STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-101 (f) (1) (B) The facility reported a census of 36 residents. The sample included 2 Residents ((R's), R1 and R2). Based on interview and record review the operator failed to protect R1 from neglect, when the facility "Certified Medication Aides" (CMAs) failed to follow the written order for contacting the facility nurse when R1's blood glucose results were outside of the parameters defined by R1's physician. This placed R1 in immediate jeopardy when the actions of not following the physician order and defined parameters, resulted in R1 having a documented blood sugar result of 51 milligrams/deciliter (mg/dL) and the facility CMA failed to notify the facility nurse and administered 17 units of NovoLog (short acting) insulin, the CMA further neglected to check on the resident for 4 hours, resulting in the resident being taken to a local hospital on 03/26/23 when found unresponsive. The resident continues to be out of the facility related to this incident as of 03/29/23.	S3026		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

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S3026	Continued From page 1 Findings include: - Record review on 3/29/23 for R1 revealed an admission date of 04/15/15 with diagnoses of age related osteoporosis without current pathological fracture, other peripheral vertigo, Type 2 Diabetes Mellitus without complications, cognitive deficits following unspecified cerebrovascular disease, chronic obstructive pulmonary disease, muscle weakness, difficulty in walking, age related physical debility, Type 1 Diabetes Mellitus with Hyperglycemia, anxiety disorder, malignant neoplasm of unspecified side of unspecified female breast, and Schizophrenia. Review of R1's "Functional Capacity Screen" (FCS) dated 12/01/22 identified R1 required physical assistance with bathing, dressing, and toileting. She was independent with transferring, walking/mobility, and eating. She required physical assistance with managing her medications, she was incontinent, and her cognition was intact. She was able to make herself understood and she understood others. She was marked with impaired vision, socially inappropriate disruptive behavior, and used a wheelchair mobility device. Review of R1's "Negotiated Service Agreement" (NSA) stated the facility would provide/coordinate the following health services provided by qualified facility staff: bathing three times a week, dressing daily, toileting, provide three meals daily, laundry, and management of medications. The NSA identified that R1 "self-injects" own insulin after the CMA dials up the dose.	S3026		

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	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 2 The NSA lacked the identification of facility staff providing blood glucose monitoring. Review of R1's "Health Service Plan" (HSP) under the section titled "Medication" it was marked "self-administered" and "staff administered", "Resident self-injects own insulin after CMA dials up dose". The HSP lacked the facility instructions for blood glucose monitoring and further lacked the defined parameters set by R1 physician of below 150 mg/dL and above 500 mg/dL, to contact the facility nurse. Record review of the facility electronic document titled "Carrington Self Medication Assessment" dated 12/07/22, revealed the following statement related to medication approved for self-administration: "Licensed/Certified staff to administer medications and perform simple treatments, self-injects own insulin after medication aide dials up correct dose". Review of R1 electronic "Progress Notes" dated 01/24/23 to 02/29/23 revealed the following entries in the EMAR (Electronic Medication Administration Record) Medication Administration Notes: 03/03/23 at 11:50 AM blood sugar was 53. The record lacked a note stating the nurse had been notified. 03/13/23 and 03/13/23 no test strips. 03/15/23 at 09:35 AM blood sugar 106. The record lacked a note stating the nurse had	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 3	S3026		

been notified.
03/16/23 at 08:11PM "not in".
03/26/23 to 03/29/23 "hospital" or "out of building".

The record lacked a note documenting/identifying R1 incidents, and other indications of illness or injury including the date, time, actions taken, and results of the action taken.

Review of R1 March 2023 EMAR revealed the following orders:

Levemir FlexTouch Solution Pen-injector 100units/milliliter (Insulin Detemir) Inject 35 units subcutaneously two times a day for diabetes mellitus.

NovoLog FlexPen Solution injector 100 units/milliliter (Insulin Aspart) Inject 17 units subcutaneously three times a day for diabetes mellitus, notify nurse if blood glucose results are under "150 or over 500".

Review of R1's EMAR for March 2023 revealed the following entries of blood glucose results outside of the physician defined parameters of 150 mg/dL and 500 mg/dL (requiring nurse notification) when insulin was given despite low blood glucose results of below 150.

03/01/23 - Blood sugar reading of 91 with insulin administered at 08:00 AM.
03/01/23 - Blood sugar reading of 55 with insulin administered at 12:00 PM.

