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	495108	A. BUILDING _____ B. WING _____	C 11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated standard (complaint investigation) survey was conducted 11/12/19 through 11/14/19. Two complaints were investigated during the survey; VA00047356 which was substantiated with deficiency and VA00047756 which was substantiated with deficiencies. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 176 at the time of the survey. The survey sample consisted of 4 resident reviews: Two current resident reviews (Resident #1 and #2) and two closed record reviews (Resident #3 and #4).	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		12/17/19

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

Electronically Signed | 11/26/2019

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.

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff and complainant interview and facility documentation review, the facility staff failed to promptly notify the physician for 1 of 4 residents (Resident #4) in the survey sample a change of condition, specifically of consistent elevations in blood sugars; as a result Resident #4 was admitted to the ICU (intensive care unit) with a diagnoses of	F 580	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will	

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F 580	Continued From page 2 *DKA (Diabetic Ketoacidosis) resulting in harm. The findings include: Resident #4 was admitted to the nursing facility on 11/1/19 with diagnoses that included insulin dependent type 1 diabetes mellitus (DM) and end stage renal disease (ESRD) on hemodialysis. The resident was admitted for rehabilitation. The resident was discharged to the local hospital on 11/3/19 and did not return to the nursing facility. Resident #4 was not in the facility long enough to have a completed Minimum Data Set (MDS) assessment. The Admission Assessment/Screening dated 11/1/19 indicated the resident was alert and oriented times person, place, time (day, month, year) and situation. The assessment indicated the resident's cognition was intact with no deficits, able to understand others and was understood by them. The 48 hour care plan dated 11/1/19 identified one of the resident's focus areas was diabetes mellitus. The goal set by the staff for the resident was that there would be no complications related to diabetes and some of the interventions the staff would implement to prevent complications included: administer diabetes medication as ordered by the doctor and monitor/document for side effects and effectiveness. Other interventions were to monitor/document/report PRN (as needed) any signs and symptoms of hyperglycemia (increase blood sugar levels) that may include diminished mental status, abdominal pain and muscle cramps. Resident #4 had the following physician orders dated 11/1/19 upon admission that required the	F 580	take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #4 discharged from the facility on November 3, 2019. Residents with orders to monitor blood sugars were reviewed to ensure that the physician was notified as ordered for elevated blood sugars noted during the past 30 days. Charge Nurses will be educated on following physician orders for hyperglycemia, documentation of physician notification of elevated blood sugars, the on-call protocol for physicians, the on-call protocol for facility administrative staff, and signs and symptoms of diabetic ketoacidosis. The Unit Managers will monitor blood sugar results on a weekly basis to ensure that the physician is notified of hyperglycemia as ordered. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: December 17, 2019	

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nurse to notify him for elevations in blood sugar readings as a result of FSBS (finger stick blood sugar) of 401 (milligrams per deciliter-mg/dL) or greater:

Accuchecks finger stick blood sugar (FSBS), is one method of blood glucose monitoring before (AC) meals (breakfast, lunch and dinner) and hour of sleep (HS).

-Humalog KwikPen solution per-injector 100 unit/ml (milliliter) (Insulin Lispro) inject subQ the following sliding scale (as a result of FSBS readings obtained AC and HS):
0-60=give 0 (no) units of Humalog insulin and follow hypoglycemia orders;
61-149=give 0 units of Humalog insulin;
150-200=give 2 units of Humalog insulin;
201-250=give 4 units of Humalog insulin;
251-300=give 6 units of Humalog insulin;
301-350=give 8 units of Humalog insulin;
351-400=give 10 units of Humalog insulin;
401 and above=give 10 units of Humalog insulin and recheck the blood sugar in one hour. Notify the MD (medical doctor).

The following Medication Administration Record (MAR) with subsequent nurses's notes and staff interviews is a chronology of the residents elevations in FSBS that were 401 and above with no notification to the physician:

-11/2/19 (Saturday) FSBS AC at 4:00 p.m.=401 with 10 units of Humalog insulin administered subQ. There was no record of a recheck of the resident's blood sugar in one hour nor was it recorded that the MD was called per orders. The Licensed Practical Nurse (LPN) #1, who obtained this FSBS and was assigned to the resident

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during this time, was not available for interview and no longer employed by the facility.

