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S 000	Initial Comments Complaint Investigation 2223865/IL147008 Investigation of Facility Reported Incident of May 13, 2022/IL147136	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 3001210b) 300.1210d)2)3) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the	S9999		

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S9999	Continued From page 2 nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to clarify an admission Physician order, perform diabetic monitoring and ensure necessary equipment and medication were available for one (R1) of three residents reviewed for diabetic care in the sample of three. These failures resulted in R1's blood sugar not being monitored, R1 not having an insulin pump for insulin medication and R1 not receiving medically necessary insulin by other means subsequently resulting R1's blood sugar level becoming elevated, and R1 becoming unresponsive without a pulse or respirations, CPR (cardiopulmonary resuscitation) being initiated, R1 being transferred to the local hospital and R1 expiring due to Diabetic Ketoacidosis. The facility also failed to notify the Physician of a change in a resident's condition for one (R1) of three residents reviewed for diabetic care in the sample of three. These failures resulted in R1 experiencing increased thirst, increased urination and vomiting which led	S9999		

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S9999	Continued From page 3 to the continual decline in R1's condition leading to R1's unresponsiveness, absence of pulse and respiration, initiation of cardiopulmonary resuscitation, transfer to the local hospital and subsequent death. Findings include: The Facility Assessment, dated 01/2021 through 12/2021, documents, "Part 2: Services and Care We Offer Based on our Residents' Needs" includes: "Administration of medications that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc." "Management of medical conditions" includes "Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as diabetes." "Competencies for new direct care staff are completed during their orientation phase, verified annually and as needed thereafter. (The facility) has a core group of competencies for nursing staff that include: 1. Licensed Nurses a. Injections, b. Blood Glucose Monitoring." "Additional References to the Facility Assessment: Nursing Services 483.35 - The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70(e)."	S9999		

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S9999	Continued From page 4 The facility Admission Policy, dated 12/11/2012, documents, "4. Each resident shall be required to undergo a physical examination by the Physician of his/her choice either prior (within five days) to his/her admission to the home, or within 72 hours of such admission. The report of such examination, together with the Physician's orders for the care of the resident, will become a part of the permanent record of the resident." The facility Admission Check List - Nurse form, dated 4/2009, documents on admission the Nurse is to "Verify orders" and complete the resident's Physician Orders, "Fax orders to or call pharmacy" and "Make out medication sheet." The facility Physician Order policy, dated 8/2008, documents "a) all medications and treatment shall be given only upon the written order of the Physician. All such orders shall be written on the medical record and shall be given as prescribed by the Physician and at the designated times. g) If for any reason, a Physician's medication or treatment cannot be followed, the Physician shall be notified as soon as is reasonable, depending upon the situation, a notation of this will be made into the medical record." The CDC (Centers for Disease Control and Prevention) documents, "Diabetic ketoacidosis (DKA) is a serious complication of diabetes that can be life-threatening. DKA is most common among people with Type I Diabetes. People with Type II diabetes can also develop DKA. DKA develops when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy. Instead, your liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced	S9999		

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too fast, they can build up to dangerous levels in your body. DKA usually develops slowly. Early symptoms include: Being very thirsty, urinating a lot more than usual. If untreated, more severe symptoms can appear quickly such as: Fast, deep breathing. Dry skin and mouth. Flushed face. Fruity-smelling breath. Headache. Muscle stiffness or aches. Being very tired. Nausea and vomiting. Stomach pain."

The facility Blood Glucose Testing and Monitoring policy and procedure, Revised 2/2016, documents, "Blood glucose levels will be monitored and obtained per licensed health care practitioner's orders. If a resident exhibits signs or symptoms of hypoglycemia or hyperglycemia, licensed nurse may obtain a blood glucose level." The facility provided a Hypoglycemia policy and procedure, however, was unable to provide a policy and procedure for Hyperglycemia.

