STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065110	A. Building B. Wing	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on record review and interviews, the facility failed to ensure the residents were kept free from significant medication errors for one (#1) out of three sample residents. On 10/19/22 Resident #1's insulin orders were discontinued by licensed practical nurse nurse (LPN) #1. The facility failed to have a system in place to confirm and verify the accuracy of the discontinuation of resident medications. Resident #1's insulin orders were discontinued on 10/19/22 by the LPN #1 who thought the orders were a duplicate. This caused the resident to miss (one dose) of 16 units of her Basaglar (long acting insulin) and three units (one dose) of her Novolog (short acting insulin). The resident's blood sugar on 10/21/22 at 7:30 a.m. was 600 milligram/deciliter (mg/dl, with a normal fasting range 70 to 100 mg/dl). The resident was sent to the emergency room for evaluation and treatment, and passed away on 10/21/22 at 11:41 a.m. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 11/7/22 to 11/10/22, resulting in the deficiency being cited as past noncompliance with a correction date of 10/27/22. I. Facility policy and procedure The Medication Errors policy and procedure, revised 6/1/21, was provided by the nursing home administrator (NHA) on 11/9/22 at 6:11 p.m. It documented the following: Medication error at a (name of the facility) will be investigated and appropriate interventions will be implemented. Staff will report, log, and trend medication errors. A medication error is defined as a discrepancy between what the physician/advanced practice provider ordered and what the patient received. Types of errors include; medication omission; wrong patient, dose, route, rate, or time; incorrect preparation; and/or incorrect administration technique. The NHA stated the facility did not have a policy prior to 10/19/22 for the process to discontinue medications. The NHA stated the facility had implemented a new policy and procedure on 10/27/22. That policy and procedure documented the following: (continued on next page)

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.

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Under no circumstances are resident orders to be discontinued without physician orders. Moving forward all verbal orders will be written on the new physician telephone order form provided. 1. The nurse will take the physician order and write it on the order form and read it back to the physician to ensure orders are clear and concise. 2. (The) nurse will enter (the) order in the computer and place the written order and place it in the queue (of the electronic medical record system). 3. (The) physician order form will be given to the second (2nd) nurse to read and confirm (the) order was entered correctly. 4. (The) physician order will be placed in a folder labeled 24 hour chart checks. 5. (The) night shift (nurse) will conduct 24 hour chart checks to ensure order accuracy. 6. Every nurse on every shift (willO process orders for their shift, no exceptions. 7. Order baskets (are) available at one (1) hall and four (4) hall. II. Immediate Jeopardy for serious harm A. Situation of Immediate Jeopardy Resident #1 insulin orders were discontinued on 10/19/22 by the LPN #1 who thought the orders were a duplicate. This caused the resident to miss (one dose) of 16 units of her Basaglar (long acting insulin) and three units (one dose) of her Novolog (short acting insulin) on 10/20/22. The resident's blood sugar on 10/21/22 at 7:30 a.m. was 600. The resident was sent to the emergency room for evaluation and treatment, and passed away on 10/21/22 at 11:41 a.m. The NHA was notified of the immediate jeopardy on 11/9/22 at 11:40 a.m. Record review and interviews during the complaint investigation confirmed the deficient practice which had been correct and the facility was in substantial compliance at the time of the survey. B. Facility plan to remove the Immediate Jeopardy situation The NHA provided the facility's plan of correction (POC) dated 10/27/22, on 11/8/22 at 11:15 a.m. The POC documented the following: 1. Corrective action- Resident (#1) insulin discontinued. (The) resident (was) sent out to the hospital of choice. 2. Identification of others - All residents have the potential to be affected by this practice. All other residents' on insulin orders were reviewed and confirmed for accuracy by the Medical Director (MD). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Systematic measures- Director of nursing (DON) and/or designee provided education to licensed personnel on transcribing and implementing physician orders, medication administration, second (2nd) nurse verification for an new orders or discontinuation of orders, shift to shift report, process for reviewing new orders, identifying change in condition documentation. (The) pharmacy representative to audit for any duplicate orders. 