-11/2/19 FSBS HS at 9:00 p.m.=401 with 10 units of Humalog insulin administered subQ. There was no record of a recheck of the resident's blood sugar in one hour nor was it recorded that the MD was called per orders. LPN #1 who obtained this FSBS was the same aforementioned nurse.

-11/3/19 FSBS at 6:30 a.m.=460 with 10 units of Humalog insulin administered subQ. The nurse's notes indicated that LPN #2 made a call to the on call service and left a message to inform them of the results of the FSBS. The message log that was presented to the surveyor by the Medical Director on 11/13/19 at 2:15 p.m. indicated the on- call service returned the call at 6:45 a.m., but they were left on hold and spoke to no one, thus this elevated blood sugar was not addressed.

-11/3/19 FSBS at 12:00 p.m. (lunch time) was reading *"HI" as well as the rechecked FSBS at 1:30 p.m. The nurse's notes indicated LPN #2 called the on call, left a message and was awaiting a call back. The message logs presented by the Medical Director did did not evidence any calls to them at that time, and said because they were not made aware there was no opportunity to address them with any further orders. The Medical Director also confirmed that there were no calls made to the on call service on 11/2/19 at 4:00 p.m. or 9:00 p.m. which would have enabled the on call provider to address the elevated blood sugars early on prior to the critical stages of her condition on 11/3/19.

*"HI" FSBS readings via accucheck means the FSBS level was in the "Critical Range" above 600

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(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144771/).

Lack of prompt notification resulted in Resident #4 being transferred to the local Emergency Department (ED) on 11/3/19 at 3:53 p.m., admitted to ICU with a diagnosis of *DKA (Diabetic Ketoacidosis).

The hospital records indicated Resident #4 presented in the local Emergency Department (ED) on 11/3/19 at 4:14 p.m. with high blood sugars with complaints of nausea, vomiting and abdominal pain. The patient reported she was "not getting insulin administered when I needed it." The resident's serum (blood) glucose level was 724 (74-106=normal). The urine glucose level was 250 (negative=normal), ketones were 40 (negative=normal). The resident was admitted to the hospital and diagnosed with diabetic ketoacidosis and started on protocol with an insulin drip. The hospital history and physical (H&P) dated 11/3/19 indicated the resident was accompanied by her daughter and she herself called ambulance services to transport her mom to the hospital because she states, "I just knew she was in DKA." The daughter reiterated, as evidenced in the H&P that there were issues with the patient receiving her insulin in a timely manner. The hospital H&P indicated the resident had nausea, vomiting, abdominal pain, felt fatigued and lethargic. The H&P also indicated the resident was being admitted to the ICU and treated with "a life threatening illness."

*DKA is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones.

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The condition develops when your body can't produce enough insulin. Insulin normally plays a key role in helping sugar (glucose), a major source of energy for your muscles and other tissues enter your cells. Without enough insulin, your body begins to break down fat as fuel. This process produces a buildup of acids in the bloodstream called ketones, eventually leading to DKA if untreated. Untreated diabetic ketoacidosis can lead to unconsciousness and death.

The warning signs and symptoms (S&S) of DKA can develop quickly, sometimes within 24 hours and include:
Excessive thirst
Frequent urination
*Nausea and vomiting (Resident #4's S&S)
*Abdominal pain (Resident #4's S&S)
*Weakness or fatigue (Resident #4's S&S)
Shortness of breath
Fruity-scented breath
Confusion
*High blood sugar level (hyperglycemia) (Resident #4's S&S)
*High ketone levels in the urine (Resident #4's S&S)

Seek emergency care if:
Blood sugar levels are consistently higher than 300 milligrams per deciliter (mg/dL) and you have multiple signs and symptoms of diabetic ketoacidosis.

Without enough insulin, your body can't use sugar properly for energy. This prompts the release of hormones that break down fat as fuel, which produces acids known as ketones. Excess ketones build up in the blood and eventually "spill over" into the urine.

