Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 5, 2024

Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

RE: CCN: 245475
Cycle Start Date: February 22, 2024

Dear Administrator:

On March 6, 2024, we notified you a remedy was imposed. On April 3, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 20, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 21, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 6, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 22, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 5, 2024

Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

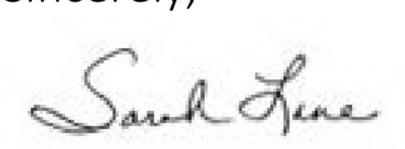
Re: Reinspection Results
Event ID: DNKZ12

Dear Administrator:

On April 3, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 22, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS On 2/20/24 through 2/22/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F760 began on 2/5/24, when when it was identified that the facility failed to ensure insulin was administered according to manufacturer's guidelines for 1 of 1 resident (R1), resulting in actual harm when R1 had to be sent to the emergency department for evaluation and treatment. The administrator, and director of nursing (DON) were notified of the IJ on 2/21/24 at 2:22 p.m., The IJ was removed on 2/22/24 at 11:37 a.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 2/21/24 through 2/22/24. The following complaints were reviewed: H547596687C (MN100657) with a deficiency cited at F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/14/2024

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.

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure insulin was administered according to manufacturer's guidelines for 1 of 1 resident (R1) resulting in the potential for serious harm or death when R1 had to be sent to emergency department (ED) for hypoglycemia (low blood sugar (BS)) when staff administered R1's insulin without ensuring he ate within the required time frame of 5-10 minutes. The IJ began on 2/5/24, when licensed practical nurse (LPN)-A failed to follow manufacturer guidelines when administering Novolog (a rapid acting insulin) to R1. R1 was administered insulin at 11:14 a.m. without being fed any type of meal or sustenance within 5-10 minutes of administration and was subsequently sent to the ED with severe hypoglycemia for medical treatment. The facility administrator and director of nursing (DON) were notified of the IJ on 2/21/24 at 2:22 p.m., which was identified at the scope and severity of J-ISOLATED. The IJ was removed on 2/22/24 at 11:37 a.m., but non-compliance remained at the lower scope and severity of D: No actual harm with potential for more than minimal harm, that is not immediate jeopardy.	F 760	The director of nursing [DON] and administrator reviewed the policy and procedure related to medication errors on 2/23/24 no revisions required. The protocol for Hypoglycemic Event was also reviewed by the DON and administrator on 3/27/24 and no revisions were required. The DON, Primary care provider and consulting pharmacist made revisions to (R1) insulin orders applying a sliding scale within the order to prevent the medication from being given if the blood sugar level is below 100. Additional special instructions were written into the order to provide guidance when to provide a carbohydrate for low blood sugar reading. New admissions who have orders for insulin will be reviewed during the admission process by the DON, Primary care provider, and consulting pharmacist. The order will contain special instructions as needed to prevent insulin from being administered if the blood sugar is below a specified value. A copy of the specific insulin(s) medication prescribing information will be printed and available in	3/14/24

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F 760	Continued From page 2 Findings include: Review of current, Novolog manufacturer guidelines for Novolog, located at https://www.mynovoinsulin.com/insulin-products/novolog/home.html, identified it was a rapid acting insulin and patients using Novolog should eat a meal within 5 to 10 minutes after taking it. Review of the 2/7/24, report to the State Agency (SA) identified LPN-A had checked R1's blood sugar at 11:14 a.m., then immediately administered 10 units of rapid acting Novolog insulin. R1 was found in his room unresponsive approximately 1 hour and 20 minutes later. It was discovered he had not eaten any of his dinner (normal was to consume 100% of his meals). R1's blood sugar was checked and found to be 39 (severe hypoglycemia requiring medical attention). He was given a tube of glucose gel. The DON and LPN-A suspected possible seizure activity and called for ambulance transport to the hospital's ED for evaluation and treatment. The DON identified in the report R1 was a "brittle diabetic" and should not have been administered his rapid acting insulin that long prior to receiving his meal or some form of sustenance. R1's 12/14/23, Minimum Data Set (MDS) identified R1 had a diagnosis of diabetes mellitus type II (DM) and he required staff assistance with meal tray set up or clean up. R1's 2/20/24, diagnosis list identified he had a developmental disorder and other signs and symptoms involving cognitive functioning. R1's Novolog physician orders identified the following on:	F 760	each individual resident medication cupboard for reference. The DON provided education to all the nurses regarding completing second medication order checks / verification of new orders as they are received. The licensed nurses were also provided education on the insulin pen use policy & procedure. This education was completed for all licensed nurses on 3/12/24. The facility purchased and received two new "Nursing Drug Handbooks" on 3/1/24. The DON reviewed the consulting pharmacist process for medication reviews on 3/6/24. The DON and consulting pharmacist work collaboratively using email and telephone communication to discuss oversight of resident medication management, monthly reviews are completed and the information is provided to each individual residents primary care provider. The DON will be auditing medication administration weekly x 8 weeks, then monthly x 3 months. Data will be reviewed and education will be provided to nurses as needed. All audits will be reviewed at the quarterly QAPI meeting to maintain compliance, oversight, and monitoring.	

