STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675894	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Conroe	1600 Grand Lake Dr Conroe, TX 77301

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on interview and record review, the facility failed to ensure 1 resident (CR#1) of 8 residents reviewed for medication administration were free of significant medication errors. -CR#1 was transferred to the hospital due to concerns of hyperglycemia (high blood sugar), and when he arrived at the hospital his blood sugar (the amount of glucose in the blood) was over 600, when the normal range should be 70-130. There was an omission of insulin injections to treat diabetes from 08/20/2024-08/24/2024, and the first dosage was given on 08/25/2024 the same day CR#1 discharged to the hospital. CR #1 was hospitalized from 08/25/24 - 08/29/24 with Diabetic Ketoacidosis (DKA a potentially life-threatening complication of diabetes that occurs when the body doesn't have enough insulin) and was admitted to the Intensive Care Unit (ICU). The noncompliance was identified as Past Non-Compliant. The IJ (Immediate Jeopardy) began on 08/20/2024 and ended on 08/30/2024. The facility corrected the noncompliance prior to entrance. The failure placed the residents receiving insulin to treat diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired) at higher risk for hospitalization to treat hyperglycemia and DKA. Findings included: Record review of CR#1 preadmission assessment dated [DATE] reflected an active diagnosis of type 2 diabetes mellitus. Record review of the Facesheet for CR#1 dated 08/20/2024 revealed he was an [AGE] years old male that admitted to the facility on [DATE], with a primary diagnosis of Metabolic Encephalopathy (a brain disorder due to an underlying condition caused by a chemical imbalance in the blood), and secondary diagnosis of type 2 diabetes mellitus. CR#1 discharged to a local hospital on 08/25/2024, due to evaluated blood sugar. Record review of CR#1's Interim Plan of care dated 08/20/2024 revealed a focus of Diabetic Alert, with a goal to manage symptoms, and intervention to monitor s/s of hypo/hyperglycemia. Record review of CR#1's MDS assessment dated [DATE] revealed in section C a BIMS score of 09 indicating he was moderately impaired cognitively. He was assessed to have diabetes mellitus in Section I and receiving insulin injections in section N. (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of SBAR dated 08/25/2024 at 7:01am and completed by LVN A revealed CR#1 had a change in condition in which b/s (blood sugar) came back high with blood glucose(also known as blood sugar) reading at 600, physician was notified with orders for insulin with sliding scale at 12 units and recheck in 1 hour. Record review of CR#1's discharge hospital records dated 09/04/2024 reflected that on 08/20/2024, CR#1 discharged from a local hospital with glucose level reading of 103 with a reference range of 70-110 mg/dl. Record review of CR#1's discharge hospital record medication list dated 08/20/2024 reflected orders for Basaglar KwikPen U-100 Insulin 100 Unit/ML (3mL), 16 unit(s) Sub-Q Twice Daily Generic drug: Insulin Glargine. The orders reflected NovoLOG FlexPen U-100 Insulin 100 Unit/ML (3mL) 3-8 unit(s) Sub-Q as directed generic drug: insulin Aspart U-100. Record review of progress note dated 08/25/2024 at 8:05am and complete by LVN A reflected MD return call order received for NovoLOG FlexPen Subcutaneous solution Pen-Injector 100 unit/ML (Insulin Aspart). Inject sliding scale. Recheck FBS in 1 hour and repeat SSI. Recheck in 1 hours if FSBS remains>400 notify MD. Record review of progress note dated 08/25/2024 at 10:05am and complete by LVN A read in part, B/c [sic] continue to remain high MD notified order to continue with current sliding scale orders. 15 units given. Resident remains Alert and follow simple commands. Record review of progress note dated 08/25/2024 at 10:05am and complete by LVN A read in part, B/c [sic] continue to remain high MD notified order to continue with current sliding scale orders. 15 units given. Resident remains Alert and follow simple commands. Record review of progress note dated 08/25/2024 at 11:02am and complete by LVN A read in part, B/c [sic] continue to remain high MD notified order to continue with current sliding scale orders. 15 units given. Resident remains Alert and follow simple commands. Record review of progress note dated 08/25/2024 at 12:16pm and complete by LVN A reflected in part, Resident b/s continued to remain high vitals WNL see vitals notes. Resident remain alert to his [NAME]-line[sic] and responsive to care. RP at bedside and requested a resident be taken to ER (emergency room) for evaluation. 911 called and EMS (Emergency Medical Service) arrived all further care handed all care over. Resident ambulated with assistance from EMT (Emergency Medical Technician) from gurney chair to stretcher. MD notified and aware. Record review of the August 2024 Order Summary Report for CR#1 reflected phone orders with a start date of 08/25/2024 for Basaglar KwikPen Subcutaneous Solution Pen-Injector 100 Unit/ML (Insulin Glargine) Inject 16 unit subcutaneously two times a day related to Type 2 diabetes mellitus. The orders reflected NovoLOG FlexPen Subcutaneous Solution Pen-Injector 100 Unit/ML (Insulin Aspart), to inject as per sliding scale: If 70-50=0 units; 151-200=2 units; 201-250=4 units; 251-300= 6 units; 301-350 = 8 units; 351-399 = 10 units; 400+ = 12 units and call MD, subcutaneously before meals and at bed time related to type 2 diabetes mellitus. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's hospital records with admitted [DATE] and discharge date of [DATE] reflected that CR#1 presented to the emergency room from the facility for hyperglycemia with evaluated blood sugar of 600. On admission, blood glucose was greater than 900. CR#1 was admitted to the ICU and treated for diabetic ketoacidosis without coma associated with type 2 diabetes mellitus, and the RP of CR#1 said that the facility had not given any insulin for 4 days. Record review of grievance dated 08/26/2024 reflected it was completed by DON and signed by the DON, SW, and Admin reflected in part, The relative of resident called the facility and stated there was an issue with the residents diabetic medications. Residents medications renewed [sic]; it became evident insulin was omitted at admission. Orders added by MD to admisister[sic] sliding scale as directed. Self-Reported Incident (SRI) completed. Record review of Medication Error Report dated 08/25/2024 that the date of the transcription error was 08/20/2024 involving CR#1 when insulin medication as ordered was not on the MAR and not administered. The outcome to resident was hospitalization . Corrective action taken in-services, one on one, and sliding scale audit of insulin. In an interview on 08/30/2024 at 1:28pm with both Unit Manager C and Admin, who said that CR#1 admitted to the facility on [DATE] and discharged on [DATE]. Both said that on 08/26/2024 a relative of CR#1 alleged that the facility was responsible for CR#1's hospitalization when he did not get prescribed medication. Both said that a clinical audit of the medical record of CR#1 was completed by the DON, ADON, Unit Manager C and Unit Manager D, the audit revealed there was an omission of insulin injections to treat diabetes from 08/20/2024-08/24/2024, and the first dosage was given on 08/25/2024 the same day CR#1 discharged . Both said that a root cause analysis revealed that the admitting nurse, LVN A, enlisted the help of LVN B in clarifying the orders from CR#1's hospital discharge summary medication list at the time of the admission with the primary physician (Medical Director). Both said that LVN B did not enter the orders for insulin into the facilities EMR(electronic medical record) system, and LVN A as the admitting nurse was responsible for ensuring the orders were entered. Both said that both Unit Managers, ADON, DON, and ADMIN failed to review the admission of CR#1 thoroughly, the review would have caught the error, the error should have been corrected immediately, and delay in treatment prevented. Both said that residents with diabetes should have medication and glucose monitoring orders at admission. Both said that going without medication and monitoring for long periods of time could cause abnormal blood sugars, cause a need to be sent to hospital, and prolong/untreated elevated blood sugars could be fatal. Both said that LVN A, LVN B, Unit Manager C, Unit Manager, D, ADON, DON, and Admin received one on one counseling/training and disciplinary action. Both said that there was a QAPI held to review the system and correct failure, and there is a PIP in place. In an effort to complete a phone interview on 08/30/2024 at 3:05pm with LVN A when there was no answer, and a message was left. In a phone interview on 08/30/2024 at 3:44pm with a relative of CR#1, who said that she was a MD. She said that CR#1 went without insulin to treat diabetes or glucose monitoring from 08/20/2024-08/24/2024. She said that CR#1 was transferred to the hospital due to concerns of hyperglycemia, and when he arrived at the hospital his blood sugar was over 600, when the normal range should be 70-130. She said that CR#1 was admitted to ICU and treated for DKA. She said that the facility could have killed CR#1. She said that CR#1 was discharged from the hospital on 08/29/2024, he was transferred to another facility, and he was doing much better. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an effort to complete a phone interview on 09/03/2024 at 12pm with LVN A, there was no answer, and a message was left. In an interview on 09/04/2024 at 9:45am with RN E and RN F at a local hospital, who said that CR#1 presented to theER on [DATE], with a chief complaint of hyperglycemia, and his initial labs for blood glucose were 738. Both said that the normal range should be 70-110. Both said that the level of the blood glucose that CR#1 presented to the ER caused a concern that his diabetes was not controlled, treated, or monitored. Both said that CR#1 was admitted to ICU and treated for DKA. Both said that DKA occurs when the body doesn't have enough insulin, it can be fatal, and can be prevented if diabetes is controlled with medication and monitoring. Both said that when CR#1 discharged from the hospital on 08/20/2024 and transferred to the facility his blood glucose