4. Monitoring performance- (The) DON and/or designee will conduct audits 5 (five) times a week of blood glucose (sugar) results and insulin administration for 4 (four) weeks, then weekly for 4 (four) weeks, then monthly for one (1) month, until compliance is sustained. The nursing home administrator (NHA) and/or DON and/or designee will review the results of the audits and reports results in the monthly quality assurance performance improvement (QAPI) Committee meeting monthly for one quarter to ensure compliance is achieved and sustained. Subsequent plans of corrections will be implemented as necessary. 5. Date of compliance- immediately. A review of the training completed by the DON revealed all the nurses in the facility had been trained prior to 10/27/22. C. Removal of Immediate Jeopardy Interview and record review during the complaint investigation revealed corrective actions to identify the resident and other residents having potential to be affected by the deficient practice, systematic changes to prevent its recurrence and monitoring to ensure sustained correction. Therefore, the deficient practice was corrected prior to the onsite investigation and represented past noncompliance at G level, actual harm that is isolated. III. Failure to have a system in place to confirm and verify discontinued medications A. Resident #1 status A. Resident status Resident #1, age 85, was admitted to the facility on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included type 1 diabetes, and long term (current) use of insulin. The 8/11/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required extensive assistance of one person for bed mobility, transfers and dressing, and total dependence of one person for eating, personal hygiene and eating. The MDS documented the resident received insulin for seven days of the seven day look back period. B. Record review A review of the resident's October 2022 physician orders revealed the following orders: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Basaglar KwikPen Solution Peninjector (long acting insulin) 100 unit/ml (milliliter); inject 16 units subcutaneously one time a day for diabetes, with a start date of 8/19/22, and a discontinue date of 10/19/22. The discontinue note read: duplicate of order: Three (3) units every 12 hours as needed for BG (blood glucose) above 400. -Novolog solution (fast acting insulin) 100 units/ml; inject 3 (three) units subcutaneously in the morning for diabetes, give only if she eats more than 50 percent of breakfast, with a start date of 8/19/22, and a discontinue date of 10/19/22. The discontinue note read: duplicate of order: Three (3) units every 12 hours as needed for BG (blood glucose) above 400. -HumaLog injection (fast acting insulin) solution 100 unit/ml; inject 3 (three) units subcutaneously as needed up to twice daily if blood sugar (is) over 400, with a start date of 9/24/22, and a discontinue date of 10/19/22. The discontinue note read: duplicate of order: Three (3) units every 12 hours as needed for BG (blood glucose) above 400. A review of the resident's nursing progress notes revealed the following progress notes on 10/21/22: 3:57 a.m. Resident c/o (complained of) indigestion. Stated she had a big supper with mac and cheese. CNA (certified nurse aide) confirmed this report stated resident ate 100 percent of her meal. Resident requested ginger ale or seven-up for GI (gastrointestinal) upset. Small amount of Mt. Dew (soda) given, less than 100 cc (cubic centimeter). Approximately 10 minutes later, resident had an emesis which was dark brown and roughly 100 cc (cubic centimeters). Resident a/o (alert and oriented) stated she felt much better. Vital signs taken, resident back to sleep shortly after this no further complaints. 5:09 a.m. Received (a) report from (the) CNA resident with GI (gastrointestinal) upset. BG (blood glucose) taken 393. Reviewed previous day BGs which were all running in the 200 range which is the resident norm. Historically PRN (as needed) insulin not given until BG greater than 400. 5:40 a.m. Received confirmation from (name of Resident #1) (that an) order (was) placed on resident MAR (medication administration record) for HgA1C (diagnostic test to determine the amount of glucose in the blood). Advised (the) resident labs to be drawn in house since hospital personnel (were) unavailable. Resident stated that she did not want to go to the hospital. Remained alert and oriented and stated she felt ok. 6:15 a.m. Report given to oncoming nurse at bedside. Previous emesis retained in the sink for inspection. A variety of open snacks noted on residents bedside table specifically a package of graham crackers with several crackers missing. It is unknown to this author how much or how many of the residents personal snacks were consumed. Resident remains alert and oriented with little changes in vital signs (which) were taken by (name of CNA). Advised resident further physician involvement (was) warranted to evaluate source of GI upset and or additional orders. Resident still stating she did not want to go to the hospital. Oncoming nurse will place (a) call (to the) physician. 