STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195635	A. Building B. Wing	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Oaks Nursing & Rehabilitation Center LLC	4100 North Blvd Baton Rouge, LA 70806

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44615 Based on observations and interviews, the facility failed to ensure residents had a safe, functional, sanitary and comfortable environment for 7 (Room a, Room b, Room c, Room d, Room e, Room f, Room g) of 32 resident rooms observed in the initial pool. The facility failed to ensure: 1. Floors were intact and free from missing planks in rooms a, c, e; 2. Floors were free of stains or glue/residue in room a, b; 3. Bathrooms were free of missing cabinet doors in room a; 4. Bathrooms had working light bulbs and light bulb covers in room d; 5. Closet doors properly functioned and remained on track in rooms f, g; 6. Toilets functioned properly, remained free from a constant loud noise in room f and the toilet seat was not cracked in room d; 7. Bathroom sink handles were secure and free from leaking in room c; 8. Bed hand rails were securely fastened and sturdy in room e; 9. Bathroom tub remained free of dirt/residue in room c; and There were 123 licensed beds in the facility. Findings: On 02/20/2024 at 10:22 a.m. an initial walk through of the facility revealed the following: Room a's floor was missing a 3x2 foot section of laminate floor pieces; Room b's floor was sticky like gum and appeared dirty with black discoloration and uneven texture; (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Room c's floor had cement exposed where a 1/2 Ft long section of laminate flooring was missing, the faucet handles in the bathroom were loose and blackish colored debris noted in the bathtub; Room d's bathroom light bulb did not illuminate, had aluminum foil in between the two bulbs at the base area and did not have a cover over the light bulbs; Room d's toilet seat had a large crack on the left side; Room e's floor had missing floor tiles with exposed cement and had a loose handrail on the bed; Room f's toilet made a constant loud noise; Room f's closet door was wobbly and unstable; and Room g's closet doors did not properly affix to the tracks on top and bottom. On 02/20/2024 12:21 p.m., an environmental tour was conducted with S4MS. He confirmed the above items listed were present and needed repair. On 02/20/24 01:52 p.m., an interview was conducted with S1ADM. The above listed room observations were reviewed. He confirmed he was aware the listed items needed repair and all the repairs had not been completed as of 02/20/2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48537 Based on interviews, and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident for 1 (#85) of 32 residents reviewed for abuse during the initial pool. The facility failed to protect Resident #85 from physical abuse by Resident #22. This deficient practice resulted in an actual harm situation on 02/12/2024 at 3:41 a.m. when Resident #22, pulled Resident #85, a moderately cognitively impaired resident, out of her bed and began punching her in the head and face. At 3:41 a.m., S10LPN entered the residents' room and found Resident #85 on the floor with Resident #22 holding Resident #85's right hand while she punched her in the head and face. S10LPN heard Resident #85 yell, Please help me. She's gonna kill me. The residents were then separated. Even though there was no significant decline in mental or physical functioning for Resident #85, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the physical abuse, since a reasonable person would not expect to be treated in this manner in his own home or a health care facility. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: A review of the facility's policy titled, Abuse/Neglect Policy Statement revealed the following: Policy: This facility will not condone any form of resident abuse or neglect. Each resident residing in this facility has the right to be free from verbal and physical abuse . Residents must not be subjected to abuse by anyone, including but not limited to other residents. Abuse/Neglect Reporting Definitions: 1. Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 6. Physical abuse - includes hitting, slapping, pinching, and kicking. Resident #22 A review of the Clinical Record for Resident #22 revealed she was admitted to the facility on [DATE], with diagnoses which included Unspecified Psychosis, Recurrent Mild Major Depressive Disorder, Generalized Anxiety Disorder, and Cognitive Communication Deficit. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/2023 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) of 14, which indicated she was cognitively intact. Resident #85 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the Clinical Record for Resident #85 revealed she was admitted to the facility on [DATE] with diagnoses which included Generalized Anxiety Disorder, Moderate Major Depression, Cognitive Social or Emotional Deficit Following Cerebral Infarction, and Cognitive Communication Deficit. A review of the Admission MDS with an ARD of 12/08/2023 revealed Resident #85 had a BIMS of 9, which indicated she was moderately cognitively impaired. A review of the facility's Resident Incident Report dated 02/12/2024, revealed the following: Victim: Resident #85 Accused: Resident #22 Allegations: Resident to Resident Physical Abuse Allegation Findings: Substantiated Incident Description: Resident #22 was witnessed attacking her roommate Resident #85. Resident #22 was seen pulling Resident #85 to the floor and repeatedly punching Resident #85 in the face. Resident #85 was found on the floor in a supine position. Both residents were immediately separated and Resident #22 was taken to the dining room in her wheelchair. Resident #22 was transported to local emergency room for further evaluation via local ambulance service. Resident #22 was evaluated and deemed not a candidate for PEC and returned to the facility. Resident #85 was transported to the local emergency room via local ambulance service. Resident #85 underwent CT scans of her brain, cervical spine, thoracic spine and lumbar spine along with an x-ray of her right wrist. All scans were negative for any abnormalities or injury. Resident #85 was transported back to the nursing facility. The facility nurse practitioner and both residents' responsible parties were notified of the incident. A review of the Nurse's Notes dated February 2023 for Resident #85 revealed the following: 02/12/2024 5:19 a.m.-{LATE ENTRY} @ 3:40 a.m. S10LPN heard a loud scream for help. Resident #85 was noted lying flat on her back on the floor with roommate (Resident #22) holding Resident #85's right arm and punching Resident #85 in the face. S10LPN immediately grabbed Resident #22 to get her off Resident #85. Resident #85 was yelling out saying Please help me. She's gonna kill me. S10LPN along with assigned nurse attempted to get Resident #85 off the floor. S10LPN stabilized Resident #85 put a pillow under her head. Resident #22 was removed from the room and the on-call nurse practitioner was notified of Resident #85 being dragged out of her bed by Resident #22 who then began punching Resident #85 in the face. Signed by: S10LPN. On 02/20/2024 at 3:30 p.m., an interview was conducted with Resident #85. Resident #85 stated about a week ago in the early morning, she was awoken to Resident #22 pulling her out of bed onto the floor and repeatedly punching her in the face. She stated Resident #22 accused her of stealing money and was yelling and screaming at her while she beat the s*** out of her. She stated she yelled for help and a staff member came immediately. She stated staff removed Resident #22 from the room. She stated shortly after Resident #22 was removed from the room, the paramedics arrived and she was taken to a local hospital to be evaluated. She stated when she returned to the facility, she was placed in a different room away from Resident #22. She stated she was not fearful of Resident #22 following the incident and upon returning to the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/20/2024 at 3:35 p.m., an interview was conducted with S11LPN. She stated she was not working on the night of the incident, but was aware of the incident between Resident #22 and #85 on 02/12/2024. She stated she had to complete a mandatory in-service training last week before returning to work regarding abuse, resident-to-resident altercations, and a new intervention to ensure Resident #85 was kept away from Resident #22. She stated she was informed Resident #85 had been moved to a new room away from Resident #22. She confirmed a resident hitting another resident was physical abuse. On 02/20/2024 at 3:40 p.m., an interview was conducted with S9LPN. She stated she was not working on the night of the incident, but was aware of the incident between Resident #22 and #85 on 02/12/2024. She stated she had to complete a mandatory in-service training last week before returning to work regarding abuse, resident-to-resident altercations, and a new intervention to ensure Resident #85 was kept away from Resident #22. She stated she was informed Resident #85 had been moved to a new room away from Resident #22. She confirmed a resident hitting another resident was physical abuse. On 02/20/2024 at 3:45 p.m., an interview was conducted with S3SSD. She stated she was made aware of the incident between Resident #22 and #85 on the morning of 02/12/2024. She confirmed the altercation between Residents #22 and #85 was physical abuse. She stated both residents were sent out to local emergency departments to be evaluated. She stated upon their individual returns back to the facility, she spoke with both residents. Resident #85 was moved to a different room away from Resident #22. She stated since the incident, she began daily check-ins with Resident #22 and #85 to counsel and assess for behaviors. She stated this would continue weekly for four weeks. On 02/20/2024 at 4:07 p.m., a telephone interview was conducted with S10LPN. She stated she was aware of the incident between Resident #22 and #85 on 02/12/2024. She stated she was the first staff member to enter the room. She stated when she entered the room, she saw Resident #22 holding Resident #85's right arm while she punched her in the head and face. She stated Resident #85 was lying on the floor. She stated she immediately removed Resident #22's hand from Resident #85's arm and moved her in her wheelchair to the other side of the room. She stated S15CNA entered the room and assisted with the situation. She stated S15CNA removed Resident #22 from the room while she assessed Resident #85. She stated