03/02/23 - Blood sugar reading of 145 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

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S3026	Continued From page 4	S3026		

insulin administered at 08:00 AM.
03/02/23 - The EMAR lacked documentation for the 12:00 PM and 05:00 PM blood sugar results and administration of insulin.
03/03/23 - Blood sugar reading of 123 with insulin administered at 08:00 AM.
03/04/23 - Blood sugar reading of 124 with insulin administered at 08:00 AM
03/04/23 - Blood sugar reading of 143 with insulin administered at 12:00 PM.
03/04/23 - The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin.
03/06/23 - Blood sugar reading of 126 with insulin administered at 08:00 AM.
03/07/23 - Blood sugar reading of 132 with insulin administered at 08:00 AM.
03/07/23 - Blood sugar reading of 110 with insulin administered at 12:00 PM.
03/07/23 - The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin.
03/09/23 - R1 refused the having her blood sugar taken and she further refused her insulin.
03/10/23 - Blood sugar reading of 106 with insulin administered at 08:00 AM.
03/11/23 - Blood sugar reading of 118 with insulin administered at 08:00 AM.
03/11/23 - Blood sugar reading of 83 with insulin administered at 12:00 PM.
03/11/23 - Blood sugar reading of 85 with insulin administered at 05:00 PM.
03/12/23 - Blood sugar reading of 86 with insulin administered at 08:00 AM
03/12/23blood sugar reading of 110 with insulin administered at 12:00 PM.
03/13/23 - Blood sugar reading not obtained and insulin not administered related to not having any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

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S3026	Continued From page 5 glucose test strips. 03/13/23 - Blood sugar reading of 54- insulin administered at 12:00 PM. 03/13/23 - The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin. 03/14/23 - Blood sugar reading of 99-with insulin administered at 08:00 AM. 03/14/23 - Blood sugar reading of 86 with insulin administered at 12:00 PM. 03/14/23 - Blood sugar reading of 97 with insulin administered at 05:00 PM. 03/15/23 - Blood sugar reading not obtained and insulin not administered. 03/15/23 - Medication Administration Note stated R1's blood sugar was 106. The record lacked a note stating the nurse had been notified. 03/16/23 - The EMAR lacked documentation of the 05:00PM blood sugar results and administration of insulin. 03/16/23 - "Progress Note" had the following entry at 8:11 PM EMAR Medication administration note "not in". The note lacked documentation of the nurse being notified. 03/17/23 - Blood sugar reading of 149 with insulin administered at 08:00 AM. 03/17/23 - Blood sugar reading of 81 with insulin administered at 12:00 PM. 03/17/23 - Blood sugar reading of 109 with insulin administered at 05:00 PM. 03/18/23 - Blood sugar of 75 with insulin administered at 08:00 AM. 03/18/23 - Blood sugar of 117 with insulin administered at 12:00 PM. 03/18/23 - The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin. 03/19/23 - blood sugar reading of 59 with insulin	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

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S3026	Continued From page 6	S3026		

administered at 12:00 PM.
03/20/23 - Blood sugar reading of 144 with insulin administered at 05:00 PM.
03/21/23 - Blood sugar reading of 107 with insulin administered at 08:00 AM.
03/21/23 - Blood sugar reading of 57 with insulin administered at 12:00 PM.
03/21/23 - The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin.
03/22/23 - Blood sugar reading of 110 with resident refusal of insulin at 08:00 AM.
03/23/23--Blood sugar reading of 79 with insulin administered at 08:00 AM.
03/23/23 - The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin.
03/24/23 - Blood sugar reading of 98 with resident refusal of insulin at 08:00 AM.
03/24/23 - Blood sugar reading of 125 with resident refusal of insulin at 12:00
03/25/23 - Blood sugar reading of 115 with insulin administered at 08:00 AM.
03/25/23 - Blood sugar reading of 112 with insulin administered at 12:00 PM.
03/25/23 - Blood sugar reading of 81 with insulin administered at 05:00 PM.
03/26/23 - Blood sugar reading of 51 with insulin administered at 08:00 AM.
03/26/23 at 12:00 PM to 03/29/23 05:00 PM EMAR documentation for the scheduled blood sugar reading and insulin administrations indicated the resident is "hospitalized".

Interview on 03/29/23 at approximately 12:45PM with "Licensed Nurse" (LN) A and Operator/LN B, confirmed the facility CMAs did not notify the nurse when R1's blood sugars were outside of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

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S3026	Continued From page 7	S3026		

the defined physician parameters.

