DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00376508, IN00376668, IN00376685, IN00376737, IN00377233, IN00378184, and IN00379704. Complaint IN00376508 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376668 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376685 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684 Complaint IN00376737 - Substantiated. Federal/state deficiencies related to the allegations are cited at F559, F661, F684, and F757. Complaint IN00377233 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00378184 - Unsubstantiated due to lack of evidence. Complaint IN00379704 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 9, 10, and 11, 2022 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 94 Total: 94	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Census Payor Type: Medicare: 2 Medicaid: 80 Other: 12 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/16/22.			
F 0559 SS=D Bldg. 00	483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.			
	Based on record review and interview, the facility failed to ensure the resident and his or her family were notified in writing of an intrafacility transfer for 1 of 3 residents reviewed for discharge/transfer. (Resident J) Finding includes: The closed record for Resident J was reviewed on 5/10/22 at 12:12 p.m. The resident was admitted to the facility on 2/10/22 and was discharged to an	F 0559	1. 1. Resident J was not harmed by the alleged deficient practice. The DON/designee have reviewed intra-facility transfers to ensure residents and/or family have been notified and appropriate documentation is in place. 2. 2. All residents requiring room changes have the potential to be affected by same alleged	06/13/2022

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	assisted living facility on 2/25/22. Diagnoses included, but were not limited to, spinal stenosis, renal dialysis, type 2 diabetes, COPD, asthma, history of cocaine abuse, glaucoma, heart failure, major depressive disorder, high blood pressure, chronic active hepatitis, and atrial fibrillation. The Admission Minimum Data Set (MDS) assessment, dated 2/15/22, indicated the resident was cognitively intact. A census inquiry indicated the resident was admitted to room 228 and was moved to room 217 on 2/12/22. There was no documentation of why the resident was moved or if the resident and/or family waived their right to be moved. There was no notification to an interested family member the resident was moved. There was no intrafacility notification completed. A Care Plan conference, dated 2/18/22, indicated at that time, the family was informed of the resident's room change. Interview with the Director of Nursing on 5/11/22 at 9:30 a.m., indicated the resident had tested positive for C-Difficile toxin that was why she was moved to a room by herself. The resident was not moved due to COVID-19. This Federal tag relates to Complaint IN00376737. 3.1-12(a)(15) 3.1-12(a)(16)		deficient practice. A room transfer notification review has been conducted on residents with room transfers within the last 30 days, and all appropriate parties have been notified, with appropriate documentation in place. 3. 3. The social services designee/IDT has been educated on the “Resident Room Change” policy with emphasis on proper notification and documentation. 4. 4. DON/Designee will observe 5 residents who completed room transfers weekly for one month, and after will observe 2 residents weekly for one month, and then 5 residents monthly for one month to ensure that appropriate parties are notified according to the facility policy and are documented appropriately. The room transfers will be audited for completion Monday-Friday as this is an on-going facility practice. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months.	

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F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on record review and interview, the facility failed to ensure the Discharge Instructions/Summary included the recapitulation of stay as well as information for home health services and specialized equipment for post discharge from the facility for 2 of 3 residents reviewed for discharge. (Residents J and E)	F 0661	1. 1. Resident E and J were not harmed by the alleged deficient practice. The DON/designee has reviewed discharged residents. Resident E and J no longer reside at the facility.	06/13/2022