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F 580	Continued From page 7 Diabetic ketoacidosis can be triggered by a problem with insulin therapy. Missed insulin treatments or inadequate insulin therapy can leave you with too little insulin in your system, triggering DKA. The risk of diabetic ketoacidosis is highest with type 1 diabetes. Complications of DKA include abnormal electrolytes that can affect the brain (swelling) heart, muscles and nerves (https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551). The facility's policy ad procedures titled "Significant Change in Condition" dated 2/1/15, indicated assessment of a significant change in condition shall be reported to the primary physician. Potentially life threatening conditions require nursing assessment skills and expertise to determine whether a patient should be transferred to an acute care setting. The decision shall be made by a licensed nurse when the patient's condition is so acute that time does not permit waiting for physician's response. On 11/14/19 at 3:45 p.m., a debriefing was conducted with the Administrator, DON and Corporate Nurse. An opportunity was provided for further questions and/or clarification. No further information was provided prior to survey exit. Complaint Deficiency.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		12/17/19

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F 657	Continued From page 8 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff and complainant interviews and facility documentation review, the facility staff failed for 1 of 4 residents in the survey sample (Resident #3) to revise the comprehensive care plan to include impulsive behaviors, non-compliance with safety instructions. Also, revisions to the care plan to prevent injuries to legs from sharp or hard surfaces were not made until after the second injury to the right leg. The findings include:	F 657	Resident #3 discharged from the facility on July 31, 2019. Residents with hemiplegia, use of anticoagulants, and impulsive behaviors placing them at risk for skin tear injuries were reviewed to ensure that the risk is identified and interventions to prevent injuries are included in the resident plan of care. Nurses will be educated to revise care plans as indicated for prevention of injury	

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F 657	Continued From page 9 Resident #3 was admitted to the nursing facility on 7/1/19 with a diagnoses that included, but not limited to, stroke with *hemiparesis. *Hemiparesis is muscular weakness or partial paralysis restricted to one side of the body (https://www.merriam-webster.com/medical/hemiparesis). Resident #3's most recent Minimum Data Set (MDS) assessment was an admission dated 7/8/19 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 10 out of a possible score of 15 which indicated the resident was moderately impaired in the necessary skills for daily decision making. He was not assessed to have any behavioral problems, nor did he reject care that would have affected his ability to achieve his goals for health and well-being. The resident was assessed to require extensive assistance from one staff for transfers, dressing and toilet use. He used his wheelchair as the main mobility device. The assessment coded the resident to walk in his room only once or twice during this 7-day assessment period. The resident was occasionally incontinent of bowel and bladder. The assessment coded the resident to have hemiparesis following a stroke that affected his right dominant side. The resident was coded to be on an anticoagulant seven days a week. He was not on any antipsychotic, anti-anxiety, antidepressant or hypnotic medications. The resident was assessed to have speech, occupational and physical therapy. The care plan dated 7/2/19 identified the resident had deficits in activities of daily living (ADL) self-care performance related to fatigue, he was	F 657	for hemiplegia, use of anticoagulants, and when impulsive resident behaviors are noted. Charge Nurses will also be educated to revise care plans as indicated to include interventions for prevention of injury. The Unit Managers will monitor skin tear injuries on a weekly basis to ensure that the care plan was revised to include new interventions for prevention of injury. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: December 17, 2019	

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at risk for falls related to right sided weakness and fatigue and he was on anticoagulant therapy related to chronic atrial fibrillation. The goals the staff set for the resident was that the resident will improve his current level of functioning in ADLs, be free of falls, be free of adverse reactions or discomfort related to anti-coagulant use. Some of the interventions to accomplish theses goals for the resident included, staff to assist as needed, encourage use of call bell for assistance, keep environment free of hazards, daily skin inspections related to anticoagulant use. The care plan dated 7/17/19 identified an actual impairment to skin integrity of the right calf related to laceration and that the goal set by the staff was that the resident would have no complications related to the laceration. Some of the interventions to accomplish this goal included to educate resident/family/caregivers of causative factors and measures to prevent skin injury, identify/document potential causative factors and eliminate/resolve where possible. The care plan dated 7/24/19 identified that the resident had a potential for skin tears related to fragile skin and the goal set by the staff for the resident was that identify potential causative factors and eliminate/resolve them when possible, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.

The operational care plan dated 7/2/19 and revised on 7/8/19, 7/1719 and 7/24/19 did not identify or was revised for impulsive behaviors, non-compliance with safety instructions or that he refused care, treatment or staff assistance. Revisions to the care plan to prevent injuries to arms and legs from sharp or hard surfaces were made after the second injury to the right leg, the

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resident's weaker dominate side on 7/17/19 and 7/24/19.

The resident was admitted to the nursing facility with physician orders dated 7/1/19 for *Apixaban (Eliquis) tablet 5 milligrams (mg) two times a day at 9:00 a.m. and 6:00 p.m. for anticoagulation therapy treatment related to chronic atrial fibrillation.