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F 760	Continued From page 3 1) 6/20/23, R1 was to be given Novolog 10 units 2 x a day. No other instructions were noted on the order. 2) 2/9/24, R1 was to be given Novolog 10 units 2 x a day, however staff were to hold his insulin if his BS was less than 100 milligrams per deciliter (mg/dL). 3) 2/21/24, R1 was to be given Novolog per sliding scale. If R1's BS was 0-100 mg/dL, staff were to hold his insulin. It was also noted staff were to administer R1's insulin within 5-10 minutes before a meal. Meal times were listed as 12:00 noon and 4:50 p.m.. Staff were to ensure the resident received a meal within 10 minutes of administration. There was no mention staff should call the provider if the insulin was held to determine when they would potentially give it. R1's 2/5/24, Medication Administration Audit Report related to the above incident identified LPN-A checked R1's blood sugar which was 85 mg/dL and administered 10 units of Novolog at 11:14 a.m. at the time his insulin was administered. Observation on 2/20/24 at 11:45, with LPN-A identified she checked R1's blood sugar and documented it as being 86 mg/dL. She administered 4 ounces of orange juice and left the room. LPN-A was unable to be interviewed at this time. Interview on 2/20/24 at 12:30 p.m., with LPN-B identified staff were to check R1's blood sugar (BS) prior to dinner. If it was below 100 milligrams mg/dL, facility management advised staff they were to give him orange juice and give him dinner to artificially raise his BS to 100 mg/dL or above, and then go back and recheck his blood sugar so	F 760		

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F 760	Continued From page 4 they could then administer his insulin, even though that was not according to the physician order noted above. She identified staff have no access to manufacturer's guidelines, nor had they any professional references to follow. Interview on 2/20/24 at 2:30 p.m., with the medical director (MD)-A identified while at the facility doing rounds on 2/9/24, he had been notified of the incident that occurred on 2/5/24 with R1. His understanding was R1's BS was at the "lower end of normal" when R1 was administered 10 units of Novolog. When made aware of how low R1's BS had gotten after the administration at the time of the 2/5/24 incident, MD-A stated R1 should not have been administered his insulin without getting food within 10-15 minutes of administration at the latest, and agreed that was what caused R1's acute hypoglycemic episode. After the incident, MD-A reviewed R1's medications on 2/9/24, and placed a new order for staff to hold his insulin if his BS was less than 100 mg/dL. He was unaware nursing staff were currently giving R1 orange juice in an attempt to elevate his BS so they could administer insulin (as seen in the above observation on 2/20/24 at 11:45 a.m.). MD-A identified this was not in accordance with his physician order. He would not expect staff to give orange juice unless R1's BS was below 70 mg/dL, as intentionally raising his BS prior to insulin would be counter-productive and not according to his MD order or manufacturer's guidelines. Interview on 2/20/24, at 2:40 p.m., with the DON identified she was unaware staff were not following the physician's current order for R1's insulin by holding his insulin if it dropped less than	F 760		