The facility policy and procedure for Physician Notification of Change in Resident Condition, Revised 4/2019, documents, "Staff observe, document and communicate to the Physician, changes in resident condition promptly. Change in condition may include but is not limited to the following: Nausea and vomiting. It is the responsibility of each nurse to notify the Physician of a significant change in condition before the end of the shift."

On 5/20/22 at 12:15 pm, V3, Regional Director of Operations, stated the facility does not have a policy for Hyperglycemia, only Hypoglycemia. V3 was uncertain why the facility did not have a policy on Hyperglycemia.

The RN (Registered Nurse) Job Description,

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effective 9/1/2018, documents some of the RNs essential job functions are, "Responsible for nursing care of assigned residents. Consult with supervisor and Director of Nursing when necessary. Administer parenteral, intramuscular, and sub-cutaneous injections. Transcribe Physician's orders. Personally, receive or place calls to Physician. Order medications. Possesses skills for handling, fingering and feeling required for palpation, operating, and maintaining equipment, and providing medical treatments for abnormal conditions, i.e.: Wound care, resident care and medication administration."

The Restorative Nurse Job Description, effective 4/6/21, documents some of the Restorative Nurse's Knowledge, skills, and abilities include, "Ability to follow set rules and protocol; provide direction to team members. Possesses skills for continuous handling, fingering, and feeling required for palpation, operating and maintaining equipment, and providing medical treatments for abnormal conditions, i.e.: Wound care, resident care and medication administration."

The DON (Director of Nursing) Job Description, effective 9/1/2016, documents some of the essential job functions of the DON are to, "Coordinate admissions. Be accountable for nursing compliance, excellence, and delivery of resident-care services in adherence with federal, state, and local regulations. Ensure that adequate and proper equipment and supplies are available to staff."

The History and Physical for R1, dated 5/6/22, documents R1 with the following diagnoses: "Diabetes, bipolar disorder, hypertension, hyperlipidemia, hypothyroidism, GERD (Gastro-esophageal reflux disease), s/p

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S9999	Continued From page 7 (status/post) BKA (below the knee amputation). Past medical history includes: Arrhythmia, Bipolar disorder, Breast cancer, Closed bimalleolar fracture, Complication of anesthesia, Diabetes mellitus, Exercise tolerance finding, Gallstones, GERD, Hyperlipidemia, Hypertension, Hypothyroidism, Inflammatory arthritis, Osteoporosis, Pneumonia, PONV (postoperative nausea and vomiting), sleep apnea, Status post right breast lumpectomy." The Hospital medical record for R1, dated 5/6/22 through 5/11/22 documents R1 was receiving the following insulin orders during her hospital stay: "Insulin glargine (Lantus) injection - vial, 18 units nightly, Insulin lispro (Humalog) - vial, 0-12 units, TID (three times daily) PC (after meals), Insulin lispro (Humalog) injection - vial, 0-11 units, nightly, Insulin lispro (Humalog) injection - vial, 7 units, TID PC." The Hospital Discharge paperwork and Discharge Summary for R1, dated 5/11/22, documents a follow up appointment with R1's Endocrinologist for Diabetes on 5/31/22 and includes an Insulin order for R1 as: "Insulin Aspart 100 unit/ml (milliliters) injection - vial, Commonly known as: Novolog. Use per Insulin pump "est (estimated): 100 units per day as directed." The Discharge Summary includes further diagnoses for R1 as: "Dehydration, Cellulitis of left knee, Chronic allergic conjunctivitis, Anxiety state, Atypical bipolar affective disorder, Depressive disorder, Type I Diabetes mellitus with Stage I chronic kidney disease, Essential hypertension, Osteoporosis, Reflux esophagitis, Hypothyroidism, Depression, Hyponatremia, Hyperkalemia, Anemia, Hyponatremia, Inflammatory arthritis, Bilateral hand pain, History of breast cancer, Encounter for long-term	S9999		

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(current) use of other medications, Sepsis duet to urinary tract infection, Microcytic anemia, Peripheral neuropathy, Charcot ankle, Subacute osteomyelitis of left foot, Muscle twitching, Acute cystitis without hematuria, Hx (history) of left BKA (below the knee amputation), Hyponatremia, Diabetes, Hypertension and Hyperlipidemia."