*What is ELIQUIS? ELIQUIS is a prescription medicine used to:
Reduce the risk of stroke and blood clots in people who have atrial fibrillation (AFib), a type of irregular heartbeat, not caused by a heart valve problem.

What are the possible serious side effects of ELIQUIS?
This is a list of some of the serious side effects of ELIQUIS.
Bleeding
ELIQUIS can cause bleeding, which can be serious, and rarely may lead to death. This is because ELIQUIS is a blood thinner medicine that reduces blood clotting. While taking ELIQUIS, you may bruise more easily and it may take longer than usual for any bleeding to stop https://www.eliquis.bmscustomerconnect.com/

The resident was ordered on 7/2/19 to have physical therapy 6-7 times/week for 6 weeks; speech therapy 5-7 days/week for 4 weeks and occupational therapy 6-7 times a week for 8 weeks.

The nurse's notes dated 7/6/19 at 10:10 p.m., indicated the Certified Nursing Assistant (CNA) notified Licensed Practical Nurse (LPN) #7 that

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CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

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Resident #3 had sustained a skin tear while being assisted to bed because he did not allow the CNA to lock the right side of his wheelchair before he stood up which resulted in the leg bracket scrapping his right leg causing a skin tear. The skin tear was treated with normal saline, followed by Bacitracin and a dry dressing. The care plan was not revised with any preventative measures to protect the resident's skin from subsequent injuries related to the leg brackets. An in house incident report was generated dated 7/7/19 that reflected the same information. It was added that the "resident appears very impatient and does not allow staff time to perform task." The care plan was not revised to reflect this resident behavior.

The nurse's notes dated 7/9/19 at 9:45 p.m. indicated LPN #7 heard the resident calling out for help. The nurse's notes indicated the resident was found sitting in his wheelchair outside of the bathroom and blood was noted on the floor coming from his left (error, should be right) lateral leg. The nurse's notes indicated the bleeding was controlled by applying pressure, gauze and Kerlix and was able to visualize a sizeable gash to the left lateral leg (error, should be right) above area where resident has skin tear. The resident was sent to the ED via medical transport. The facility incident report noted under "other info" that "Resident does not lock his right side of the wheelchair when using the toilet and w/c (wheelchair) moved and caused injury, resident did not use his call bell for assistance for toileting." The incident report indicated, "No witnesses found."

The nurse's notes evidenced on 7/2/19, 7/9/19,7/21/19, 7/22/19, 7/24/19, 7/25/19 that the resident was found attempting to transfer himself.

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Care plans did not evidence this behavior.

On 11/12/19 at 1:15 p.m., the Assistant Rehabilitation Director was interviewed. She stated she was not familiar with Resident #3, but said if a resident is in therapy, they have the opportunity to assess the wheelchair and determine if there are any safety needs to include the need for padding, contour cushions, positioning devices and/or determine proper width and height of the wheelchair. She stated with the bariatric patients their legs may be more abducted and place a greater risk at rubbing the foot rest brackets on the wheelchair. She stated they had a room with many devices to protect and pad areas on wheelchairs and sometimes "we are inventive" depending in the resident's individual needs, and also depend on the nursing staff to tell them if they have any safety concerns.

On 11/13/19 at 1:30 p.m., an interview was conducted with the Occupational Therapist (OT) who provided OT services for Resident #3. She stated she went to the resident's room to get him for therapy on the day after the first incident (7/7/19) and asked the resident what happened. She stated the resident said he tried to transfer by himself and scraped his leg on the wheelchair. She stated the day before the first incident the resident was able to transfer from chair to commode with minimum/moderate assist of 1 person and because of is size, he could not use a bedside commode. She said based on his stroke he could use his right leg, but it was weaker than the left leg. She said the goal was to have him propel himself with his arms and legs in the wheelchair without foot rests so that he could be as independent as possible. She stated they were not looking at walking, but wanted the

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resident to be able to utilize his wheelchair as his the mode of mobility within his environment.

During the above interview, the OT stated on 7/9/19 and 7/10/19 the resident was doing more toward reaching his goal to be able to stand from the wheelchair, use the forward wheel-walker, stand pivot to transfer to the chair with contact guard assist (touching only). She stated neither therapy or nursing thought about the bolsters after the first skin tear to the right leg, but after the second incident with a laceration and sutures, bilateral bolsters with Velcro straps were placed over the brackets/prongs on each side of the wheelchair where the foot rest connected to prevent further injury. She stated it was important to have the resident be as proficient as possible in the use of his wheelchair because the goal was to have him mobile in his wheelchair and not use the foot rest. The OT stated the resident only used the foot rest, if he was pushed somewhere by his wife. She said the wife was happy about the bolsters and said the injury to the resident's right leg was in the same place with each incident.