Resident #85 was shaken up and stunned at what happened. She stated another nurse called the on-call provider and received an order to send both residents to the local emergency room s for evaluation. She stated when administration arrived to the facility that morning, she had to complete a mandatory in-service training regarding abuse, resident-to-resident altercations, and a new intervention to ensure Resident #85 was kept away from Resident #22. She confirmed a resident hitting another resident was physical abuse. On 02/20/2024 at 4:22 p.m., a telephone interview was conducted with S18CNA. She stated she was working the night of the incident between Residents #22 and #85. She stated that morning administration held a meeting and discussed abuse and how to handle aggressive residents. She stated they also stated both residents should be separated and Resident #85 would be moved to a room away from Resident #22. On 02/21/2024 at 8:42 a.m., an interview was conducted with S17CNA. She stated when she arrived to work on 02/12/2024 administration held a staff meeting to discuss abuse and how to handle aggressive residents. She stated administration made the staff aware of the incident between the two residents. She stated the plan was to keep the two residents separated and Resident #85 would be moved to a room away from Resident #22. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/21/2024 at 9:15 a.m., an interview was conducted with S2DON. She stated she was made aware of the incident between Residents #22 and #85. She confirmed the incident was physical abuse. She stated in-service trainings were conducted with all staff who provided care to residents regarding abuse, how to deal with an aggressive resident, and specific instructions to keep Residents #22 and #85 apart. She stated during the in-service training, the incident was discussed with all staff and they were informed Resident #85 had been moved to another room away from Resident #22. She confirmed all staff were in-serviced by 02/16/2024. She stated since the incident, S3SSD conducted daily check-ins with Residents #22 and #85 to counsel and assess for behaviors. She stated this would continue weekly for four weeks. On 02/21/2024 at 9:20 a.m., an interview was conducted with S1ADM. He confirmed the incident between Residents #22 and #85 took place, was physical abuse, and should not have happened. He outlined the immediate plan of correction the facility implemented. He confirmed the facility completed their staff in-services on 02/16/2024. He stated since the incident, S3SSD conducted daily check-ins with Residents #22 and #85 to counsel and assess for behaviors. He stated this would continue weekly for four weeks. The facility has implemented the following actions to correct the deficient practice: On 02/12/2024 at 3:40 a.m., Residents #22 and #85 had a Resident-to-Resident physical abuse altercation. S11LPN immediately separated the residents. Resident #22 was pushed in her wheelchair to the dining room and Resident #85 stayed in the room until paramedics arrived. The on-call nurse practitioner was notified and orders were given to send both residents out for evaluation at local emergency departments. In the late morning of 02/12/2024, both residents returned to the facility and Resident #85 and all of her belongings were moved to another room. Beginning on 02/12/2024 and concluding on 02/16/2024, all staff who provided direct care to residents were in-serviced on abuse, how to handle an aggressive resident and to keep Residents #22 and #85 separated. On 02/12/2024, both residents were evaluated by the house nurse practitioner with no additional order placed. On 02/13/2024, both residents were evaluated by the psychology nurse practitioner. On 02/12/2024, S3SSD began daily check-ins with both residents for the rest of the week, which transitioned to twice weekly for four weeks to ensure no behaviors or concerns are identified. A lock box was also ordered for Resident #22 to keep her money in. On 02/12/2024, education was conducted by S2DON on Policy and Procedure: How to Respond to an Aggressive Resident, abuse and to keep Residents #22 and #85 apart to prevent further stress or altercations. Quality Monitoring: Quality Monitoring for abuse was began on 02/12/2024 and is ongoing. A Quality Assurance Performance Improvement Committee Meeting was held on 02/12/2024 to review the incident of resident-to-resident abuse to conduct a root cause analysis and review the plan of correction. Attendees at the meeting included Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, CNA Supervisor, Social Services Director, Charge Nurse, Maintenance Director, Activities Director and Dietary Manager. Facility compliance date as of 02/16/2024. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Throughout the survey on 02/19/2024 and 02/21/2024, observations, record reviews, and staff interviews revealed staff received training on the facility's abuse policies and procedures, de-escalating aggressive behaviors, were knowledgeable of the types of abuse, and were aware abuse should be reported to administration immediately. Observations were made throughout the survey with no abuse identified. Observations, interviews, and record review, revealed monitoring had begun with no further issues identified.