levels were 103. In an interview on 09/04/2024 at 11:15am with Admin and DON, who both said that LVN A self-terminated on 09/03/2024 when he did not report to his scheduled shift, and his last day worked was 09/02/2024. In a phone interview on 09/04/2024 at 12:10pm with LVN A, who said that he quit his job, and he does not want to be a part of the investigation. He said that when he was hired at the facility admissions was an all hands-on deck process, it was not assigned to one nurse, and other nurses helped with the admission of CR#1. He said that there was insulin missed, he gets that, but the unit managers were supposed to review all admissions to make sure they are done correctly. He said that he was not going to provide any more details. Interview on 09/04/2024 at 12:26pm with LVN L who works 6am-6pm shift, RN M at 12:42pm who works 6am-6pm shift, and LVN N who works 6am-6pm shift, who acknowledged that training was received on the topics of the admission process, admission orders, and s/s of hyperglycemia and was knowledgeable on the training topics. In an interview on 09/04/2024 at 1:37pm with Perspective Payment System (PPS) Coordinator, she said that she was an LVN, and she ensures the MDS assessments are completed for short term residents. She said that she was a part of the Interdisciplinary Team (IDT), along with social worker, dietary department, rehab department, activities department, but she is the clinical oversight as the nurse. She said that the IDT meets 48 hours after admission, review the clinical records, and ensure initial treatments are in place and addressed. She said that if there are any errors found they should be addressed and corrected immediately. She said that CR#1 had high blood sugar as he had no orders to treat or monitor his diagnosis of diabetes. She said that during the IDT of CR#,1 she only reviewed the current medications, and as the clinical oversight she should have caught that there were no orders to treat or monitor his diagnosis of diabetes. She said that the risk of not receiving medications to treat diabetes was hyperglycemia, a blood sugar of 600 could cause DKA and coma, and that could be fatal. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/04/2024 at 2:08pm with MDS Coordinator, who said that she was an LVN, and she ensures the MDS assessments are completed for long term residents. She said that she was a part of the Interdisciplinary Team (IDT), along with social worker, dietary department, rehab department, activities department, but she was the clinical oversight as the nurse. She said that the IDT meets 48 hours after admission, review the clinical records, and ensure initial treatments are in place and addressed. She said that if there are any errors found they should be addressed and corrected immediately. She said that CR#1 had high blood sugar because she was not getting insulin, and she was sent out to the hospital. She did not take part in the IDT for CR#1 because he was a short term stay resident. She said that the PPS Coordinator should have caught that CR#1 had an admitting diagnosis of diabetes with no orders in place to treat or monitor during the IDT, but any nurse that reviewed the record or provided care should have caught the error. She said that the risk of not receiving medications to treat diabetes could cause DKA and coma, and that could be fatal. In an interview on 09/04/2024 at 2:21pm with DON, who said that LVN B assisted LVN A with contacting the physician to clarify orders at the time CR#1 was admitted on [DATE]. She said that LVN B did not put the orders into the EMR for CR#1's insulin, and LVN A did not ensure the task was completed as the admitting nurse. She said that the Unit Mangers did not review the admission for accuracy the next day, because it was assumed the ADON completed it when she received the chart. She said that Unit Managers and ADON did not review the admission of CR#1 thoroughly to prevent delays in treatment, an as the oversight she did not ensure the Unit Managers and ADON completed the task. She said that CR#1 had a change in condition on 08/25/2024 due to evaluated blood sugar of 600, and he received the initial dose of insulin the same day. She said that the risk to CR#1 was evaluated blood sugar, hyperglycemia, DKA that could lead to coma, and that could be fatal. She said that there was a QAPI held to review the system and correct failure, and there is a PIP in place. She said that LVN A, LVN B, Unit Manager C, Unit Manager D, ADON, Admin, and DON received disciplinary action and one on one training. She said that LVN A self-terminated. In an interview on 09/04/2024 at 3:01pm with the Medical Director, who said that he was the primary physician of CR#1 who admitted to the facility with a diagnosis of diabetes. He said that when nursing staff contacted him to reconcile medications at admission, he gave a verbal order to continue medications on the medication list from the hospital at discharge until he was able to round. He said that he was contacted with change in condition due to evaluated, was told he had not received insulin since admission, gave orders to treat, blood sugar was coming down, but family request CR#1 be sent to the hospital. He said that he participated in a QAPI and there is a PIP in place to ensure the accuracy of the admission process and that mediations are entered and implemented at the time of admission. He said that the admitting nurse should have ensured the orders were in place, and any nurse that reviewed the chart should have been able to correct the error. He said that that the risk to the resident was DKA that can be fatal. He said that it's his expectation that if he gives a verbal order to continue all discharge orders from the hospital that should be done. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/04/2024 at 3:50pm with LVN B, who said that she assisted LVN A with the admission of CR#1 with medication orders. She said that she called the physician (Medical Director) who gave orders to continue medications from the medication list from the hospital at the time of discharge. She said that CR#1 had a diagnosis of diabetes and orders to continue insulin. She said that she did not enter the orders to the EMR, it was an error, and she just missed it. She said that she was not sure how long CR#1 went without insulin to treat diabetes. She said that the risk of CR#1 not receiving insulin from 08/20/2024-08/20/2024 was death, because hyperglycemia could cause DKA. She said that it was the admitting nurse responsibility to ensure the medications are clarified and entered by checking the tasks completed by other nurse, and the unit managers were supposed to review the next day to ensure no errors were made. She said that she received disciplinary action and one on one counseling and training to address the admission process, admission orders, and s/s of hyperglycemia. In an interview on 09/04/2024 at 4:35pm with Unit Manager D, who said there was a QAPI held to review the system and correct failure, and there was a PIP in place. She said that LVN A, LVN B, Unit Manager C, Unit Manager D, ADON, Admin, and DON received disciplinary action and one on one training. In an interview on 09/04/2024 at 4:54pm with the ADON, who said there was a QAPI held to review the system and correct failure, and there was a PIP in place. She said that LVN A, LVN B, Unit Manager C, Unit Manager D, ADON, Admin, and DON received disciplinary action and one on one training. Interview on 09/04/2024 at 5:12pm with RN K, who said that she received disciplinary action and one on one counseling and training to address the admission process, admission orders, and s/s of hyperglycemia as she assisted LVN A with the admission of CR#1, and she was knowledgeable on the training topics. Interview on 09/04/2024 at 6:09pm with LVN G who works 6pm-6am shift, RN H at 6:22pm who works 6pm-6am shift, and LVN I who works 6pm-6am shift, who acknowledged that training was received on the topics of the admission process, admission orders, and s/s of hyperglycemia and was knowledgeable on the training topics. Interview on 09/05/2024 at 6:30am with LVN J who works 10pm-6am shift, who acknowledged that training was received on the topics of the admission process, admission orders, and s/s of hyperglycemia and were knowledgeable on the training topics. Record review of SSA reporting database TULIP reflected Incident intake# 527741 was received on 08/26/2024 with the PIR submitted on 09/04/2024 with the documents to support the following actions were taken, RP and MD notified, and in-service on topics abuse/neglect, blood sugar and accu checks, signs and symptoms of hyper/hypoglycemia, changes in conditions and review of medications list at admission. Further documents to support that satisfaction surveys were conducted, witness statements completed, audit of past 10 admission completed, implemented an audit tool for future admission checklist, Root Cause Analysis completed, QAPI conducted, PIP completed, and one on one counseling and disciplinary actions with LVN A, LVN B, RN K, Unit Manger C, Unit Manger D, ADON, DON, and Admin completed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of QAPI held on 08/27/2024 reflected that that there was a review the facility's admission review practices related to accuracy with review of orders and entering them with use of an admission checklist and noted there was a need for an immediate change in the process. Administrator and DON initiated an action plan on 08/26/2024, with a compliance goal of 08/28/2024, Root Cause Analysis initiated and attached to the system for sustainability, and once compliance was established the DON/Designee would monitor assessments weekly. Record review of PIP dated 08/27/2024 reflected a concern that a nurse omitted insulin medication admission. Goals were for admission checklists to be completed within 24 hours of admission without any omissions. Interventions were for the Don/Designee to complete reeducation on admission checklist, reviewing medication list upon admission, accuchecks, signs and symptoms of hypo/hyperglycemia, and change in condition. Don/Designee will audit the last ten admissions to ensure there were no omissions. DON/Designee would audit admissions checklist five times a week x 4 weeks and periodically thereafter and would upload in the facilities drive monthly ongoing for administrator to review. Record