<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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| F 333 | SS=D | **483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS**  
The facility must ensure that residents are free of any significant medication errors.  
This REQUIREMENT is not met as evidenced by:  
Based on observations, record review and staff interviews, the facility failed to follow the prescribed schedule for insulin administration resulting in an unscheduled dose of insulin being given to 1 of 1 residents (Resident #173) who received an insulin injection during the medication administration observation.  
The findings included:  
Resident #173 was admitted to the facility on 3/16/15 with cumulative diagnoses which included diabetes.  
During the medication administration observation on 3/17/15 at 8:27 AM, Nurse #1 was observed as she prepared and administered 25 units of Levemir insulin to Resident #173 as a subcutaneous (under the skin) injection. Levemir insulin (generic name of insulin detemir) is an intermediate to long-acting insulin. According to LexiComp, a comprehensive on-line medication database, Levemir insulin has an onset of action of 3-4 hours; peak effect of 3-9 hours; and duration of action of up to 23 hours.  
A review of Resident #173’s admission orders dated 3/16/15 revealed a physician’s order was written for 25 units of Levemir insulin to be injected subcutaneously once daily at 9:00 PM, with the first dose scheduled for 3/16/15 at 9:00 | F 333 | | It is the policy of this facility to ensure that all residents are free of any significant medication errors. Actions taken towards accomplishing this goal:  
**Immediate Actions:**  
1) Director of Nursing notified of medication error.  
2) Physician notified of medication error and orders received to hold further insulin on 3/17/15 and to change scheduled insulin administration from the evening to the morning starting the next day.  
3) Resident #173’s blood glucose was monitored every two hours for 12 hours on 3/17/15 to ensure stable blood glucose level with no hypoglycemic events.  
**Subsequent Actions: (Corrective Actions & Systemic Changes)**  
1) Policy on “Proper Administration of Medication Administration”, with a strong emphasis on insulin administration was reviewed with all scheduled nurses. | 3/17/15 | 3/17/15 | 3/17/15 | 3/18/15 |
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<tr>
<th>(X4) ID</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 333</td>
<td>3/18/15</td>
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**F 333 Continued From page 1**

PM. A review of the resident's electronic medical record revealed there was no documentation on the resident’s Medication Administration Record (MAR) to indicate the resident had been given the Levemir insulin on 3/16/15. Documentation on the MAR indicated an injection of 25 units of Levemir insulin was given to the resident on 3/17/15 at 8:30 AM (as observed during the medication administration observation).

An interview was conducted with Nurse #1 on 3/17/15 at 2:42 PM. During the interview, inquiry was made as to why there was a discrepancy between the scheduled time of insulin administration for Resident #173 and the time it was observed to be given. Nurse #1 stated that the electronic MAR had indicated the insulin was due that morning. She questioned whether a new order had possibly been received to change the administration time of the Levemir insulin. Upon review of Resident #173’s MAR, Nurse #1 reported that she could not find any indication that the insulin administration time had been changed. Nurse #1 then stated is was possible the Levemir insulin had not been given the previous night (3/16/15) and may have been “carried over” by the electronic MAR to the morning of 3/17/15, prompting her to administer a dose of the insulin. Nurse #1 reported she did not recall the electronic MAR providing any type of alert about the medication being administered at the wrong time.

On 3/17/15 at 2:50 PM, Nurse #1 was observed as she consulted with the hall's Charge Nurse (Nurse #2). On 3/17/15 at 2:55 PM, Nurse #2 stated she had contacted the facility's pharmacy by telephone and reported the pharmacy did not have a record of an order change for Resident #173.
F 333 Continued from page 2

#173's Levemir insulin. The current order indicated Levemir insulin was to be administered once daily at 9:00 PM. Nurse #2 stated the resident's physician would need to be contacted and informed the Levemir insulin had been administered to Resident #173 at 8:30 AM on 3/17/15.

An interview was conducted with Nurse #3 on 3/17/15 at 2:57 PM. Nurse #3 was the 2nd shift nurse who cared for Resident #173 from 3:00 PM to 11:00 PM on 3/16/15. Nurse #3 reported the 3rd shift nurse had called him last evening (3/16/15) to inquire whether or not he had given Resident #173 her 9:00 PM dose of Levemir insulin. Nurse #3 reported he clearly recalled giving the resident a 9:00 PM dose of Levemir insulin, but stated he apparently had not documented the insulin administration on the resident's MAR. Nurse #3 indicated he asked the 3rd shift nurse to document that the 9:00 PM insulin dose had been given to Resident #173 on 3/16/15. He stated that he had planned to make an additional notation about the missed documentation of the insulin administration when he returned to work on 3/17/15.

A follow-up interview was conducted with Nurse #2 on 3/17/15 at 3:03 PM. Upon review of Resident #173's medical record, Nurse #2 reported a Nursing Progress Note was written by the 3rd shift nurse on 3/17/15 at 12:55 AM. The note read, "Scheduled insulin, Levemir, given per (Nurse #2), verified to (3rd shift nurse) by (Nurse #2)." Nurse #2 confirmed there were no notations made on the MAR to indicate a dose of Levemir insulin was administered to the resident on 3/16/15 at 9:00 PM. Nurse #2 indicated further review of the MAR revealed the
<table>
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<th>F 333</th>
<th>Monitoring Plan:</th>
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<td>Continued From page 3</td>
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| computerized system had generated a pop-up alert of "Medium Importance" on 3/17/15 at 8:30 AM. Nurse #2 reported a response would have been required to acknowledge and continue past the electronic alert on the MAR. The MAR records indicated Nurse #1 had input an "Early/Late Reason" for administering the Levernir insulin on 3/17/15 at 8:30 AM, with the reason noted as, "Nursing Judgment."

An interview was conducted with the Director of Nursing (DON) on 3/17/15 at 3:04 PM. The DON acknowledged the 8:30 AM dose of Levernir insulin administered to Resident #173 on 3/17/15 was an unscheduled dose. The DON reported the physician had been contacted, informed of the unscheduled administration of Levernir insulin to Resident #173 at 8:30 AM, and new orders were received for the resident.

A follow-up interview was conducted with the facility’s Administrator and DON on 3/17/15 at 5:13 PM. During the interview, the situation involving Resident #173’s unscheduled Levernir insulin administration was discussed. The DON indicated Nurse #3 (the 2nd shift nurse assigned to care for the resident on 3/16/15), “did not follow the process in place.” Both the Administrator and DON reported corrective measures had been initiated to prevent similar occurrences in the future.

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<th>F 333</th>
<th>Implemented on 3/18/15 and Ongoing</th>
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<td>1) The Director of Nursing will monitor medication records to ensure accurate administration of insulin with rounds and through chart audits 3 times per week for the first 30 days or until 100% compliance is achieved for 30 consecutive days.</td>
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2) Ongoing audits will be conducted monthly with 70 insulin administrations reviewed each month for two months, then 70 insulin administrations per quarter for 3 quarters.

3) Any deficiencies will be corrected and reported in a timely manner according to facility policy.

4) Quality monitoring findings, including any correction actions taken in response to deficiencies, will be reported to the Quality Assurance Committee and the organization-wide Quality Coordinating Council.