STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHERIDEN WOODS	**321 STONECREST DRIVE BRISTOL, CT 06010**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records review, review of facility documentation and interviews for one sampled resident reviewed for a medication error (Resident #1), the facility failed to ensure physician orders [REDACTED]. The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition, required extensive assistance with bed mobility and transfers. The Resident Care Plan dated 7/6/20 identified a problem with diabetes with interventions to perform an Accucheck per physician's orders [REDACTED]. A physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Additionally, the MAR indicated [REDACTED]. A Reportable Event Form dated 7/8/20 at 11:00 PM identified at approximately 10:30 PM on 7/8/20, Resident #1 received Toujeo (Insulin [MEDICATION NAME]) 80 units (which was intended for another resident/Resident #2) in error, in addition to the scheduled insulin of 40 U of [MEDICATION NAME] Solution. The physician was notified, directed to administer [MEDICATION NAME] injection, and to transport to the emergency room for monitoring. A blood sugar result at the time of the medication error was 205 mg/dL. The Emergency Department (ED) Report dated 7/9/20 at 12:19 AM identified Resident #1 was having stable glucose levels, in upper 100's while receiving frequent meals and juice. However, upon repeat evaluation, the resident's last glucose level was 70 mg/dL, at that point the Toujeo Insulin was just taking effect, and could take effect for up to 30 hours. Additionally, the ED Report identified that the resident was hospitalized . The Hospital Discharge Report dated 7/10/20 identified Resident #1 was admitted for [DIAGNOSES REDACTED] secondary to accidental overdose on long-term insulin. The resident was treated with intravenous fluids and blood glucose monitoring every 2 hours. The resident's diet was resumed and fingersticks remained stable. Resident #1 returned to the facility on [DATE]. Interview and clinical record review with DNS on 7/29/20 at 11:10 PM identified that LPN #1 made a medication error when he administered to Resident #1 Insulin that was ordered for another resident (Resident #2). The DNS further identified that LPN #1 had mistaken the resident's identity and did not check the name bracelet or talk to Resident #1. The DNS further identified that LPN #1 received final written warning, nursing staff was in-serviced on the importance of identifying residents before medication administration. The DNS also identified audits would be done to assure that residents had name bracelets in place to identify all residents for correct medication administration. Interview with LPN #1 on 7/29/20 at 4:40 PM identified he checked Resident #1 identity during 9:00 PM medication administration, however failed to do so later on 7/8/20. LPN #1 identified that both Resident #1 and Resident #2 had room that were near each other and the medication cart was placed between those two rooms. LPN #1 was wearing a face shield and mask, the light was adequate, and he was not wearing his glasses. Further interview with LPN#1 identified that he usually does not work on that unit and was nervous about administering medications timely. LPN #1 stated while providing care to Resident #2, he realized he had administered the Insulin to the wrong resident. LPN #1 immediately reported the medication error to the Nursing Supervisor. Review of facility Medication Administration and Documentation policy directed Licensed Nurse to identify the resident before administration of medications by (a) checking identification band and/or (b) checking photograph attached to administration record, (c) asking resident their name or (d) asking another staff member to identify the resident.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records review, review of facility documentation and interviews for one sampled resident reviewed for a medication error (Resident #1), the facility failed to ensure Resident #1 was free from a significant medication error. The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition, required extensive assistance with bed mobility and transfers. The Resident Care Plan dated 7/6/20 identified a problem with diabetes with interventions to perform an Accucheck per physician's orders [REDACTED]. A physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Additionally, the MAR indicated [REDACTED]. A Reportable Event Form dated 7/8/20 at 11:00 PM identified at approximately 10:30 PM on 7/8/20, Resident #1 received Toujeo (Insulin [MEDICATION NAME]) 80 units (which was intended for another resident/Resident #2) in error, in addition to the scheduled insulin of 40 U of [MEDICATION NAME] Solution. The physician was notified, directed to administer [MEDICATION NAME] injection, and to transport to the emergency room for monitoring. A blood sugar result at the time of the medication error was 205 mg/dL. The Emergency Department (ED) Report dated 7/9/20 at 12:19 AM identified Resident #1 was having stable glucose levels, in upper 100's while receiving frequent meals and juice. However, upon repeat evaluation, the resident's last glucose level was 70 mg/dL, at that point the Toujeo Insulin was just taking effect, and could take effect for up to 30 hours. Additionally, the ED Report identified that the resident was hospitalized . The Hospital Discharge Report dated 7/10/20 identified Resident #1 was admitted for [DIAGNOSES REDACTED] secondary to accidental overdose on long-term insulin. The resident was treated with intravenous fluids and blood glucose monitoring every 2 hours. The resident's diet was resumed and fingersticks remained stable. Resident #1 returned to the facility on [DATE]. Interview and clinical record review with DNS on 7/29/20 at 11:10 PM identified that LPN #1 made a medication error when he administered to Resident #1 Insulin that was ordered for another resident (Resident #2). The DNS further identified that LPN #1 had mistaken the resident's identity and did not check the name bracelet or talk to Resident #1. The DNS further identified that LPN #1 received final written warning, nursing staff was in-serviced on the importance of identifying residents before medication administration. The DNS also identified audits would be done to assure that residents had name bracelets in place to identify all residents for correct medication administration. Interview with LPN #1 on 7/29/20 at 4:40 PM identified he checked Resident #1 identity during 9:00 PM medication administration, however failed to do so later on 7/8/20. LPN #1 identified that both Resident #1 and Resident #2 had room that were near each other and the medication cart was placed between those two rooms. LPN #1 was wearing a face shield and mask, the light was adequate, and he was not wearing his glasses. Further interview with LPN#1 identified that he usually does not work on that unit and was nervous about administering medications timely. LPN #1 stated while providing care to Resident #2, he realized he had administered the Insulin to the wrong resident. LPN #1 immediately reported the medication error to the Nursing Supervisor. Review of facility Medication Administration and Documentation policy directed Licensed Nurse to identify the resident before administration of medications by (a) checking identification band and/or (b) checking photograph attached to administration record, (c) asking resident their name or (d) asking another staff member to identify the resident.

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.