R1's Medical Record documents R1 was admitted to the facility on 5/11/22 at 12:49 PM.

On 5/20/22 at 1:47 pm, V4 LPN (Licensed Practical Nurse) stated she admitted R1 to the facility on the afternoon of 5/11/22. V4 stated the hospital sent admission medication orders for R1 to receive insulin per insulin pump. V4 stated she had never had a patient with an insulin pump before and called the local hospital for more information. V4 stated the hospital informed her they were not using the insulin pump but were giving insulin as sliding scale. V4 stated she talked with V5 LPN/Restorative Nurse who told her she would take care of it. V4 stated she did not call R1's Physician for clarification orders but did report off to V7 Agency RN (Registered Nurse) that R1's admission paperwork was done, and she was just waiting for clarification of R1's insulin pump order.

On 5/23/22 at 2:49 pm, V7 Agency RN stated she worked on 5/11/22 from 6:00 pm to 5/12/22 at 6:00 am. V7 stated she does not recall V4 LPN telling her in report that R1 was diabetic, had an order for an insulin pump or that they were waiting for clarification of the order. V7 stated she did not perform blood glucose monitoring or give R1 any insulin during her shift because she was unaware R1 was diabetic.

On 5/20/22 at 12:32 pm, V5 LPN/Restorative

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S9999	Continued From page 9 Nurse stated V4 LPN called (V5's) attention to R1's insulin pump order. V5 stated, "We do not use insulin pumps in the facility. I was going to get a MD (Medical Doctor) order for sliding scale." V5 stated she put the order on her desk because she got pulled away to do something else and stated, "Out of sight out of mind." V5 stated she forgot about it, did not speak to anyone about R1's insulin pump or clarify the order with a Physician. The facility admission POS (Physician Order Sheet) for R1, dated 5/11/22, does not include any orders for blood glucose monitoring, an Insulin pump, or insulin medication to be administered for R1. On 5/20/22 at 9:15 am V15 CNA (Certified Nursing Assistant) stated she worked 5/11/22 and 5/12/22 and provided cares for R1. V15 stated R1 would use the bedpan and wore a brief because she was incontinent at times. V15 stated R1 would use her call light and ask for water a lot. V15 stated she didn't know R1 was diabetic and does not recall seeing the Nurses do any Accuchecks (blood glucose monitoring) or giving R1 insulin. On 5/23/22 at 11:00 am, V21 CNA stated on 5/12/22 around 9:45 pm, R1 was complaining about upset stomach and a "nasty taste" in her mouth. V21 stated she grabbed a trash can and R1 threw up into the trash can which smelled sour. V21 stated she reported this to V17 RN and left the facility at the end of her shift at 10:00 pm. V21 stated she did not know that R1 was diabetic. On 5/22/22 at 10:26 am, V22 Agency CNA stated she worked on 5/11/22 from 6:00 pm to 5/12/22	S9999		

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6:00 am and does not recall anything that was concerning to her that would need reported to the Nurse. V22 stated she did vital signs and filled R1's water pitcher a few times on her shift but does not remember how many times. V22 stated R1 was continent on her shift, and she did not have to change her and R1 denied having to go to the bathroom. V22 stated she did not know R1 was diabetic.

On 5/20/22 at 10:00 am, R7 (R1's roommate) stated R1 was not feeling well that night (5/12/22), (R1) had nausea, throwing up, kept asking for water and staff were changing her (R1) (incontinence brief) frequently.