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F 760	Continued From page 5 100 mg. She was unaware there was no physician order to give R1 orange juice to artificially raise his blood sugar prior to administer insulin. She agreed she had directed staff to give orange juice to elevate his BS. She placed a re-education document in each nurse's mailbox for them to review after the incident occurred which included R1's insulin order. She identified all the staff signed and returned the printed information except for LPN-A who incorrectly administered R1's insulin at the time of the incident. She did not follow up with LPN-A to see if she had received the re-education document, and confirmed LPN-A had worked several more shifts following the incident. She did not complete any face-to-face training with any of the nursing staff and did not complete any competencies to confirm the training was successful. She identified LPN-B was contracted from an agency, and she does not do any re-education or competencies with contracted nurses. Review of the 2/7/24, Reportable Incident Re-education, identified signs and symptoms of hypoglycemia, which was also noted to be identified by a BS below 70 mg/dL regardless of the presence of symptoms. The document advised staff to "not give fast acting insulin unless the resident will be eating in 20-30 minutes, if blood sugar is low you should wait to administer insulin until closer to meal-time or give an oral equivalent to increase their blood glucose level prior to administering the insulin". The document included a signature line for staff to sign indicating they read and understand the education and directions to return the form to the DON. The training document did not provide the correct administration guidelines for Novolog rapid acting insulin that was administered to R1	F 760		

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F 760	Continued From page 6 on 2/5/24. R1's current care plan printed 2/20/24, identified he had a diagnosis of DM and was at risk for alteration in glucose levels. Staff were to ensure R1 received his diet and medications as ordered, staff should be aware, observe, and report signs and symptoms of hypoglycemia (low blood sugar). Interview on 2/21/24 at 9:07 a.m., with dietary aid (DA)-A who delivered and picked up R1's meal tray the date of the incident identified that day staff were "running behind in the kitchen". The dietary manager (DM) had gone to the assisted living area of the facility and did not return until 12:00 noon. Staff finished serving the residents in the dining room and then served the room trays. "I delivered R1 his meal tray around 12:15, and I noticed he was 'loopy'". DA noted she had not reported R1's abnormal mental function to the nurse she observed when she delivered his room tray. DA-A reported she continued delivering room trays and returned to R1's room later "around 12:45" to collect his tray and noticed he had not consumed any food and found R1 to be "incoherent". DA-A left the room and reported to the nurse that "something was wrong". Interview on 2/21/24 at 8:11 a.m., with LPN-A identified she had checked R1's blood sugar and administered Novolog on 2/5/24, at 11:15 a.m. She was not certain when he received his meal tray, and she did not alert the kitchen R1 had received his insulin or that he needed a meal tray right away. When she was told R1 was in his room and unresponsive, she went to assess R1 and found him to have a blood sugar of 39 mg/dL. She was able to arouse him enough to	F 760		

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F 760	Continued From page 7 give him sips of orange juice and call the DON to bring the emergency kit to the room. He was diaphoretic (sweating) and swaying back and forth, and his speech was slurred. Glucose gel (sugar gel used in diabetic emergencies for low BS) from the emergency kit was administered. R1 started to display "seizure like activity". LPN-A used her personal cell phone to call emergency services (EMS) for an emergency transport to the ED for evaluation and treatment. R1's 2/5/24, ED provider notes identified R1 presented to the ED at 1:45 p.m., after being found to be hypoglycemic and having a blood sugar of 39 mg/dL. R1 was diagnosed as having had an episode of acute hypoglycemia due to insulin administration. He had received glucose prior to arrival and was served a plate of food while at the ED. R1 returned to baseline, laboratory tests were completed and R1 was discharged from the ED back to the facility at 4:45 p.m. Interview on 2/21/24, at 9:36 a.m., with administrator identified he would have expected the DON to provide face to face training and competencies with all licensed nurses following the incident and prior to their next shift to avoid an incident like this from happening again. Review of the current, undated Insulin Pen and Storage Policy identified how staff were to administer insulin. Staff were to always review the physician order prior to administering any medication. Next, the procedure was described, however, monitoring for signs or symptoms of hypoglycemia was not present, nor was there any indication staff should contact the physician and hold the insulin if it fell below acceptable	F 760		