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on observations, interviews, and record reviews, the facility failed to ensure services provided by the facility met professional standards of quality. The facility failed to ensure: 1. Accuchecks were obtained and insulin was administered before meals as ordered for 1 (#47) of 3 (#47, #75, and #100) residents reviewed for insulin administration and 2. Nursing staff accurately documented the trimming of fingernails for 1 (#74) of 3 (#41, #74, and #109) residents reviewed for ADLs. Findings: 1. Review of the facility's policy titled, General Guidelines revealed the following, in part: Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices . Procedures: 2. Medications are administered in accordance with written orders of a physician. Resident #47 Review of Resident #47's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses which included Type 2 Diabetes Mellitus and Long Term (Current) Use of Insulin. Review of Resident #47's current Physician Orders revealed the following, in part: Accucheck AC and HS Novolog FlexPen U-100 Insulin Aspart 100 units/mL (3mL) subcutaneous: administer 4 units subcutaneously before each meal every day On 02/19/2024 at 11:45 a.m., an observation was made of Resident #47. He was in the main dining room eating his lunch. On 02/19/2024 at 12:09 p.m., an interview was conducted with S9LPN. She confirmed she was assigned to Resident #47. She stated Resident #47 was currently eating lunch and she would check his blood glucose and administer his insulin after lunch. On 02/19/2024 at 12:05 p.m., an observation was made of Resident #47. He was ambulating away from his dining table. He consumed 95% of his lunch. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/19/2024 at 12:09 p.m., an observation was made of S9LPN. S9LPN obtained Resident #47's blood glucose level. S9LPN then administered Resident #47's 4 units of Novolog 100 units/mL. On 02/19/2024 at 12:43 p.m., an interview was conducted with S9LPN. S9LPN stated Resident #47's Novolog insulin was ordered before meals. S9LPN confirmed she obtained Resident #47's accucheck and administered the insulin after he consumed lunch. She confirmed the order was before meals, and she should have obtained the accucheck and administered the insulin as ordered. On 02/20/2024 at 11:15 a.m., an interview was conducted with S2DON. S2DON confirmed Resident #47 had orders for accuchecks and Novolog 4 units before meals. S2DON stated Resident #47's accucheck should have been obtained and Novolog insulin administered before meals as ordered. 2. Review of Resident #74's Clinical Record revealed he was admitted to the facility on the mental health locked unit on 09/16/2019, and had diagnoses which included, Type 2 Diabetes Mellitus, Major Depressive Disorder, recurrent with Psychotic Symptoms, Anoxic Brain Damage, and Cognitive Communication Deficit. Review of Resident #74's February TAR revealed the following, in part: Check nails weekly- Trim and clean prn Further review revealed the task was completed on 02/02/2024, 02/16/2024 by S7LPN and 02/09/2024 by S5RN. On 02/20/2024 at 2:13 p.m., an interview was conducted with S7LPN. She stated just because she signed the TAR did not mean she completed the task. She confirmed she did not check or trim Resident #74's fingernails in February but signed the TAR on 02/02/2024, and 02/16/2024 that the task was completed. On 02/21/2024 at 9:52 a.m., an interview was conducted with S5RN. She confirmed she did not check or trim Resident #74's fingernails in February but signed the TAR on 02/09/2024 that the task was completed. On 02/20/2024 at 2:42 p.m., an interview was conducted with S2DON. She confirmed nursing staff should not document on the TAR that the task was completed if they did not check or trim the nails. 44965

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43868 Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out ADLs received the necessary services to maintain good grooming and personal hygiene for 1 (#74) of 3 (#41, #74 and #109) residents reviewed for ADL's. The facility failed to trim fingernails for Resident #74. Findings: Review of the Facility Policy titled, Hygiene and Grooming revealed the following, in part: Essential Points: 6. Nail care is part of good grooming. Some residents, diabetics, for example, nail clipping should be done only by licensed staff or a podiatrist. Review of the Facility Policy titled, Nail Management revealed the following, in part: Policy: Nail management is the regular care of the fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails. It includes cleansing, trimming, smoothing, and cuticle care and is usually done during the bath. Residents with DM will have nail care performed by a nurse or podiatrist. Procedure: 7. Trim nails with a clipper, rounding for the fingernails. Review of the Medical Record for Resident #74 revealed the resident was admitted to the facility on [DATE]. Diagnoses included Diabetes Mellitus 2, Major Depressive Disorder, recurrent with Psychotic Symptoms, Anoxic Brain Damage, and Cognitive Communication Deficit. Review of the most recent MDS (Minimum Data Set) for Resident #74 with an ARD (Assessment Reference Date) of 11/21/2023 revealed Resident #74 had a BIMS (Brief Interview for Mental Status) of 6, which indicated the resident was severely cognitively impaired. Review