On 5/22/22 at 1:35 pm, V19 CNA stated she worked 5/11/22 from 6:00 pm to 5/12/22 at 6:00 am and was told there was a new admission. V19 stated she provided incontinence care and gave R1 ice water that night but does not recall R1 being on her call light or anything unusual. V19 stated she also worked on 5/12/22 at 6:00 pm to 5/13/22 at 6:00 am and provided care to R1. V19 stated she noticed a change in R1 with R1 being a bit confused from the previous night. R1 would say she was dry and when (V19) checked R1 she would be wet (incontinent). V19 stated around 7:00 or 8:00 pm, R1 put the call light on and asked for ice water. V19 stated she changed R1's wet brief and got R1 more ice water. Around 10:00 pm, R1 put the call light on and asked for ice water again and an emesis basin. V19 stated R1 had the trash can next to her and had thrown up for the first time. V19 stated R1 vomited all over herself and into the trash can. V19 stated she cleaned R1 up, got R1 an emesis basin, another pitcher of ice water told V17 Former RN that R1 had thrown up and was drinking a lot of water. V19 stated when she returned from her break, she saw another CNA getting R1 more ice

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water. V19 stated she again told V17 Former RN that this was third pitcher of ice water R1 had requested. V19 stated that V17 Former RN told her to, "reduce the amount of water, to give more ice and less water." V19 stated at 4:30 am, she asked R1 about getting cleaned up and dressed but R1 didn't have any of her clothes at the facility yet and R1 was fine with the gown. V19 stated she peaked in on R1 before she left at the end of V19's shift at 6:00 am and R1 was fine then. V19 stated she did not know R1 was diabetic and that no one reported that to V19.

On 5/22/22 at 12:57 pm, V20 CNA stated on 5/11/22 at the end of her 6:00 am to 2:00 pm shift, R1 was admitted to the facility. V20 stated she helped get R1's weight, vital signs, and got R1 settled prior to leaving for the day. V20 stated on 5/12/22 there was nothing concerning reported to V20 when she came into work. V20 stated she took R1 to the bathroom and filled her pitcher of water that day but that's all. V20 stated on 5/13/22 when she came into work the third shift CNA reported R1 had thrown up during the night. V20 stated that V13 RN also told V20 that R1 had thrown up a few times during the night and had been drinking lots of water and to let (V13) know if R1 threw up any more. V20 stated she was not aware that R1 had diabetes, it was not reported to her and neither R1 nor V10 (R1's) Family Member ever said anything about it to V20. V20 stated shortly after 7:00 am a Housekeeper asked (V20) where the crash cart was and took it to (R1's) room. V20 stated when she walked into R1's room she saw a Nurse from the other side of the facility doing compressions and (V20) stepped in to help with the respirations. V20 stated, "We continued until the EMTs (emergency medical transport) got here and took over."

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S9999	Continued From page 12 On 5/23/22 at 3:35 pm, V18 Agency CNA stated she worked 5/12/22 at 9:45 pm until 5/13/22 at 6:00 am. V18 stated that R1 began throwing up shortly after she came on shift to work. V18 stated the first time she was in the room was around 10:00 pm, and R1 had thrown up all over herself and threw up again while V18 was cleaning R1 up. V18 stated that R1 was throwing up on and off throughout the shift. V18 stated that V18 gave her a basin to use and every time she turned her light on and V18 would go in there, she had more throw up in the basin. V18 stated that the vomiting started out with substance but, "the last time she threw up it was as clear as water with a slight yellow mixed in." V18 stated that V18 had to change her bed at least three times during the night. V18 stated that R1 was only incontinent one time for V18 during the night but someone else may have checked or changed her and V18 may not be aware. V18 stated, "What I thought was strange was that every time I went into her room, she was asking for another pitcher of water." V18 stated she told V17 Former RN every time R1 threw up and that R1 kept asking for water. V18 stated, "I don't remember there being any odors, or her sweating and she (R1) never complained of pain. I did not know she was diabetic. No one told me that. (R1) never told me that either." On 5/22/22 at 8:31 am, V17 Former RN stated she was the Nurse assigned to R1 on 5/12/22 at 6:00 pm to 5/13/22 at 6:00 am. V17 stated around 10:30 pm V18 CNA reported (R1) had vomited and she had to do a complete bed change. V17 stated, "I took (R1's) vitals and gave her nausea medicine she had ordered and checked her for COVID, and she was negative. (R1) asked for a bucket for vomiting, which we gave her. About 45 minutes later, (R1) vomited again. (R1) said she	S9999		