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F 760	Continued From page 8 parameters. Review of the 3/17/17 Notification of Changes in Resident Condition policy identified a significant change in status was noted to be a deterioration in health that could lead to a life-threatening condition or clinical complications. The objective of the policy was to ensure staff made the appropriate notification to a physician where there was a change in a residents condition that may require physician intervention. There was no mention on any specifics related to insulin administration or hypoglycemia noted to identify when those situations would require an immediate call to EMS or the physician. The IJ was removed on 2/22/24 at 11:37, when it could be verified through observation, staff interviews, and document review, the facility medical director reviewed R1's current physician order and made appropriate changes to follow manufacturers guidelines. Face-to-face education was provided to licensed nurses on how to manage diabetics with respect to low BS or changes of condition, insulin administration, review of the facility's insulin pen policy and manufacturer guidelines for Novolog and was completed prior to licensed staff returning to work on the unit.	F 760		
F 840 SS=F	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an	F 840		3/15/24

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F 840	Continued From page 9 arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an emergency dental agreement had been completed which had the potential to affect all 22 residents residing in the facility reviewed during the extended survey. Findings include: During the extended survey document review on 2/21/24 at 2:20 p.m., a copy of the facility dental agreement was requested. The facility was unable to provide a copy of an agreement. The Administrator confirmed the facility did not have a current dental agreement in place. There was no policy related to ensuring dental services were provided through contract.	F 840	The facility administrator and director of nursing [DON] reviewed and revised the facility Dental policy and procedure on 3/7/24. The policy indicates that the facility will assist residents to obtain routine and emergency dental care provided by outside resources. The facility will maintain a dental agreement for emergency dental services. All scheduled nursing staff will be trained by 3/15/24 on the Dental policy and procedure and the new Dental Agreement. The DON will complete 3 random audits over the next 3 months. The audits will be reviewed and recommendation discussed at the quarterly QAPI committee meeting.	

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- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 21, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 6, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 22, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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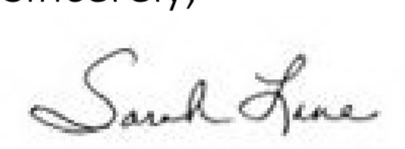
Please feel free to call me with any questions.

Sincerely,



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00543	A. BUILDING: _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/20/24 through 2/22/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H547596687C (MN100657) with a licensing orders issued at 260 and 1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 260	MN Rule 4658.0075 Outside Resources If a nursing home does not employ a qualified professional person to furnish a specific service to be provided by the nursing home, the nursing home must have that service furnished to residents under a written agreement with a person or agency outside the nursing home. The written agreement must specify that the service meets professional standards and principles that apply to professionals providing services in a nursing home, and that the service meets the same standards as required by this chapter. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an emergency dental agreement had been completed which had the potential to affect all 22 residents residing in the facility reviewed during the extended survey. Findings include: During the extended survey document review on 2/21/24 at 2:20 p.m., a copy of the facility dental agreement was requested. The facility was unable to provide a copy of an agreement. The Administrator confirmed the facility did not have a current dental agreement in place. There was no policy related to ensuring dental	2 260	The facility administrator and director of nursing [DON] reviewed and revised the facility Dental policy and procedure on 3/7/24. All scheduled nursing staff will be trained on or before 3/15/24 on the Dental policy and procedure and the new Dental Agreement. The DON will complete 3 random audits over the next 3 months. The audits will be reviewed and recommendation discussed at the quarterly QAPI committee meeting.	3/14/24

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2 260	Continued From page 3 services were provided through contract. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 260		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		3/14/24

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21545	Continued From page 4 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure insulin was administered according to manufacturer's instructions for 1 of 1 resident (R1). This resulted in actual harm when R1 had to be sent to emergency department (ED) for low blood sugar because staff failed to ensure he ate within the required time after receiving insulin. Findings include: Review of the 2/7/24, report to the State Agency (SA) identified LPN-A had checked R1's blood sugar at 11:14 a.m., then immediately administered 10 units of rapid acting Novolog insulin. R1 was found in his room unresponsive approximately 1 hour and 20 minutes later. It was	21545	The director of nursing [DON] and administrator reviewed the policy and procedure related to medication errors on 2/23/24 no revisions required. The DON provided education to all the nurses regarding completing second medication order checks / verification of new orders as they are received.The licensed nurses were also provided education on the insulin pen use policy & procedure. This education was completed for all licensed nurses on or before 3/12/24. The facility purchased and received two new "Nursing Drug Handbooks" on 3/1/24. The DON reviewed the consulting pharmacist process for medication	