9:32 a.m. Resident had dark brown emesis last night and this morning. Her BG (blood glucose) also higher than 600. PCP (primary care physician) and family have been notified. The PCP gave (an) order to send (the) resident to (name of hospital) at 9:30 a.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1:00 p.m. The nurse called to check on the resident if there was any update. The daughter who answered informed the nurse that her mom passed away. It was heartbreak for the staff. A review of the residents blood glucose monitoring revealed the following: 10/19/22 8:37 a.m. 150 mg/dl (milligram per deciliter) 12:45 p.m. 138 mg/dl 5:44 p.m. 158 mg/dl 7:50 p.m. 151 mg/dl 10/20/22 7:35 a.m. 208 mg/dl 2:02 p.m. 279 mg/dl 4:58 p.m. 231 mg/dl 7:22 p.m. 268 mg/dl 10/21/22 5:09 a.m. 392 mg/dl 8:33 a.m. 600 mg/dl A review of the hospital documents from Resident #1's hospitalization on [DATE] documented the following: History of present illness: Patient is an [AGE] year old female with a history of insulin-dependent diabetes .presents to the emergency department by EMS (emergency medical services) for evaluation of elevated blood sugars, nausea and vomiting the (sic) been getting progressively worse over the last two days. Patient herself is an extremely poor historian. She states she began feeling very nauseous and had multiple episodes of vomiting over the last 48 hours. Patient states that the nurses noted the emesis was extremely dark sometime yesterday. They attempted to obtain a blood sugar this morning and it was over 400. Patient states that she has not gotten any of her insulin due to her not eating or drinking in the past in the last one to two days. Medical decision making: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11:00 a.m. Patient appears to be extremely ill at this point. Patient appears to be in acute diabetic ketoacidosis. She does have evidence of acute renal insufficiency. She also most likely has an upper GI (gastrointestinal) bleed .Patient is started on insulin drip. 11:41 a.m. Called to the patient's bedside for bradycardia (slow heart rate) and altered mental status .patient is pronounced dead at 11:41 a.m. C. Interviews The county coroner was interviewed on 11/8/22 at 10:30 a.m. He stated an autopsy had been completed with Resident #1, as well as various pathology tests. The coroner said the pathology tests had not been completed as of 11/8/22, and until they were completed he would be unable to determine a cause of death for Resident #1. The coroner said he had completed his own investigation, and had determined that Resident #1's insulin orders had been discontinued on 10/19/22, with the reason of being a duplicate order and no physician order to discontinue any of the insulin medications. He said the resident had several health problems, and was a very sick person, but her insulin medication not being administered could have contributed to her death. Licensed practical nurse (LPN) #1 was interviewed on 11/8/22 at 11:41 a.m. She stated she was the nurse who had discontinued all of Resident #1 insulin medications, but she did not recall doing it. She said the facility had done education with her regarding when and how to discontinue resident medications. She said she was still on administrative leave while the facility investigated the incident, and she was getting additional training when she returned to the facility. The LPN said the facility had implemented a new system for discontinuing medication, which included having two nurses verify the physician orders to ensure the accuracy of the order. The medical director (MD) was interviewed on 11/8/22 at 12:34 p.m. The MD said she was also Resident #1 primary care physician (PCP). The MD said she was not aware Resident #1 insulin orders had been discontinued until several days after Resident #1 had been sent to the hospital. The MD said the facility had made her aware of the resident's change of condition on 10/19/22, 10/20/22 and 10/21/22, but at that time she was not aware the resident's insulin had been discontinued. The MD said the facility had continued to monitor the resident's blood glucose (BG), which was within Resident #1's BG parameters. The MD said although Resident #1 had other medical conditions that also contributed to her death, however it was not good that she had missed her insulin. The MD