of the current Physician Orders for Resident #74 revealed the following, in part: 09/23/2022- Check nails weekly- trim and clean prn On 02/19/2024 at 9:31 a.m., an observation was conducted of Resident #74. Resident's fingernails are noted to be approximately 1/2 cm past the tip of all 10 fingers. An interview was conducted at this time with Resident #74. He stated his nails were too long and wanted them trimmed. On 02/20/2024 at 11:03 a.m., an interview was conducted with S14CNA. She stated the wound care nurse was responsible for trimming Resident #74's fingernails. On 02/20/2024 at 11:15 a.m., an observation was conducted of Resident #74. Resident's fingernails are noted to be approximately 1/2 cm past the tip of all 10 fingers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/2024 at 11:22 a.m., an interview was conducted with S6LPN. She stated the wound care nurse was responsible for trimming Resident #74's fingernails and it was documented on the TAR. On 02/20/2024 at 2:13 p.m., an interview was conducted with S7LPN. She stated she was responsible for trimming fingernails and it was on the TAR. She confirmed she did not trim Resident #74's fingernails in February. On 02/20/2024 at 2:13 p.m., an observation was conducted with S7LPN and Resident #74. S7LPN confirmed the resident's fingernails were long, approximately 1/2 cm past the tip of his fingers, and needed to be trimmed. She further confirmed she had not trimmed his fingernails and should have. On 02/20/2024 at 2:42 p.m., an interview was conducted with S2DON. She stated the wound care nurse was responsible for trimming Resident #74's fingernails. She confirmed Resident #74's fingernails should not be 1/2 cm past the tip of his fingers and should have been trimmed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195635	A. Building B. Wing	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Oaks Nursing & Rehabilitation Center LLC	4100 North Blvd Baton Rouge, LA 70806

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44965 Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5% for 2 (#34 and #47) of 6 (#34, #35, #47, #75, #100, and #107) residents observed during medication administration. A total of 27 opportunities were observed with 2 medication errors, which resulted in a medication error rate of 7.41%. The facility failed to ensure: 1. Resident #34's Voltaren Gel was not omitted; and 2. Resident #47's Insulin was administered before meals as ordered. Findings: Review of the facility's policy titled, General Guidelines revealed the following, in part: Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices . Procedures: 2. Medications are administered in accordance with written orders of a physician. Resident #34 Review of Resident #34's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included Other Chronic Pain, Unspecified Osteoarthritis, and Fibromyalgia. Review of Resident #34's current Physician Orders revealed the following, in part: Voltaren Arthritis Pain 1% gel apply 2 grams to bilateral shoulders daily. Scheduled at 8:00 a.m. An observation was made of S8LPN administering medications to Resident #34 on 02/19/2024 at 8:58 a.m. Resident #34 had an order for Voltaren Arthritis Pain 1% Gel apply 2 grams to bilateral shoulders daily at 8:00 a.m. S8LPN did not administer Resident #34's Voltaren gel. An interview was conducted with S8LPN on 02/19/2024 at 9:15 a.m. S8LPN stated Resident #34's Voltaren gel was not available for administration. S8LPN confirmed Resident #34 missed her daily dose of Voltaren. Resident #47 Review of Resident #47's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses which included Type 2 Diabetes Mellitus and Long Term (Current) Use of Insulin. Review of Resident #47's current Physician Orders revealed the following, in part: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Novolog FlexPen U-100 Insulin Aspart 100 units/mL (3mL) subcutaneous: administer 4 units subcutaneously before each meal every day. An observation was made of Resident #47 on 02/19/2024 at 11:45 a.m. He was in the main dining room eating his lunch. An interview was conducted with S9LPN on 02/19/2024 at 12:09 p.m. She stated Resident #47 was currently eating lunch and she would administer his scheduled insulin after lunch. An observation was made of Resident #47 on 02/19/2024 at 12:05 p.m. He was ambulating away from his dining table. He consumed 95% of his lunch. An observation was made of S9LPN on 02/19/2024 at 12:09 p.m. S9LPN administered Resident #47's 4 units of Novolog 100 unit/mL subcutaneously. An interview was conducted with S9LPN on 02/19/2024 at 12:43 p.m. She stated Resident #47's Novolog insulin was ordered before meals. She confirmed she administered Resident #47's Novolog insulin after he consumed lunch and should have administered the insulin before lunch as ordered. An interview was conducted with S2DON on 02/20/2024 at 11:15 a.m. S2DON confirmed Resident #34 had an order to administer Voltaren gel daily and it should have been administered as ordered. S2DON confirmed Resident #47 had an order for Novolog insulin 4 units subcutaneously before meals. S2DON stated Resident #47's Novolog insulin should have been administered before meals as ordered. S2DON confirmed omission of Voltaren gel and administration of insulin after a meal when ordered before meals were medication errors.