administered 55 units of Humalog instead of the intended 55 units of Lantus. LVN A said she could not recall what Resident #1's FSBS was on the evening of 6/2/24. LVN A said regarding her witness statement stating Resident #1 was to receive 11 units of Novolog - she was just very upset and probably wrote it down done wrong. LVN A said she was crying and shaking as she wrote the witness statement because she was so upset. Resident #1 said she would administer sliding scale based of the physician order. LVN A said she felt she made the error because she had both vials out to Resident #1 distracted her as she picked up the vial and drew up the medication. LVN A said going forward and based on in-service- she will pull and administer 1 type of insulin at a time. LVN A said she will also always have another nurse come check her cart to see if they (the other nurse) sees the resident's medication on the cart before calling the physician for an interchange order. LVN A said she had heard that Resident #1 's Novolog pen was on the med cart the whole time and she just overlooked it. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 6/21/24 at 2:50 p.m., she said with each FSBS (Finger Stick Blood Sampling) Skills Check Lists dated 6/3/24 through 6/5/24 the nurse was observed not only checking the FSBS of the resident but administering insulin as ordered. It was ensured the nurse upon taking the FSBS checked the MAR verified the 5 rights with the administration of the insulin. The DON said we (DON and ADON) continued those checks and until all nurses were checked off/ observed on FSBS and insulin administration before they could return to work on the floor - including LVN A who was observed on 2 occasions. The DON said no issues were observed with the checks. The DON said she felt her nurses were high alert since incident and were being extra careful to check and double check their five rights of medication administration. The DON said that the medication carts with insulin and the fridge in the med room were the E-kit is kept has been checked daily since the incident to ensure that ordered insulins are present, within date and are labeled. The DON said Resident #1's Novolog pen was found on the nurse med cart and believed LVN A had overlooked the pen. The DON said the checks also found the vial of Humalog that had been labeled with Resident #1's name and dated 6/2/24. The DON said that medication was destroyed per protocol as the ordered pen was on the cart and medication interchange was not needed. The DON said the cart/ fridge checks would continue for 3 additional weeks if no issues were identified. The DON said she and the ADON will continue to monitor nurses randomly three times per week to ensure continued adherence to the careful check of medication five rights with inulin administration. The DON said these checks would continue for 2 months. The DON said in addition to the spot checks specific to insulin the facility was performing Med error monitoring in which herself or the ADON watched the nurse perform med pass for a resident at random. The DON said this was done daily and was done to ensure nurses were following medication five rights and ensure no errors were made. The DON said they were also questioning nurses regarding what to do if med interchange was needed during these observations to ensure understanding with the previous in-services. The DON said these observations would continue another 2 weeks for a total of 5 weeks as that was the plan determined during the ADHOC QAPI meeting, as long as no issues were identified. The DON said if issues were identified the checks would go beyond 5 weeks and would discussed in QAPI. Record review of the facility's Medication Administration Procedures revised 10/25/17 indicated, .All current medications and dosage schedules are to be listed on the resident's current medication administration record . A specific order must be obtained by the physician to change the dosage form of a resident's medication. Medication errors and adverse drug reactions are immediately reported to the resident's physician. In addition, the Director of Nurses and/or designee should be notified. Any medication error will require a medication error report that includes the error and action to prevent reoccurrence .The 10 rights of medication should always be adhered to: 1. Right patient 2. Right medication 3. Right dose 4. Right route 5. Right time 6. Right patient education 7. Right documentation 8. Right to refuse 9. Right assessment 10. Right evaluation. The facility had corrected the noncompliance by the following: Suspending LVN A Notification to the physician In-servicing nurses regarding medication rights and interchanging medication Ensuring all nurses were up to date on their finger stick blood sampling check offs. The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Employee Disciplinary Report indicated LVN A was placed on unpaid investigatory suspension following the incident of administering Resident #1 55 units of fast acting insulin instead of 55 units of long-acting insulin. Record review of a Coaching Form dated 6/3/24 indicated LVN A received education regarding the 5 Rights of Medication Administration (Right Patient, Right Time, Right Dose, Right Route, Right Drug) including verify medication label with MAR prior to administration, verify interchange in medication with the physician, and write a clarification order prior to interchanging the medication. Record review of an in-service dated 6/3/24 indicated nurses were in-serviced regarding the 5 Right of Mediation Administration. Record review of an in-service dated 6/3/24 indicated nurses were in-serviced regarding interchanging medication. Record review of Finger Stick Blood Sampling Skills Check Lists dated 6/3/24 through 6/5/24 indicated LVN B; the DON; LVN C; LVN D; LVN E; the ADON; LVN F; and LVN G had been successfully checked off on Finger Stick Blood Sampling and insulin administration. Staff interviewed (LVN B, LVN C, and the ADON) on 6/6/24 between 8:56 a.m. and 9:16 a.m. were able to answer questions re: trainings/in-services. Record review of the FSBS (Finger Stick Blood Sampling) Skills Check Lists dated 6/4/24 indicated LVN A had been checked off/ observed performing FSBS and administering ordered insulin by the ADON. Record review of the nurse proficiency check sheet dated 6/4/24 indicated LVN A had been checked off/ observed performing FSBS and insulin administration. Record review of medication error monitoring document with a start date of 6/3/24 indicated the DON or designee had observed apportion of medication pass with varying nurses from 6/3/24 to 6/21/24. Record review of the Medication Cart/Fridge log with a start date of 6/3/24 indicated the DON or designee had checked the nursing carts with insulin and the fridge to ensure all insulin on the carts and in the fridge matched current orders for each resident on insulin daily from 6/3/24 to 6/21/24. Record review of Resident order listing for residents on insulin/antidiabetics dated 6/21/24 and the CMS 802 provided on 6/21/24 found the facility had 6 total residents receiving insulin therapy. During observations on 6/22/24 from 6:20 a.m. to 11:30 a.m., LVN C and LVN F (these were the only nurses working the floor on 6/22/24) were observed during FSBS checks and insulin administration to 5 residents (the 6th resident did not have any insulin orders until bedtime). Of the five residents observed three of residents had orders for Lantus and a short acting sliding scale insulin (including Resident #1). No concerns were identified during these observations. During these observations the Investigator checked both nursing medication carts (the carts that contain insulin). There was no unlabeled insulin, there was no out of date insulin, all insulin on the carts matched the orders for the six residents receiving insulin in the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation 6/22/24 at 11:37 a.m., the medication refrigerator was observed with the ADON. There were no unmarked, unlabeled vials or pens of insulin in the fridge outside of the EKIT (emergency kit). The insulin in the fridge matched the orders for the six residents in the facility that received insulin. The EKIT (emergency kit) box was locked and dates for insulin within the EKIT were visible. No issues were identified with the observation. The noncompliance was identified as PNC. The noncompliance began on 6/2/24 and ended on 6/3/24. The facility had corrected the noncompliance before the survey began.