said she had not been a part of the facility investigation, but she did ask the facility to tell her the result of their investigation and what they determined were the system failures. The MD said the conclusion of the investigation was there was not a system in place to check the accuracy of nurses discontinuing medications. Licensed practical nurse (LPN) #2 was interviewed on 11/9/22 at 9:05 a.m. She said she had been in the facility for about three months, and recently had training regarding discontinuing physician orders. She said prior to 10/27/22, nurses would simply discontinue an order in the resident's medical record, and just create a note which stated the reason the medication was discontinued. She said now when an order comes in for a medication to be discontinued, that order had to be verified by a second nurse working the floor, and then the order was placed into a folder for a third check by the night nurse, to ensure the accuracy of the discontinued order. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN #3 was interviewed on 11/9/22 at 9:11 a.m. She said she had worked in the facility for about two years, and there had been a recent change to the process of discontinuing orders for residents. The LPN said prior to the medication error with Resident #1, nurses would discontinue orders in resident's medical records by writing a quick note of why the medication was discontinued and there was no system in place to confirm the accuracy of the order being discontinued. She said as of 10/27/22 there was a new process in place. She said now when a nurse gets an order to discontinue a medication, the order is now written out so there is a paper trail to ensure the order is accurately understood by the nurse, and the nurse is to read back the order to the physician to ensure it was transcribed correctly. The nurse then needed to have a second nurse double check the physician order before it was discontinued. The LPN said the final step was placing the order in a folder, which the night nurses reviewed, essentially creating a triple check of each order to ensure the accuracy. The unit manager (UM) was interviewed on 11/9/22 at 9:22 a.m. She said she was the nurse who had discovered Resident #1's insulin medications had been discontinued. She said there was no physician order for any of the insulin medications to be discontinued, and LPN #1 stated the orders were discontinued because they were duplicate orders. The UM said they were not duplicate orders, and should never have been deleted. The UM said the facility had a new process in place which included two nurses checking discontinued medications when they were put into the resident's electronic medical record, and a third check happening on the night shift to ensure the accuracy of all discontinued medications. The director of nursing (DON) was interviewed on 11/9/22 at 9:37 a.m. She said prior to the medication error on 10/19/22, the facility did not have a system in place to ensure the accuracy of discontinued medications. The DON said nurses would discontinue physician orders, and there was no second or triple check system in place, so if orders were transcribed incorrectly, or discontinued incorrectly it could potentially take days before the error was identified and corrected. The pharmacist was interviewed on 11/9/22 at 10:48 a.m. She stated she had been made aware of the situation with Resident #1 yesterday (11/8/22), and had briefly looked over her medical record. The pharmacist stated from her review, all of Resident #1's prescribed insulin had been discontinued. She said she was unable to locate a physician order to discontinue the medications. She said LPN had noted the insulin was discontinued due to being a duplicate order, but the pharmacist said it was not a duplicate order. The pharmacist said the standard practice for discontinuing a medication was to have a nurse check the system was in place, meaning a nurse could not discontinue a physician order without having a second nurse checking the accuracy of the order that was being discontinued. The pharmacist said had that system been in place prior to 10/19/22, this would not have occurred. The pharmacist said since LPN #1 discontinued the medications without a physician order, and therefore the medications were not given, a significant medication error occurred. The nursing home administrator (NHA) was interviewed on 11/9/22 at 11:30 p.m. She said the facility did not have a system in place prior to 10/19/22 to ensure nurses were accurately discontinuing medications. The NHA said the new system, implemented on 10/27/22, now had two nurses verifying physician orders at the time the order was put into the resident's electronic medical record to discontinue medication, along with a third nurse checking for accuracy during night shift.