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	IL6007199	A. BUILDING: _____ B. WING _____	C 05/27/2022

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S9999	Continued From page 13 had GERD (Gastro-esophageal reflux disease), so I gave her Tums, and she was better and didn't vomit again. (R1) did ask for water quite a few times. (V19 CNA) brought (R1's) water pitcher out to get water and told me (V17) that this was the 3rd pitcher of water she had gotten for (R1) since her shift started at 6:00 pm." V17 stated, "I didn't think anything of it because residents are always asking for things during the night and (R1) was voiding as well." V17 stated, "(R1) was taking two antibiotics, and I thought that maybe this was causing her to have an upset stomach. I didn't know she was a diabetic, no one told me in report, or I would have checked her blood sugar. (R1) never said anything about being diabetic or needing insulin only said that (R1) had GERD." V17 stated that she didn't know R1 was diabetic until she worked the next day and reviewed R1's medical record and saw the diagnosis. V17 stated, "No, I did not call her doctor. I was terminated for not calling the Physician and for giving Tums without a Physician order." On 5/23/22 at 11:40 am, V9 R1's FNP (Family Nurse Practitioner) stated she did a video telehealth visit with R1 on 5/12/22 due to her being a New Admission. V9 stated that generally she reviews the electronic health record for diagnoses and Physician orders and completes her assessment. V9 stated that Type II diabetes was listed on R1's orders but (V9) was not concerned about R1 not having orders for this because some diabetics are controlled by diet, and R1 didn't have any insulin orders listed. V9 stated that R1 was admitted the previous day and her orders would have already been verified by the admitting Nurse. V9 stated she was not notified or called and does not have any	S9999		

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clarification order requests for R1. V9 stated they (facility nursing staff) should be clarifying these orders upon admission and checking all medications and reaching out for clarification if they need it. V9 stated that she does not have any clarification requests regarding an insulin pump, insulin or blood glucose monitoring for R1. V9 stated usually the DON initiates the telehealth visits, meets with (V9) and lets (V9) know if there are any concerns or resident needs that need addressed. The DON, a Nurse or CNA will round with (V9) and then (V9) circles back to the Nurse or DON if (V9) needs to for orders, clarifications or for whatever is needed. V9 stated that V6 Former DON initiated the telehealth visit on 5/12/22 and never mentioned anything about an insulin pump, insulin, or glucose monitoring for R1. V9 stated R1 did not mention anything about it either and had no concerns for (V9) other than constipation.

On 5/19/22 at 6:24 pm, V10, (R1's) Family Member, stated that R1 has been a Type I Diabetic since (R1) was 13 years old and admitted to the facility on 5/11/22 after a hospital stay. V10 stated the hospital did not use R1's insulin pump while she was there but was checking her blood sugars manually and giving R1 insulin injections based off the blood sugar result. V10 stated that R1 would not initiate a conversation with anyone and would usually only answer "yes "or "no" to questions when asked and does not believe R1 would have been able to communicate her needs to the facility staff if she was not feeling well or something was wrong. V10 stated that when (R1) was discharged to the facility, they were supposed to be using her Insulin pump and stated, "I would think that was in her orders. I had no idea they weren't (using the insulin pump). No one asked me about it. I

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assumed they knew what they were doing and expected them to know what to do." V10 stated that he was at home on 5/13/22 when the facility called him reporting that R1 was not doing well. V10 stated he immediately got dressed and went to the facility and, "by the time I got there, they already had her on the floor and had the thumper thing on her doing CPR." V10 stated that he heard one of the staff say they didn't know (R1) had an insulin pump and that was very concerning to V10 that no one knew, but at the moment V10 was too concerned with R1's condition. V10 stated that R1 was taken to the local hospital and kept alive until family could get to the hospital and when the Doctor removed the tube, "(R1) didn't even take a breath, she just died." V10 stated, "The Doctor told us that her blood sugar was so high that she was in ketoacidosis, which stopped her heart. We were married for 44 years, and this was a senseless and careless death that didn't have to happen."