On 11/13/19 at 5:20 p.m., LPN #7 stated she tried to watch Resident #3 the best she could by parking her medication cart outside of his room because he was impulsive at times and confused and she wanted to be able to hear him try to move around, but at times he would manage to stand and try to go the bathroom on his own. The LPN stated, "There was so much blood with the second incident. I left the old dressing from the skin tear with the first incident and applied dressings and pressure over top until we could get him sent out." She verified that the bolsters were placed over the areas on the wheelchair

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where the foot rest attach after the second incident to prevent further incidents. She stated the resident did not have any further injuries from the wheelchair after the bolsters were applied. When asked why these impulsive behaviors and intermittent episodes of confusion with interventions were not care planned, especially in light of the fact that the resident was on an anti-coagulant twice a day which put the resident at higher risk for bleeding from any injuries, LPN #7 responded, "I am just getting into care planning because I was taught in nursing school that LPN's could not enter anything on the care plan." She could not provide an explanation as to why the brackets were not padded after the first incident, a skin tear, to prevent the second one in the same are which was a significant injury/laceration requiring ED evaluation and sutures.

The facility's procedure titled "Measures to Prevent Skin Tears" (undated) indicated "Pad bed rails and wheelchairs arms, foot plates, and leg supports and follow the care plan. Some patient's move quickly and without warning... Fragile skin is common in older adults."

On 11/14/19 at 3:45 p.m., a debriefing was conducted with the Administrator, Director of Nursing and the Corporate Nurse. The Administrator stated he felt that the second incident may have happened another way since it was not witnessed and felt it was from the door jam and he had fragile skin. An opportunity was provided for the facility to present any further information. No further information was provided before survey exit.

Complaint Deficiency.

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F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff and complainant interviews and facility documentation interviews, the facility staff failed to effectively monitor and provide treatment for consistent elevations in blood sugar for 1 of 4 residents (Resident #4) in the survey sample which resulted in a hospital admission to the intensive care unit (ICU) with blood sugar level of 724 (74-106 mg/dl (milligrams/deciliter)=normal) and diagnosis of *DKA (diabetic ketoacidosis) constituting harm. The findings include: Resident #4 was admitted to the nursing facility on 11/1/19 with diagnoses that included insulin dependent type 1 diabetes mellitus (DM) and end stage renal disease (ESRD) on hemodialysis. The resident was admitted for rehabilitation. The resident was discharged to the local hospital on 11/3/19 and did not return to the nursing facility. Resident #4 was not in the facility long enough to have a completed Minimum Data Set (MDS) assessment. The Admission Assessment/Screening dated 11/1/19 indicated	F 684	Resident #4 discharged from the facility on November 3, 2019. Residents with orders for sliding scale insulin were reviewed for the month of November to ensure that the insulin was administered as ordered. Charge Nurses were reviewed to ensure that a successful Medication Pass Observation has been completed within the past year. Charge Nurses will be educated on administration of insulin as ordered, clarification of telephone or verbal order as indicated, following physician orders for hyperglycemia, documentation of physician notification of elevated blood sugars, the on-call protocol for physicians, the on-call protocol for facility administrative staff, signs and symptoms of diabetic ketoacidosis, and notification of EMS when emergency services are required. The Unit Managers will monitor blood sugar results on a weekly basis to ensure	12/17/19

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F 684	Continued From page 17 the resident was alert and oriented times person, place, time (day, month, year) and situation. The assessment indicated the resident's cognition was intact with no deficits and she was able to understand others and was understood by them. The 48 hour care plan dated 11/01/19 identified one of the resident's focus areas was diabetes mellitus. The goal set by the staff for the resident was that there would be no complications related to diabetes and some of the interventions the staff would implement to prevent complications included administered diabetes medication as ordered by the doctor and monitor/document for side effects and effectiveness. Other interventions were to monitor/document/report PRN (as needed) any signs and symptoms of hyperglycemia (increase blood sugar levels) that may include diminished mental status, abdominal pain and muscle cramps. Resident #4 had the following physician orders upon admission to the nursing facility on 11/1/19 related related to diabetes management: -Accuchecks finger stick blood sugar (FSBS), which is one method of blood glucose monitoring before (AC) meals (breakfast, lunch and dinner) and hour of sleep (HS). -Humalog KwikPen solution per-injector 100 unit/ml (Insulin Lispro) inject 5 units subcutaneously (subQ) (under the skin-into the fat layer between the skin and the muscle) before meals for DM which was a scheduled standing order. -Lantus SoloStar solution pen-injector 100 unit/ml (insulin Glargine) inject 18 units subQ at	F 684	that insulin is administered as ordered and the physician is notified of hyperglycemia as ordered. The Unit Managers will monitor successful completion of a Medication Pass Observation prior to completion of orientation for newly hired Charge Nurses. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: December 17, 2019	