03/29/23 at 01:17 PM Operator/LN B and LN A were notified of immediate jeopardy for failure to protect R1 related to facility CMAs not following physician orders and failing to notify the facility nurse when blood glucose readings were outside the physician defined parameters. This failure led to a facility CMA administering 17 units of short-acting insulin to R1 when she had a recorded blood glucose of 51 mg/dL resulting in R1 being found unresponsive and transferred to a local hospital where she continued to remain during the survey process.

Review of CMA C signed, and notarized witness statement revealed she did not call the nurse when R1's blood sugars were out of the physician defined parameters.

Review of CMA D signed and notarized witness statement included the following statement: "Did not notify nurse as per protocol on the days mentioned when blood sugar was low".

Facility abatement plan provided by Operator/LN B and immediacy lifted at 02:08 PM which included the following:

All CMA's educated immediately on insulin. CMA's must attend prior to working their next shift. All new CMAs hired will be provided new education prior to beginning work. A LN or designee will audit insulin dependent medication management daily for the next 30 days. If all audits are "good" the audit time will be changed to weekly for 90 days, then to monthly. All discrepancies to procedures and standards of

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	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 8 practice and will be addressed and the staff re-educated.	S3026		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: K.A.R 26-41-105 (f) (11) The facility reported a census of 36 residents. The sample included 3 "Residents'" ((R's) R's 1, 2 and 3), and one closed record review (R4). Based on record review and interview the operator failed to ensure the resident record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions taken for R1, R2, and R4. Findings include: - Record review for R1 revealed an admission date of 04/15/15 with diagnoses of age related osteoporosis without current pathological fracture, other peripheral vertigo, Type 2 Diabetes Mellitus without complications, cognitive deficits following unspecified cerebrovascular disease, chronic obstructive	S3261		

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	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

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S3261	Continued From page 9	S3261		

pulmonary disease, muscle weakness, difficulty in walking, age related physical debility, Type 1 Diabetes Mellitus with Hyperglycemia, anxiety disorder, malignant neoplasm of unspecified side of unspecified female breast and Schizophrenia.

Review of R1 "Functional Capacity Scree" (FCS) dated 12/01/22 identified R1 required physical assistance with bathing, dressing, and toileting. She was independent with transferring, walking/mobility and eating. She required physical assistance with managing her medications, she was incontinent, and her cognition was intact. She was able to make herself understood and she understood others. She was marked with impaired vision, socially inappropriate disruptive behavior and used a wheelchair mobility device.

Review of R1 "Negotiated Service Agreement" (NSA) stated the facility would provide/coordinate the following health services provided by qualified facility staff: bathing three times a week, dressing daily, toileting, provide three meals daily, laundry, and management of medication. The NSA identified that R1 "self-injects" own insulin after the CMA dials up the dose.

Review of R1 "Health Service Plan" (HSP) under the section titled "Medication" it is marked "self-administered" and "staff administered", "Resident self-injects own insulin after CMA dials up dose".

Record review of the facility electronic document titled "Carrington Self Medication Assessment" revealed the following statement related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON HOUSE CENTRAL	1432 N WACO STREET WICHITA, KS 67230

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S3261	Continued From page 10	S3261		

medication approved for self-administration: "Licensed/Certified staff to administer medications and perform simple treatments, self-injects own insulin after medication aide dials up correct dose".

Review of R1 electronic "Progress Notes" dated 01/24/23 to 02/29/23 revealed the following entries:

03/03/23 at 11:50 AM eMAR Medication Administration Note blood sugar was 53.
The record lacked a note stating the nurse had been notified.
03/13/23 and 03/13/23 eMAR Medication Administration Note no test strips.
03/15/23 at 09:35 eMAR Medication administration note blood sugar 106.
The record lacked a note stating the nurse had been notified.
03/16/23 at 20:11 eMAR Medication administration note "not in".
03/26/23 to 03/29/24 eMar Medication administration notes read "hospital" or "out of building".

The record lacked a note documenting/identifying R1 incidents, and other indications of illness or injury including the date, time, actions taken, and results of the action taken.