The Employee Disciplinary Action form for V17 RN, signed and dated 5/18/22, documents that V17 RN's employment was terminated due to, "Unsatisfactory job performance, or substandard quality of work" with description of the violation documented as "Failure to report resident condition/symptoms to MD (Medical Doctor), dispensing OTC (over the counter) medication without orders."

On 5/20/22 at 10:45 am, V6 Former DON stated she generally checks new resident admission orders within 24 hours of their admission; however, she been working the floor, trying to keep up, and had just not gotten around to it.

The Progress Notes for R1, dated 5/11/22 at 12:49 pm document R1 was admitted to the

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facility (on 5/11/22) and on 5/13/22 at 7:20 am, approximately 31.5 hours after R1 was admitted to the facility, CPR (cardiopulmonary resuscitation) was initiated for R1 due to being found unresponsive, without a pulse and without respirations. R1's Progress Notes, do not document R1's Physician was notified for clarification of R1's insulin pump orders. R1's Progress Notes also do not document any insulin orders, diabetic monitoring orders or notification of any changes in R1's condition.

The hospital Emergency Department Notes, dated 5/13/22, documents: "(R1) female with history of diabetes who presents to the ED (Emergency Department) for cardiac arrest" and was intubated and a central line was placed. The laboratory results for R1's CMP (comprehensive metabolic profile) blood draw showed abnormal laboratory values including a Glucose level of 864 and, "large amount" of ketones. The ED report documents, "Concern for DKA (Diabetic ketoacidosis) and severe acidosis precipitating cardiac arrest." This note documents after multiple medications were administered to R1, "The patient never had a shockable rhythm. Total of about 1.5 hours of resuscitation before ROSC (return of spontaneous circulation)." "Clinical Impression: 1. Cardiac arrest, 2. DKA, 3. Metabolic acidosis, 4. Hyperkalemia."

On 5/19/22 at 9:50 am, V3 Regional Director of Operations stated she terminated V17 RN (Registered Nurse) due to not notifying V8 (R1's) PCP (Primary Care Physician) of R1's change in condition and giving R1 a medication, Tums, that was not ordered.

On 5/19/22 at 1:20 pm, V8, R1's PCP (Primary Care Physician), V8 stated he was unaware of

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S9999	Continued From page 17 any problems or concerns with R1 and he did not receive any calls from the facility requesting clarification of admission orders. V8 said he did not receive any calls from the facility regarding insulin orders, diabetic monitoring or R1's vomiting, increased thirst, or increased urination. V8 stated it is uncommon for the nursing homes to have someone with an insulin pump. V8 stated that it was probably a Nurse who was unfamiliar with an Insulin Pump and was a poor order from the hospital. V8 stated he would have expected the Nurse to get clarification orders, usually managed by their Endocrinologist. V8 stated that the Nurse should have at least been doing blood glucose checks, R1 should have been on a sliding scale and maybe a long-lasting insulin. V8 stated, "Of course" when asked if R1 was not receiving insulin for a few days could it have contributed to R1's death. On 5/19/22 at 3:03 pm, V14 County Coroner, stated Immediate cause of death was DKA (Diabetic Ketoacidosis) for days and the second was absent Insulin pump and missed insulin injections for days. V14 stated (R1) had multiple comorbidities but the DKA and missed insulin was the cause of (R1's) death. The Death Certificate for R1, dated 5/19/22, documents R1's death on 5/13/22 with immediate cause of death as, "Diabetic Ketoacidosis" due to "Absent Insulin Pump/Missed Insulin Injections." (AA)	S9999		