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	Findings include: 1. The closed record for Resident J was reviewed on 5/10/22 at 12:12 p.m. The resident was admitted to the facility on 2/10/22 and was discharged to an assisted living facility on 2/25/22. Diagnoses included, but were not limited to, spinal stenosis, renal dialysis, type 2 diabetes, COPD, asthma, history of cocaine abuse, glaucoma, heart failure, major depressive disorder, high blood pressure, chronic active hepatitis, and atrial fibrillation. The Admission Minimum Data Set (MDS) assessment, dated 2/15/22, indicated the resident was cognitively intact. A Wound Physician Note, dated 2/21/22, indicated the resident was seen for Moisture Associated Skin Dermatitis (MASD) of left the buttock. Barrier cream was to be applied once daily for 30 days. A Social Service Note, dated 2/24/22 at 4:32 p.m., indicated the resident would be discharged to an Assisted Living facility on 2/25/22. The resident's daughter was to pick her up between 4-5 p.m. The Discharge Instructions/Summary, dated 2/24/22, indicated a copy of the Physician's Order Statement and the medication list were sent with the resident. There was no recapitulation of the resident's stay documented. There was no documentation under "Consult Findings" to indicate the resident was being seen by the Wound Physician.		2. 2. All residents with discharges have the potential to be affected by same alleged deficient practice. A discharge summary review has been conducted on residents who have been discharged within the past 15 days, and all discharge summaries are complete. Any concerns will be addressed with the IDT. 3. 3. The licensed nursing staff and Interdisciplinary team members have been re-educated on the “Transfer and Discharge” policy, with emphasis on “discharge summary” completion. 4. 4. DON/Designee will observe 5 resident discharges weekly for one month, and after will observe 2 residents weekly for one month, and then 5 residents monthly for one month to ensure that all discharge summaries are completed. The discharge summaries will be audited for completion Monday-Friday as this is an on-going facility practice. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months.	

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	The last documented Nurses' Note was on 2/24/22. There was no documentation when the resident actually left the facility. Interview with the Assistant Director of Nursing on 5/11/22 at 9:20 a.m., indicated the resident's discharge recapitulation and consultations were not completed prior to discharge. 2. The closed record for Resident E was reviewed on 5/10/22 at 2:30 p.m. The resident was admitted from the hospital on 2/10/22 and was discharged home on 3/24/22. Diagnoses included, but were not limited to, osteomyelitis of the right ankle, type 2 diabetes, pain to right knee, pain in thoracic spine, depressive disorders, anxiety disorder, vitamin B deficiency anemia, fibromyalgia, psoriasis, low back pain, gerd, high blood pressure, and hyperlipidemia. The Admission Minimum Data Set (MDS) assessment, dated 2/16/22, indicated the resident was cognitively intact. Nurses' Notes, dated 2/10/22 at 8:16 p.m., indicated the resident was admitted to the facility to receive therapy and eventually discharge back home. A Care Conference, dated 2/18/22, indicated the resident wanted help with crutches to get into her house. Nurses' Notes, dated 3/24/22 at 4:03 p.m., indicated the resident was discharged to home. The face sheet, medication list, medications, bed hold policy, and discharge summary were sent with her. The resident's narcotics script was faxed			

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	over to a pharmacy close to her home. The resident was educated on the importance of visiting with a primary doctor within two weeks, and to call 911 in case of an emergency. The resident took all of her belonging and left the building safely with her father. The Discharge Instructions/Summary, dated 3/24/22, indicated nothing was documented or completed. There was no information on what DME (Durable Medical Equipment) the resident would need at home, no information about home health services and no information if appointments were made for her. The recapitulation of the resident's stay was also incomplete. The first and only Social Service Note was documented on 2/18/22 at 10:58 a.m. regarding a Care Conference meeting. There were no Social Service Notes documented regarding the discharge and any special DME the resident needed. Nothing had been set up. Telephone interview with Resident E on 5/10/22 at 3:18 p.m., indicated it took over 1 month for the equipment to arrive to her home. The primary physician helped get everything she needed as well as signed all the paper work, which the facility failed to do. Interview with the Assistant Director of Nursing on 5/11/22 at 9:20 a.m., indicated she was aware the resident had been discharged without any equipment or help at home. Interview with the Director of Nursing on 5/11/22 at 10:20 a.m., indicated the resident wanted a wheelchair, but did not use a wheelchair while at			