review of Don/Designee audit dated08/27/2024 of the last ten admissions with no omissions. Record review of Administrator Admission Checklist Audit (5 times a week for four weeks) with a starte date of 08/26/2024-09/04/2024 with no errors identified. Record review of DON/Designee Admission Checklist Audit (5 times a week for four weeks) with a starte date of 08/26/2024-09/04/2024 with no errors identified. Record review of Diabetic Resident Audit dated 08/28/2024 to ensure orders were in place treat and monitor, appropriate diet was in place with a snack, and care plan reflected diagnosis. Record review of Disciplinary Measure dated 08/26/2024 reflected that LVN A, LVN B, and RN K received disciplinary action in the form of a counseling for violation date of 8/20/2024 due to clarification with physician on admission for a discharge hospital medication list for residents with diagnosis of Diabetes Mellitus. Record review of Disciplinary Measure dated 08/26/2024 reflected that Unit Manager C, Unit Manger D, ADON, DON and Admin received disciplinary action in the form of a counseling for violation date of 8/20/2024 due to monitoring admission system to assure nurse managers completed admissions accurately to assure no omissions present. Record review of 1:1 Inservice Record dated 08/26/2024 reflected that LVN A, LVN B, Unit Manger C, Unit Manger D, RN K, and ADON received individual counseling topics of Admission System Process Regarding Medication, discharge hospital medication list and follow up with physician on admission, Nursing care of the Resident with Diabetes Mellitus, and Change in A Residents Condition or Status. Record review of 1:1 Inservice Record dated 08/26/2024 reflected that DON and Admin received individual counseling topics of Admission System Process Regarding Medication, Nursing care of the Resident with Diabetes Mellitus, Change in A Residents Condition or Status, and reviewing new admission and monitoring system. Record review of in-service titled Manager Duty-Day dated 08/26/2024 reflected that Unit Manager C and Und Manger D were in-serviced to completed review of all admission before noon the next day. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-service titled Diabetes Mellitus and Blood Sugar dated 8/26/2024 completed with nursing staff on the Admission System Process Regarding Medication, reviewing admission medication on admission and going over with the physician, Nursing care of the Resident with Diabetes Mellitus, and Change in A Residents Condition or Status. Record review of in-service titled Diabetes Mellitus dated 8/29/2024 completed with nursing staff on ensuring a blood sugar baseline is established at the time of admission time 7 days for resident with a diagnosis of Diabetes Mellitus. Record review of in-serviced titled Admission Checklist dated 08/27/2024 completed with nursing staff to ensure that all admits/readmits have a completed admission checklist submitted to the office of the ADON upon completion by the end of the shift. Record review of in-service titled Abuse and Neglect dated 8/26/2024 completed with nursing staff identifying who to report allegations to, types of abuse and neglect, and reporting timeframes. Record review of facility policy, Administering Medications with revised date December 2012 read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . 3. Medications must be administered in accordance with the orders, including any required time frame . Record review of facility policy, Medication and Treatment Orders with revised date July 2016 read in part, . Orders for medications and treatments will be consistent with principles of safe and effective order writing . 1. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order . Record review of facility policy, Nursing Care of the Resident with Diabetes Mellitus with revised date April 2009 read in part, .The purposes of this guideline are: 2. To help the resident control his/her diabetes with diet, exercise, and insulin (as ordered); 3. Prevent recurrent hyperglycemia/hypoglycemia; .The following complications are associated with diabetes: 1. hypoglycemia (blood sugar above target levels) .2. Diabetic Ketoacidosis (DKA) or hyperosmolar (nonketotic). (Note: Diabetic Ketoacidosis is a life-threatening emergency that needs immediate medical attention): .Glucose Monitoring 1. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. 2. the physician will order the frequency of glucose monitoring .4. Finger Sticks(capillary blood samples)measure current blood glucose levels .b. Normal ranges are approximately 90-130mg/dl before meals and <180 mg/dl after meals. Medication Management .3. Medication management of type II diabetes may include oral hypoglycemic agents with or without insulin .7. Assist the resident with his or specific medication regimen, as ordered and as needed . The noncompliance was identified as Past Non-Compliant. The IJ (Immediate Jeopardy) began on 08/20/2024 and ended on 08/30/2024. The facility corrected the noncompliance prior to entrance. On 09/04/23 at 5:37pm, the facility administrator was notified of past noncompliance IJ. A plan of removal was not requested. An IJ template was provided to the administrator via email.