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bedtime/HS.

-Humalog KwikPen solution per-injector 100 unit/ml (Insulin Lispro) inject subQ the following sliding scale (as a result of FSBS readings obtained AC and HS):
0-60=give 0 (no) units of Humalog insulin and follow hypoglycemia orders;
61-149=give 0 units of Humalog insulin;
150-200=give 2 units of Humalog insulin;
201-250=give 4 units of Humalog insulin;
251-300=give 6 units of Humalog insulin;
301-350=give 8 units of Humalog insulin;
351-400=give 10 units of Humalog insulin;
401 and above=give 10 units of Humalog insulin and recheck the blood sugar in one hour. Notify the MD (medical doctor).

The following Medication Administration Record (MAR) with subsequent nurses's notes and staff interviews is a chronology of the residents elevations in FSBS that were 401 and above:

-11/2/19 (Saturday) FSBS AC at 4:00 p.m.=401 with 10 units of Humalog insulin administered subQ. There was no record of a recheck of the resident's blood sugar in one hour nor was it recorded that the MD called per orders. The Licensed Practical Nurse (LPN) #1 who obtained this FSBS and was assigned to the resident during this time, was not available for interview and no longer employed by the facility.

-11/2/19 FSBS HS at 9:00 p.m.=401 with 10 units of Humalog insulin administered subQ. There was no record of a recheck of the resident's blood sugar in one hour nor was it recorded that the MD was called per orders. LPN #1 who obtained this FSBS was the same aforementioned nurse.

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-11/3/19 (Sunday) FSBS AC at 6:30 a.m.=460 with 10 units of Humalog insulin administered based on the sliding scale and the scheduled 5 units of Humalog subQ as evidenced on the MAR. The notes indicated LPN #2 left a message with the on call doctor about the 460 FSBS. The nurse's notes indicated LPN #2 rechecked Resident #4's blood sugar at 7:34 a.m. which was 596 and called the on-call (service) again and left another message. The notes indicated at 8:30 a.m., LPN #2 checked the blood sugar which was now 597 and gave 10 units of Humalog (without a physician's order to give extra at this time). The notes indicated she received a call back at 9:50 a.m. and spoke to the on call service nurse who had a question and LPN#2 placed the on call nurse on hold and upon retrieval of the call, it was noted the on call nurse had "hung up." LPN #2 called the on call nurse back. After conferring with the on call doctor, the on call nurse made a return call to the nursing unit and gave orders to LPN #2 to start sliding scale Humalog AC and HS. There was no notation in the nurse's notes that LPN #2 informed or questioned the on call nurse that the resident was already on AC and HS sliding scale and that this order would not address/treat the escalating blood sugars; nor was there any notation what information was given to the on call nurse by LPN #2.

-The nurse's notes indicated the FSBS AC on 11/3/19 at 12:00 p.m. read "HI" and rechecked to also read "HI." This "HI" reading meant the FSBS level was in the "Critical Range"above 600 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144771/). LPN #2 noted she gave the scheduled 5 units of Humalog, as well as 10 units of Humalog per the sliding scale of 401 or greater,

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and placed a call to the on call doctor at 1:30 p.m., awaiting a call back. The nurse's notes indicated at 2:53 p.m., the FSBS still read "HI" and "I just keep calling (the on-call service)." The nurse's notes indicated the resident's daughter called and was told by LPN #2 that she was waiting on a call from the physician and that the daughter wanted to send the resident to the hospital. The nurse's notes indicated "I called 911 so daughter would not take mother to the hospital in her car. I explained the ambulance can get her there faster. Continued to monitor and resident was in no distress." There were no further nurse's notes regarding EMT arrival and/or departure from the nursing facility.