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21545	Continued From page 5 discovered he had not eaten any of his dinner (normal was to consume 100% of his meals). R1's blood sugar was checked and found to be 39 (severe hypoglycemia requiring medical attention). He was given a tube of glucose gel. The DON and LPN-A suspected possible seizure activity and called for ambulance transport to the hospital's ED for evaluation and treatment. The DON identified in the report R1 was a "brittle diabetic" and should not have been administered his rapid acting insulin that long prior to receiving his meal or some form of sustenance. R1's 12/14/23, Minimum Data Set (MDS) identified R1 had a diagnosis of diabetes mellitus type II (DM) and he required staff assistance with meal tray set up or clean up. R1's diagnosis list printed 2/20/24, identified he had a developmental disorder and other signs and symptoms involving cognitive functioning. R1's 2/5/24, Medication Administration Audit Report related to the above incident identified LPN-A checked R1's blood sugar which was 85 mg/dL and administered 10 units of Novolog at 11:14 a.m. Review of current, Novolog manufacturer guidelines for Novolog. located at https://www.mynovoinsulin.com/insulin-products/novolog/home.html, identified it was a rapid acting insulin and patients using Novolog should eat a meal within 5 to 10 minutes after taking it. Observation on 2/20/24 at 11:45, with LPN-A identified she checked R1's blood sugar and documented it as being 86. She administered 4 ounces of orange juice and left the room. Interview on 2/20/24 at 12:30 p.m., with LPN-B	21545	reviews on 3/6/24. The DON and consulting pharmacist work collaboratively using email and telephone communication to discuss oversight of resident medication management, monthly reviews are completed and the information is provided to each individual residents primary care provider. The DON will be auditing medication administration weekly x 8 weeks, then monthly x 3 months. Data will be reviewed and education will be provided to nurses as needed. All audits will be reviewed at the quarterly QAPI meeting to maintain compliance, oversight, and monitoring.	

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21545	Continued From page 6 identified staff were to check R1's blood sugar (BS) prior to dinner. If it was below 100 milligrams per deciliter (mg/dL), facility management advised staff they were to give him orange juice and then dinner, then go back and recheck his blood sugar. If R1's BS was greater than 100 mg/dL, they could administer his insulin. She identified they have no access to manufacturers guidelines, nor had any professional resources to follow. Interview on 2/20/24 at 2:30 p.m., with the medical director (MD)-A identified while at the facility doing rounds on 2/9/24 he had been notified of the incident that occurred on 2/5/24 with R1. His understanding was R1's BS was at the "lower end of normal" and R1 was administered 10 units of Novolog. When made aware of how low R1's BS actually was at the time of the incident at 39 mg/dL. MD-A stated R1 should not have been administered his insulin without getting food within 10-15 minutes of administration at the latest, and agreed that was what caused the acute hypoglycemic episode. After the incident, MD-A reviewed R1's medications and placed a new order for staff to hold his insulin if his BS was less than 100 mg/dL. He was unaware nursing staff were giving R1 orange juice in an attempt to elevate blood sugar so they could administer insulin. MD-A identified this was not in accordance with his physician order. He would not expect staff to give orange juice unless R1's BS was below 70 mg/dL as intentionally raising his BS prior to insulin would be counter productive and not according to MD order or manufacturer's guidelines. R1's Medication Administration Record (MAR) printed on 2/20/24, identified an order for Novolog insulin. Staff were to inject 10 units, 2 times per	21545		