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	the facility so they went back and forth with the outside company and payor source of trying to get that approved. The Social Service Director had quit 1 or 2 weeks prior to the resident's discharge. The discharge instructions were not complete with any information for home health care, or who to contact for the DME the resident may have needed at the time of discharge. This Federal tag relates to Complaint IN00376737. 3.1-36(a)1) 3.1-36(a)(2) 3.1-36(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to provide the necessary treatment and services related to the assessment and documentation of a resident's transfer to the hospital, prompt transfer to the hospital after a change in condition, and holding insulin without parameters for 2 of 3 residents reviewed for change in condition and 1 of 3 residents reviewed for insulin dependent diabetes mellitus. (Residents D, H, and L) Findings include:	F 0684	1. 1. Resident D, H, and L were not harmed by the alleged deficient practice. The DON/designee has reviewed Resident L’s insulin orders, and parameters are in place. Resident D and H no longer resident at he facility. 2. 2. All residents that have a change of condition, taking antihypertensive medications, and antidiabetic medications have the	06/13/2022

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	1. The closed record for Resident D was reviewed on 5/10/22 at 9:30 a.m. The resident was admitted to the facility on 10/27/21 and discharged to the hospital on 1/7/22. Diagnoses included, but were not limited to, altered mental status, peg tube, aphasia, high blood pressure, substance abuse, depressive disorder, anxiety, hepatitis, pulmonary embolism, and toxic encephalopathy. The Admission Minimum Data Set (MDS) assessment, dated 11/10/21, indicated the resident was severely impaired for decision making. She was an extensive assist with 2 person physical assist for most activities of daily living. A Care Plan, dated 12/8/21, indicated the resident had altered cardiovascular status related to high blood pressure. A nursing approach was to monitor vital signs and report abnormal findings to the medical provider. Physician's Orders, dated 12/7/21, indicated vital signs every shift for 3 days to establish a baseline. Physician's Orders, dated 12/6/21, indicated Metoprolol Tartrate 100 milligrams (mg). Give 1 tablet every morning and at bedtime for high blood pressure. Lisinopril 10 mg. Give 1 tablet every morning and at bedtime for high blood pressure. A Nurses' Note, dated 1/6/22 at 7:13 p.m., indicated the writer went to assess the resident due to the sister visiting the facility and had a concern with the health and well being of the resident. "This writer addressed concerns to the best of my ability. The sister indicated she		potential to be affected by same alleged deficient practice. A change in condition review has been conducted on all residents with change in condition in the past 15 days, and all change in condition assessments are complete. An order review has been conducted on the residents requiring blood pressure and blood glucose monitoring within the last 15 days, and all orders are up to date with monitoring and parameters in place, per physician orders. 3. 3. The licensed nursing staff have been educated on the “Clinical Documentation Standards” policy and “Medication Administration” policy, with emphasis on documentation completion, and obtaining pertinent information prior to medication administration. All licensed nurses have been educated on calling 911 for emergency transport with change in condition and calling non-emergent transport. 4. 4. DON/Designee will observe 5 residents with change in conditions weekly for one month, and after will observe 2 residents weekly for one month, and then 5 residents monthly for one month to ensure that all change in condition assessments are complete and if transport to the	

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	wanted her sister to be sent to the hospital for a well being check. This writer checked the resident's blood pressure which was 57/39, pulse 45, respirations 20, temperature 97.4, and oxygen saturation was 77%. This writer placed 5 liters of oxygen on the resident and there was no change in her oxygen saturation at that time. This writer called 911 related to the ambulance company being a 60 to 90 minutes wait time. Dispatchers indicated the EMTs (Emergency Medical Technicians) were in route. Called Medical Doctor and reported resident status and decline." A Change in Condition assessment, dated 1/6/22 at 7:26 p.m., indicated the resident's sister stated that she was concerned about the resident's well being and her condition was not stable. The sister indicated the resident was receiving more end of life care than progressing in care and she wanted her removed from the facility. The Physician was notified at 5:00 p.m. of the sister's concern and wanting her sent to the hospital. A Nurses' Note, dated 1/7/22 at 1:03 a.m., indicated the resident was being admitted to the hospital with acute renal failure and possibly the need for dialysis. The Medication Administration Record (MAR) for 12/2021, indicated there was no documentation the resident's vital signs were recorded every shift for 3 days as ordered. The Vital Sign Record indicated the resident's blood pressure and pulse were not being completed daily or even weekly while on the blood pressure medications. Interview with the Assistant Director of Nursing on 5/11/22 at 9:20 a.m., indicated there was no		hospital was necessary that the correct transport system was utilized. The change in condition assessments will be audited for completion Monday-Friday as this is an on-going facility practice. DON/Designee will observe 5 residents with antihypertensive and/or antidiabetic medication orders weekly for one month, and after will observe 2 residents weekly for one month, and then 5 residents monthly for one month to ensure blood pressure and blood glucose monitoring is in place. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months.	