Review of R1 "Electronic Medication Administration Record" (EMAR) revealed the following orders:
Levemir FlexTouch Solution Pen-injector 100units/milliliter (Insulin Detemir) Inject 35 units subcutaneously two times a day for diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 11	S3261		

mellitus.
NovoLog FlexPen Solution injector 100 units/milliliter (Insulin Aspart) Inject 17 units subcutaneously three times a day for diabetes mellitus, notify nurse if blood glucose results are under "150 or over 500".

Review of R1 EMAR for March 2023 revealed the following entries of blood glucose readings being out of the physician defined parameters of below 150 and above 500.

03/01 blood sugar reading of 91 and insulin administered at 08:00 AM.
03/01 blood sugar reading of 55 with insulin administered at 12:00 PM.
03/02 blood sugar reading of 145 with insulin administered at 08:00 AM.
The EMAR lacked documentation for the 12:00 PM and 05:00 PM blood sugar results and administration of insulin.
03/03 blood sugar reading of 123 with insulin administered at 08:00 AM.
03/04 blood sugar reading of 124 with insulin administered at 08:00 AM
blood sugar reading of 143 with insulin administered at 12:00 PM
The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin.
03/06 blood sugar reading of 126 with insulin administered at 08:00 AM.
03/07 blood sugar reading of 132 with insulin administered at 08:00 AM.
blood sugar reading of 110 with insulin administered at 12:00 PM.
The EMAR lacked documentation of for the 05:00PM blood sugar results and administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 12 of insulin. 03/09 R1 refused the having her blood sugar taken and she further refused her insulin. 03/10 blood sugar reading of 106 with insulin administered at 08:00 AM. 03/11 blood sugar reading of 118 with insulin administered at 08:00 AM. blood sugar reading of 83 with insulin administered at 12:00 PM. blood sugar reading of 85 with insulin administered at 05:00 PM. 03/12 blood sugar reading of 86 with insulin administered at 08:00 AM blood sugar reading of 110 with insulin administered at 12:00 PM. 03/13 blood sugar reading not obtained and insulin not administered related to not having any glucose test strips. Blood sugar reading of 54 with insulin administered at 12:00 PM. The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin. 03/14 blood sugar reading of 99 with insulin administered at 08:00 AM. blood sugar reading of 86 with insulin administered at 12:00 PM. blood sugar reading of 97 with insulin administered at 05:00 PM. 03/15 blood sugar reading not obtained and insulin not administered. The progress notes for 03/15/23 eMAR Medication administration note stated R1 blood sugar was 106. The record lacked a note stating the nurse had been notified.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 13 03/16 The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin. The progress notes for 03/16/23 had the following entry at 8:11PM: eMAR Medication administration note "not in". The note lacked documentation of the nurse being notified. 03/17 blood sugar reading of 149 with insulin administered at 08:00 AM. blood sugar reading of 81 with insulin administered at 12:00 PM. blood sugar reading of 109 with insulin administered at 05:00 PM. 03/18 blood sugar of 75 with insulin administered at 08:00 AM blood sugar of 117 with insulin administered at 12:00 PM The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin. 03/19 blood sugar reading of 59 with insulin administered at 12:00 PM. 03/20 blood sugar reading of 144 with insulin administered at 05:00 PM. 03/21 blood sugar reading of 107 with insulin administered at 08:00 AM. blood sugar reading of 57 with insulin administered at 12:00 PM. The EMAR lacked documentation of for the 05:00PM blood sugar results and administration of insulin. 03/22 blood sugar reading of 110 with resident refusal of insulin at 08:00 AM. 03/23 blood sugar reading of 79 with insulin administered at 08:00 AM. The EMAR lacked documentation of for the	S3261		

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	N087058	A. BUILDING: _____ B. WING _____	03/30/2023

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S3261	Continued From page 14	S3261		

05:00PM blood sugar results and administration of insulin.
03/24 blood sugar reading of 98 with resident refusal of insulin at 08:00 AM.
blood sugar reading of 125 with resident refusal of insulin at 12:00
03/25 blood sugar reading of 115 with insulin administered at 08:00 AM.
blood sugar reading of 112 with insulin administered at 12:00 PM
blood sugar reading of 81 with insulin administered at 05:00 PM.
03/26 blood sugar reading of 51 with insulin administered at 08:00 AM

03/26 at 12:00 PM to 03/29 05:00 PM eMAR documentation for the scheduled blood sugar reading and insulin administrations indicated the resident is "hospitalized".

R1's record lacked note's documenting/identifying all incidents, and other indications of illness or injury including the date, time, actions taken, and results of the action taken.