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21545	Continued From page 7 day related to his diagnosis of Type 2 DM. Staff were to "hold if blood sugar is below 100 mg/dL". Interview on 2/20/24, at 2:40 p.m., with the DON identified she was unaware staff were not following the physician order for R1's insulin. She placed a document in each nurse mailbox for them to review after the incident occurred which included R1's new insulin orders. She identified all the staff signed and returned the printed information except for LPN-A who incorrectly administered R1's insulin at the time of the incident. She did not follow up with LPN-A to see if she had received the re-training document, and confirmed LPN-A had returned and worked several more shifts following the incident. She did not complete any face-to-face training with any of the nursing staff and did not complete any competencies to confirm the training was successful. She identified LPN-B was contracted from an agency, and she does not do any re-training or competencies with contracted nurses. Review of the 2/7/24 document titled Reportable Incident Re-education, identified signs and symptoms of hypoglycemia, which was also noted to be identified by a BS below 70 mg/dL regardless of the presence of symptoms. The document advised staff to "not give fast acting insulin unless the resident will be eating in 20-30 minutes, if blood sugar is low you should wait to administer insulin until closer to meal-time or give an oral equivalent to increase their blood glucose level prior to administering the insulin". The document included a signature line for staff to sign indicating they read and understand the education and directions to return the form to the DON. The training document did not provide the correct administration guidelines for Novolog	21545		

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21545	Continued From page 8 rapid acting insulin that was administered to R1 on 2/5/24. R1's current care plan printed 2/20/24, identified he had a diagnosis of DM and was at risk for alteration in glucose levels. Staff were to ensure R1 received his diet and medications as ordered, staff should be aware, observe, and report signs and symptoms of hypoglycemia (low blood sugar). Interview on 2/21/24 at 9:07 a.m., with dietary aid (DA)-A who delivered and picked up R1's meal tray the date of the incident identified that day staff were "running behind in the kitchen". The dietary manager (DM) had gone to the assisted living area of the facility and did not return until 12:00 noon. Staff finished serving the residents in the dining room and then served the room trays. "I delivered R1 his meal tray around 12:15, and I noticed he was 'loopy'". DA-A reported she continued delivering room trays and returned to R1's room later "around 12:45" to collect his tray and noticed he had not consumed any food. , she states "He was incoherent". DA-A left the room and reported to the nurse that something was wrong. DA noted she had not reported R1's abnormal mental function to the nurse she observed when she delivered his room tray. Interview on 2/21/24 at 8:11 a.m., with LPN-A identified she had checked R1's blood sugar and administered Novolog on 2/7/24, at 11:15 a.m. She was not certain when he received his meal tray, and she did not alert the kitchen R1 had received his insulin or that he needed a meal tray right away. When she was told R1 was in his room and unresponsive she went to assess R1, and found him to have a blood sugar of 39 mg/dL. She was able to arouse him enough to	21545		

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21545	Continued From page 9 give him sips of orange juice and call the DON to bring the emergency kit to the room. He was diaphoretic (sweating) and swaying back and forth, and his speech was slurred. Glucose gel (sugar gel used in diabetic emergencies for low BS) from the emergency kit was administered. R1 started to display "seizure like activity". LPN-A used her personal cell phone to call emergency services (EMS) for an emergency transport to the ED for evaluation and treatment. R1's 2/5/24, ED provider notes identified R1 presented to the ED at 1:45 p.m., after being found to be hypoglycemic and having a blood sugar of 39 mg/dL. R1 was diagnosed as having had an episode of acute hypoglycemia due to insulin administration. He had received glucose prior to arrival and was served a plate of food while at the ED. R1 returned to baseline, laboratory tests were completed and R1 was discharged from the ED back to the facility at 4:45 p.m. Interview on 2/21/24, at 9:36 a.m., with administrator identified he would have expected the DON to provide face to face training and competencies with all licensed nurses following the incident and prior to their next shift to avoid an incident like this from happening again. Review of the current, undated Insulin Pen and Storage Policy identified how staff were to administer insulin. Staff were to always review the physician order prior to administering any medication. Next, the procedure was described, however, monitoring for signs or symptoms of hypoglycemia was not present, nor was there any indication staff should contact the physician and hold the insulin if it fell below acceptable parameters.	21545		

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21545	Continued From page 10 Review of the 3/17/17 Notification of Changes in Resident Condition policy identified a significant change in status was noted to be a deterioration in health that could lead to a life-threatening condition or clinical complications. The objective of the policy was to ensure staff made the appropriate notification to a physician where there was a change in a residents condition that may require physician intervention. There was no mention on any specifics related to insulin administration or hypoglycemia noted to identify when those situations would require an immediate call to EMS or the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		