STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445105	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shannondale Health Care Center	7424 Middlebrook Pike Knoxville, TN 37909

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on medical record review and interview, the facility failed to accurately transcribe a physician's order for 1 Resident (Resident #4) of 9 residents reviewed for physician's order. The findings included: Medical record review showed Resident #4 was admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease, Type 1 Diabetes without Complications, Long Term Insulin Use, Congestive Heart Failure, Peripheral Vascular Disease, History of Transient Ischemic Attack, and Hypertension. Review of the 5 Day Minimum Data Set (MDS) assessment dated [DATE], showed Resident #4 had a Brief Interview for Mental Status Score of 10 which indicated the resident had moderate cognitive impairment. Resident #4 was dependent upon renal dialysis twice weekly and required assistance of one or two persons with activities of daily living. Review of handwritten Physician orders dated 11/25/2023, showed Resident #4 was prescribed .Humulin R (short acting insulin) with House Sliding Scale AC and HS [before meals, 3 times daily and bedtime] . per the facility standing protocol (House Sliding Scale). Review of the House Sliding Scale Protocol For Blood Glucose Monitoring showed: .House Sliding Scale Insulin Coverage .0-60 (blood glucose reading) follow hypoglycemic protocol .61-150 = (equals) 0 (units of insulin to administer), 151-200= 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units .401 or greater .15 units and recheck .in 2 hours .if .remains greater than 400 after 2 hour recheck, notify MD/NP (Medical Doctor, Nurse Practitioner) . Review of the handwritten Physician Orders for Resident #4 dated 12/13/2023, showed .DC [discontinue] CS [chemstick, blood glucose monitoring] . check chemstick AC HS and 0300 [3:00 AM] .continue house SSI (sliding scale insulin) TID AC (three times daily before meals) . Review of the Medication Administration (MAR) for Resident #4 dated 12/13/2023, showed the facility had incorrectly transcribed the name of the insulin ordered for sliding scale onto the MAR as Humulin N (an intermediate acting insulin) (not Humulin R, the actual ordered insulin medication) AC .TID [three times daily] . (continued on next page)

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
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy delivery record and billing summaries for November 2023 and December 2023 showed no Intermediate Acting Insulin (Humulin N) was delivered to the facility or billed to Resident #4 for use. Prescriptions for short acting Insulin (Humulin R, the actual ordered medication) were filled and delivered to the facility on [DATE] and 12/6/2023. Review of nursing notes dated 12/21/2023 at 2:37 PM, for Resident #4 showed .Endocrinologist office called and stated to hold insulin [Humulin N, the presumed order and the order which had been transcribed onto the MAR] .order sent from office, they are clarifying insulin orders and re-faxing this afternoon .Floor Nurse and House Supervisor notified . During interview on 3/12/2024 at 3:00 PM, the Director of Nursing (DON) confirmed a facility investigation was launched on 12/21/2023 when the facility received a telephone call from Resident #4's Endocrinologist who inquired as to the accuracy of the MAR provided them that morning in relation to the Humulin N sliding scale insulin for Resident #4. The DON reported the facility detected the transcription error of the Humulin N insulin for sliding scale usage on the MAR on 12/21/2023 and had not detected the transcription error at the time it was written on 12/13/2023. The DON explained the transcribing nurse had inadvertently clicked the wrong Insulin name in an automated drop- down menu box in the facility's electronic record system and entered Humulin N versus Humulin R for sliding scale usage onto the updated MAR on 12/13/2023, which had been sent to the Endocrinologist office on 12/21/2023, the day of the resident's appointment. The DON reported since no new prescription for Humulin N had been written, the order had not gone to the pharmacy for review or fulfillment, and Humulin N insulin was not available for Resident #4 use, the resident had not received the incorrect insulin. The DON reported the facility continued to administer Humulin R (as originally prescribed) for the sliding scale use. The DON confirmed the facility had failed to accurately transcribe new orders onto the MAR on 12/13/2023, which led to the confusion at the endocrinologist office. The DON confirmed multiple nursing staff had administered the Humulin R per the sliding scale protocol to Resident #4 between 12/13/2023 and 12/21/2023 and they had failed to detect the transcription.