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	daily monitoring of her blood pressure while on the 2 antihypertensive medications. The Physician was notified of the resident's change in condition at 5:00 p.m., however, the resident was not sent out to the hospital for over 2 hours after the physician had been notified of the sister's request. 2. The closed record for Resident H was reviewed on 5/10/22 at 10:50 a.m. The resident was admitted to the facility on 2/17/22 and discharged to the hospital on 2/27/22. Diagnoses included, but were not limited to, wedge compression fracture of second lumbar vertebra, osteomyelitis, asthma, cancer, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 2/24/22, indicated the resident was cognitively intact. Nurses' Notes, dated 2/26/22 at 3:01 p.m., indicated the resident was noted to have an increase in confusion at this time, but remained stable. The resident was alert to self only and vital signs were stable. The resident's daughter was the bedside and demanded to have the resident sent to the nearest emergency room. The daughter indicated the resident was hallucinating and did not know who she was. The daughter indicated this was far from the resident's baseline. The physician was notified and agreed to send the resident to the hospital for and evaluation. The Ambulance company was called for transport and estimated time of arrival was roughly 3 hours. The next documented entry in Nurses' Notes was on 2/27/22 at 8:22 a.m., which indicated the resident was admitted to the hospital with an			

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altered mental status.

There was no Change in Condition assessment completed. There was no other documentation in Nursing Progress Notes to indicate when the resident left the facility or the condition the resident was in when she left. There was no documentation to indicate if 911 was called with the estimated time for an ambulance being 3 hours.

Interview with the Assistant Director of Nursing (ADON) on 5/11/22 at 9:20 a.m., indicated she had no idea how the resident was transported to the hospital, 911 or regular transport. There was no documentation regarding when the resident actually left or the condition she left in.3. Resident L's record was reviewed on 5/10/22 at 9:32 a.m. Diagnoses included, but were not limited to, intracranial abscess and granuloma, diabetes mellitus, and stroke.

The Quarterly Minimum Data Set (MDS) assessment, dated 4/20/22, indicated the resident was severely cognitively impaired and had received insulin injections daily for the past 7 days.

A Care Plan, dated 11/22/21, indicated the resident had diabetes and interventions included, but were not limited to, administer insulin injections per the Physician's orders.

A Physician's Order, dated 4/2/22 at 8:00 a.m., indicated insulin lispro solution (an antidiabetic medication) 16 units injection before breakfast and lunch.

A Physician's Order, dated 4/2/22 at 5:00 p.m., indicated insulin lispro solution 8 units injection

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

with dinner.

A Physician's Order, dated 4/2/22 at 9:00 p.m., indicated insulin glargine solution (an antidiabetic medication) 10 units injection at bedtime.

The Medication Administration Record (MAR) for April 2022 indicated the following:

The insulin lispro solution 16 units scheduled at 8:00 a.m. was not administered on 4/9/22 with a blood sugar level of 60 milligram/deciliter (mg/dL) and 4/24/22 with a blood sugar level of 70 mg/dL due to "no insulin coverage required."

The insulin glargine solution 10 units at 9:00 p.m. was not administered due to "no insulin coverage required" on the following dates with accompanying blood sugar levels:
- 4/4/22, 94 mg/dL
- 4/20/22, 84 mg/dL
- 4/23/22, 101 mg/dL
- 4/27/22, 94 mg/dL

The insulin lispro solution 8 units at 5:00 p.m. was not administered on 4/20/22 with a blood sugar level of 78 mg/dL and 4/22/22 with a blood sugar level of 88 mg/dL due to no insulin coverage required.

