STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045191	A. BUILDING _____ B. WING _____	**06/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - HOT SPRINGS VILLAGE	**121 CORTEZ RD HOT SPRINGS VILLAGE, AR 71909**

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 -** Actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 310) was substantiated, all or in part, with these findings: Based on interview and record review, the facility failed to ensure physician orders [REDACTED].#1) of 2 (Residents #1 and #2) sampled residents who had physician's orders [REDACTED]. This failed practice resulted in past noncompliance at the level of actual harm to Resident #1 who received insulin when it was not required based on sliding scale blood sugar levels resulting in hospitalization to regulate the resident's blood sugar level, and had the potential to cause more than minimal harm to 2 residents who had physician's orders [REDACTED]. The findings are: Resident #1 had [DIAGNOSES REDACTED]. a. A physician's orders [REDACTED]. The physician's orders [REDACTED]. of insulin; for a blood glucose level of 351-399, the resident was to receive 8 units of insulin; and for a blood glucose level of 400 or greater, the resident was to receive 10 units of insulin, and call the Practitioner. The scheduled administration times documented on the Medication Administration Record (MAR) dated February 2020 were 7:00 a.m., 11:00 a.m., and 4:00 p.m. b. The MAR dated February 2020 documented on 2/29/2020 at 7:00 a.m., Licensed Practical Nurse (LPN) #1 performed the resident's capillary blood glucose test. The capillary blood glucose level result was documented to be 191. According to the physician's orders [REDACTED].#1 did not require any insulin administration for a capillary blood glucose level result less than 200. The Medication Administration Record documented LPN #1 administered 100 units of [MEDICATION NAME] R insulin to the resident. c. An Office of Long Term Care (OLTC) Incident and Accident Report, Division of Medical Services (DMS) form 7734 dated 2/29/2020 at 10:00 a.m. documented, .Date of Discovery . 2/29/2020 at 10:00 a.m. .The Director of Nursing (DON) reported that the Charge Nurse mistakenly administered 100 units of [MEDICATION NAME] R to (Resident #1) . APRN (Advanced Practice Registered Nurse) notified with new order obtained for following Glucogon 1 SQ (subcutaneously) . FSBS (Finger Stick Blood Sugar) monitoring; and a STAT (immediate) BMP (Basic Metabolic Panel) . Resident's condition initially stabilize, but then declined with resident becoming hypoglycemic . APRN then gave an order for [REDACTED]. Notifications were made to the Administrator and family . Charge Nurse involved in the incident suspended pending investigation . Nursing in-service on Medication Rights and an investigation was implemented . d. A Nurses Note dated 2/29/2020 at 11:19 a.m. documented, Unresponsiveness .Blood Glucose 82 . e. A Nurses Note dated 2/29/2020 at 12:12 p.m. documented, .Change in Condition . Unresponsive . The resident's capillary blood glucose result was 42. The Nurse Practitioner was notified, and Emergency Medical Services (EMS) was called. f. A Nurses Note dated 2/29/2020 at 12:30 p.m. documented, .EMS (Emergency Medical Services) administered [MEDICATION NAME] (D10) in the right antecubital after several attempts to start IVs (Intravenous site). Blood glucose level was 82 after administration of D10. At 12:52 pm the blood glucose level was 156 and Resident #1 was having facial drooping, 's/s of stroke'. The resident was transferred to the hospital, family was notified. g. The Hospital Transfer Forms, Hospital records during course of stay, and Hospital Discharge Records dated 2/29/2020 through 3/1/2020 documented Resident #1 was seen in the emergency room and continued to have an IV of [MEDICATION NAME] 10 running. According to the ER note, the resident's blood sugar result on 2/29/2020 at 1:38 p.m. upon arrival to the ER was 43, and at 2:11 p.m. the resident's blood sugar result was 144. The resident was admitted to the Intensive Care Unit (ICU) for hourly glucose checks, frequent neurological checks, and continuation of the IV fluids. According to the hospital records, Resident #1 was back to baseline with blood sugars and mental status and was discharged back to the facility. The hospital [DIAGNOSES REDACTED]. h. On 4/2/2020 at 10:35 a.m., LPN #2 was asked, Are there any special things that you do when you administer insulin? LPN #2 stated, Yes. For example, I would go in and check the resident's blood sugar, then come back and check to verify on the computer the doctor's orders. Then I would have another nurse look at the blood sugar reading, look at the doctor's orders, then look at the insulin I had drawn up before I gave it. She was asked, Is this the facility's policy or just the way you do it? She stated, This is the way we do it here now. i. On 4/2/2020 at 10:43 a.m., LPN #3 was asked, Are there any special things that you do when you administer insulin? She stated, Yes. We had an in-service on having two nurses check to verify insulin before it is given. j. A facility policy titled Medication Administration provided by the Administrator on 4/1/2020 at 9:26 a.m., documented, .Dosage of high-risk medications (e.g. Liquid narcotics, Insulin) should be double checked by another nurse prior to administration . k. This was a significant medication error due to the classification of the medication, anti-diabetic / insulin. l. The facility initiated corrective action immediately after discovering the significant medication error on 2/29/2020 by implementing the following: 1.) An Office of Long Term Care (OLTC) Incident and Accident Report, Division of Medical Services (DMS) form 7734 dated 2/29/2020 at 10:00 a.m. documented, .Date of Discovery . 2/29/2020 at 10:00 a.m. .The Director of Nursing (DON) reported that the Charge Nurse mistakenly administered 100 units of [MEDICATION NAME] R to (Resident's name) . APRN (Advanced Practice Registered Nurse) notified with new order obtained for following Glucogon 1 SQ (subcutaneously) . FSBS (Finger Stick Blood Sugar) monitoring; and a STAT (immediate) BMP (Basic Metabolic Panel) . Resident ' s condition initially stabilize, but then declined with resident becoming hypoglycemic . APRN then gave an order for [REDACTED]. Notifications were made to the Administrator and family . Charge Nurse involved in the incident suspended pending investigation . Nursing in-service on Medication Rights and an investigation was implemented 2.) On 2/29/2020, the facility initiated in-service education for licensed nurses for Medication Administration. 3.) On 2/29/2020, the facility initiated the Medication Administration Clinical Skills-Check-Off of licensed nurses. 4.) On 2/29/2020, the facility implemented a policy of dosages of high-risk medications (such as insulin) to be checked with another nurse prior to administration.

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

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.