- Record review for R2 revealed an admission date of 02/28/23 with diagnoses of encounter for orthopedic aftercare following surgical amputation, Type 2 Diabetes Mellitus with diabetic neuropathy, hyperlipidemia, hypothyroidism, muscle weakness, chronic kidney disease stage 3A, cellulitis of left lower limb, chronic multifocal osteomyelitis left ankle and foot, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, anemia, depression, unspecified mood

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S3261	Continued From page 15 disorder, post-traumatic stress disorder, and long term use of insulin. Review of R2 FCS dated 02/28/23 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility and was independent with eating. R2 required supervision for managing medications and was frequently incontinent. R2 was cognitively intact and was understood by others and understood others. R2 used a walker and wheelchair mobility devices. Review of R2 NSA stated the facility staff would provide/coordinate the flowing health services: bathing 3 times a week, incontinent issues, physical assist of 1 staff for safe transfers, manage medications and medical treatments. The NSA identified R2 "self-administers own insulin after CMA dials up dose. Review of R2 HSP instructed facility staff to assist with bathing 3 times a week and report any skin issues to the nurse, assist with dressing for safety, and under the section titled "Medication" it is marked "self-administered" and "staff administered", "Resident self-injects own insulin after CMA dials up dose". Record review of the facility electronic "Progress notes" revealed the following entries: 02/28/23 admission note Late entry "resident admitted to Carrington House Central, ambulates with walker and uses wheelchair for long distances". 03/19/23 eMAR Medication Administration Note "blood sugar to low" 03/24/23 eMAR Medication Administration Note	S3261		

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S3261	Continued From page 16 "Not giving" Record review of R2 EMAR dated March 2023 revealed R2 refused insulin on the following dates: 03/04, 03/13, 03/14, 03/17, 03/18, 03/20, and 03/24. The electronic progress notes lacked documentation of why resident refused the ordered insulin and lacked notification of physican. Interview on 03/29/23 at 03:00 PM with R2 revealed that if the blood sugar reading is below 100, R2 will refuse to self-inject the insulin. R2 continued that snacks and soda are available if needed. R2's record lacked note's documenting/identifying all incidents, and other indications of illness or injury including the date, time, actions taken, and results of the action taken. - Closed record review for R4 revealed an admission date of 10/25/22 and a discharge date of 02/14/23, with diagnoses of Other general symptoms and signs, amyotrophic lateral sclerosis, alcoholic polyneuropathy, muscle spasm, insomnia due to medical condition, and constipation. Review of R4 FCS dated 10/25/22 revealed she required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating. She lacked the ability to manager her	S3261		

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S3261	Continued From page 17	S3261		

own medications, was incontinent, and cognitively intact. She was able to make herself understood and she understood others. She was marked with fall and impaired vision, and she used a wheelchair and mechanical lift assistive device.

Review of R4 NSA dated 10/25/22 stated the facility staff would provide/coordinate the flowing health services: bathing 3 times a week, toileting assistance, transferring assistance, activities of daily living assistance, set up for meals, management of medications, and coordination of hospice services.

Review of R4 HSP instructed facility staff to assist with bathing 3 times a week and report any skin issues to the nurse, and hospice to assist with comfort care. Staff to assist with dressing/undressing and manage administration of medications and simple treatments. Staff to assist with transferring and use the mechanical lift as needed for safety.

Review of document titled "Physician Order Fax" revealed an order dated 01/17/23 that stated:" Need for higher level of care due to decline in health".

Review of document titled "Progress Note" from R4 provider revealed the following statement in the history "Staff expresses growing concern due to patient's continued alcohol consumption and risk to residents. She recently was evaluated in the emergency department due to patient accusing staff of assault and battery. There is no evidence correlated with this claim and this accusation was ruled out by emergency

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S3261	Continued From page 18 department and authorities". Review of R4 electronic "Progress Notes" lacked an entry for R4 being evaluated in an emergency department. An entry on 01/17/23 at 03:41 stated a nurse from another facility will "be out tomorrow to do care plan assessment, resident aware". The electronic "Progress Notes" lacked an entry for the investigation and allegation of the staff assault to the resident, it continued to lack the resident being evaluated in an emergency room and the note further lacked a note of discharge when the resident moved out of the facility. The operator failed to ensure the resident record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions taken for R1, R2, and R4.	S3261		