The record lacked any indication of parameters to withhold the insulin glargine and insulin lispro solutions.

Interview with the Assistant Director of Nursing (ADON) on 5/11/22 at 9:50 a.m., indicated the insulin glargine and insulin lispro should have been held according to any parameters set by the physician and no further information was provided.

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	155218	A. BUILDING 00 B. WING	05/11/2022

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	This Federal tag relates to Complaint IN00376685 and IN00376737. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure medications were administered timely after admission, blood sugars were monitored while receiving insulin or an oral antidiabetic medication, and insulin was administered as ordered by the Physician for 2 of 3 residents reviewed for unnecessary medications and 1 of 3 residents reviewed for insulin	F 0757	1. 1. Resident E, J, and F were not harmed by the alleged deficient practice. The DON/designee has conducted a review of Resident F's medication orders on dialysis days and medication regimen has been adjusted per resident's preference	06/13/2022

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	dependent diabetes mellitus. (Residents E, J, and F) Findings include: 1. The closed record for Resident E was reviewed on 5/10/22 at 2:30 p.m. The resident was admitted from the hospital on 2/10/22 and was discharged home on 3/24/22. Diagnoses included, but were not limited to, osteomyelitis of the right ankle, type 2 diabetes, pain to right knee, pain in thoracic spine, depressive disorders, anxiety disorder, vitamin B deficiency anemia, fibromyalgia, psoriasis, low back pain, gerd, high blood pressure, and hyperlipidemia. The Admission Minimum Data Set (MDS) assessment, dated 2/16/22, indicated the resident was cognitively intact. Nurses' Notes, dated 2/10/22 at 8:16 p.m., indicated the resident was admitted to the facility to receive therapy and eventually discharge back home. Discharge instructions from the hospital indicated the following medications were to be administered while at the facility and to be scheduled for 2/11/22: - Cozaar 100 milligrams (mg) daily - Folic acid 1 mg daily - Hydrochorothiazide 25 mg daily - Levothyroxine 15 mcg daily - Omeprazole 40 mg daily - Paroxetine 20 mg daily - Pravastin 20 mg daily - Pramipexole Dihydrochloride .5 mg three times a day		and physician orders. Resident E and J no longer reside at the facility. 2. 2. Any resident that is newly admitted resident and any resident on dialysis have the potential to be affected by the same alleged deficient practice. An admission medication review has been conducted on all residents admitted within the past 15 days, and any discrepancies have been addressed with the physician. A medication review of dialysis residents has been conducted and all medications requiring adjustment have been adjusted for administration in accordance with their dialysis schedule. 3. 3. All licensed nursing staff have been educated on the "Medication Administration" policy, with emphasis on medication administration in a timely manner, medications available on admission, and all pertinent vital signs are obtained prior to medication administration. Education on medication administration and availability with regards to residents that receive dialysis and their schedule. 4. 4. DON/Designee will review all new residents medication list/reconciliation five times a week as part of this facility's ongoing clinical AM meeting process. This	

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	The 2/2022 Medication Administration Record (MAR) indicated all of above medications were administered for the first time on 2/13/22. The following medications were also on the hospital discharge instructions to start immediately: - Rasuvo 15 mg inject into skin every 7 days on Monday - Sterlera 90 mg inject into the skin every 3 months - Metformin 500 mg - Restasis .05% 1 drop both eyes two times a day - Lyrica 25 mg three times a day - Cyanocobalamin Solution 1000 micrograms (mcg). Inject 1000 mcg intramuscularly one time a day starting on the 10th of every month. The 2/2022 MAR indicated Rasuvo 15 mg injection was not administered on 2/14 and 2/21/22. The Sterlera 90 mg injection was scheduled for 2/16/22 and was not signed out as being administered. The Metformin 500 mg was first signed out as being administered on 2/12/22 at 5:00 p.m. The Restasis eye drops were not administered until 2/12/22 at 8:00 p.m. and the Lyrica 25 mg was not signed out as being administered until 2/17/22. The 3/2022 MAR indicated the Cyanocobalamin injection was never administered on 3/10/22. The resident was also to have blood glucose monitoring completed daily per the discharge instructions. The 2/2022 MAR indicated there was no documentation of blood glucose monitoring. A Physician's Order, dated 3/3/22, indicated		process will continue to review all new admissions within 48 hours of the new admission to the facility weekly to ensure that all residents receive the appropriate medication regimen from admission and throughout their stay. The admission medication review will be audited for completion Monday-Friday as this is an on-going facility practice. DON/Designee will complete a Blood glucose audit on 5 residents taking antidiabetic medications weekly for one month, and 2 residents weekly for one month, and 5 residents monthly for one month to ensure that blood sugars are obtained prior to medication administration. The DON/designee will report on audits monthly to the QAPI team for 6 months during QAPI Meeting. Determination will be made as to whether audits will remain ongoing as necessary thereafter after 6 months.	

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accuchecks one time a day for diabetes.

Interview with the Assistant Director of Nursing on 5/12/22 at 9:20 a.m., indicated the resident's medications were not administered timely after being admitted to the facility.

2. The closed record for Resident J was reviewed on 5/10/22 at 12:12 p.m. The resident was admitted to the facility on 2/10/22 and was discharged to an assisted living facility on 2/25/22.

Diagnoses included, but were not limited to, spinal stenosis, renal dialysis, type 2 diabetes, COPD, asthma, history of cocaine abuse, glaucoma, heart failure, major depressive disorder, high blood pressure, chronic active hepatitis, and atrial fibrillation.

The Admission Minimum Data Set (MDS) assessment, dated 2/15/22, indicated the resident was cognitively intact.

Physician's Orders, dated 2/10/22, indicated Insulin Detemir Solution 100 units/milliliter (ml). Inject 12 units subcutaneously at bedtime and 6 units in the morning for diabetes. The scheduled times were 8:00 a.m. and 9:00 p.m.

The Medication Administration Record (MAR) for 2/2022 indicated there was no documentation of any blood sugars obtained before the administration of the evening dose of Insulin on 2/11-2/15, 2/17, 2/18, 2/20, 2/21, 2/22, 2/23, and 2/24/22. There was no documentation of any blood sugars obtained before the morning dose of Insulin on 2/11-2/16/22.

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	Interview with the Assistant Director of Nursing on 5/11/22 at 9:20 a.m., indicated there was no documentation of blood sugars prior to the administration of Insulin.3. Resident F's record was reviewed on 5/9/22 at 11:47 a.m. Diagnoses included, but were not limited to, diabetes mellitus, renal failure, high blood pressure, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/8/22, indicated the resident was cognitively intact and received dialysis treatments. A Care Plan, initiated 2/27/19, indicated the resident had diabetes and interventions included, but were not limited to, administration of insulin injections and obtaining blood sugars per the Physician's orders. A Physician's Order, dated 3/31/22 at 12:00 p.m., indicated to give the resident insulin aspart (an antidiabetic medication) 100 units/milliliters (u/mL) injection before meals per sliding scale.: if blood sugar was 0-199 = 0u; 200-250 = 4u ; 251-299 = 6u; 300-349 = 8u; 350-399 = 10u; greater than 400 give 12u and call Physician. The Medication Administration Record (MAR) for April 2022 indicated insulin aspart was not administered as ordered at 12:00 p.m. on 4/1/22, 4/4/22, 4/6/22, 4/8/22, 4/11/22, 4/13/22, 4/15/22, 4/18/22, 4/20/22, 4/22/22, 4/25/22, 4/27/22, 4/29/22. Interview with the Assistant Director of Nursing on 5/11/22 at 9:45 a.m., indicated the insulin aspart and blood sugar checks were not completed on those days due to the resident being out of the facility at dialysis. The medication schedule should have been adjusted on the scheduled			

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	dialysis days to ensure the resident did not miss any medications. This Federal tag relates to Complaint IN00376737. 3.1-48(a)(6)			