After this surveyor reviewed the nurse's notes and Medication Administration Record (MAR), an interview was conducted with the Assistant Director of Nursing (ADON) on 11/12/19 at 11:00 a.m. Areas of concern were reviewed with the ADON that included the 3 PM-11 PM shift LPN #1's failure to re-check a FSBS and call the physician for a 401 FSBS on 11/2/19 at 4:00 p.m. and 9:00 p.m. Other areas of concern included repetitious documentation by LPN #2 that she was having difficulty with call backs from the on call service about elevated FSBSs, duplicated sliding scale orders for AC and HS, as well as lack of emergent intervention until the resident's daughter called to request the resident be sent out for evaluation. The ADON stated she was not sure why LPN #2 did not call her Unit Manager, herself, or the DON based on the resident's elevated FSBSs and her indication that she was having problems with call backs from the on call service. The ADON stated that LPN#1 and LPN #2 were new hires but were not new nurses with many years of nursing experience.

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On 11/12/19 at 11:45 a.m., Unit III Manager stated Resident #4 was admitted on 11/1/19 for therapy. She said when she orients nurses to the unit, she gives them her phone number to call her for any problems, and could not understand why LPN #2 did not call her for help with Resident #4 or to inform her she was having problems with return messages from the on call service. She stated, "If (LPN #2's name) was having such difficulty contacting the physician and the sugars were steadily rising, she should have called 911 earlier and catch up with the physician afterwards." She also stated she was not aware of the duplicate sliding scale order for FSBS AC and HS at 9:50 a.m. which "would have not done anything to treat the elevated blood sugars." The Unit III manager was not aware that the 11/2/19 6:00 p.m. or 9:00 p.m. FSBS's of 401 were not rechecked after an hour or the physician notified.

On 11/12/19 at approximately 5:00 p.m., the aforementioned issues were brought to the attention of the DON and Corporate nurse. They stated during orientation all nursing staff were made aware of the unit manager's phone numbers, as well as the DON, ADON and Administrator's personal cell phone numbers. They agreed that LPN #2 failed to recheck the blood sugars on 11/2/19 and follow orders to notify the physician. They also stated they could not understand the difficulties in contacting the physician on 11/3/19 as indicated in the nurse's notes by LPN #2 because the physician's are usually prompt with return calls. It was also brought to their attention, based on the duplication in orders, Resident #4 was never treated for the rising blood sugars other than the insulin orders in place upon admission on

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11/1/19. An appointment was set to meet with the Medical Director who was most of the facility resident's attending physician 11/13/19 around 2:00 p.m., who would present the call logs for 11/2-3/19.

The Medical Director was interviewed on 11/13/19 at approximately 2:15 p.m. The corporate nurse was present during the interview. The Medical Director stated once a call is made to the on call service, the nurse takes the message and relays it to the physician on call, give the information to her and the on call nurse calls back with a response from the on call physician with any orders. He said all incoming calls are recorded and phone time stamped, the on call LPN puts in the nature of the call and scans it to send through a secure email. He stated for urgent issues, which was Resident #4's situation, the facility calls the on call, the LPN records the nature of the call and tiger text the provider and the provider responds to the LPN via tiger text. He said the LPN uses the company cell phone number to call the facility with a turn around time of one hour. The Medical Director stated for life threatening emergency issues, 911 should be called and notification to the on call as time permits.

The message logs the Medical Director presented to this surveyor reflected the following:

-No incoming calls from LPN #1 on 11/2/19 at 4:00 p.m. or 9:00 p.m.
-On 11/3/19 at 6:45 a.m. noted that a call was made from the on call service to Unit III as a result of an incoming call at 6:30 am, but they were left on hold, spoke to no one
-On 11/3/19 at 7:25 a.m., a call from LPN #2 on

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Unit III indicated Resident #4's FSBS was "593", the resident was asymptomatic and that she gave 10 units of Humalog insulin. LPN #2 indicated she would recheck the blood sugar and call back in one hour.
-On 11/3/19 at 8:35 a.m., a call from LPN #2 indicated FSBS was 597. The log indicated LPN #2 relayed to the on call nurse that "the resident gets 5 units of Humalog insulin Q (every) 6 am and Q HS, sliding scale only Q HS and Lantus 18 units Q HS." This message to be forwarded to the provider.
-The log also indicated a call had been made to Unit III on 11/3/19 at 9:45 am and they were placed on hold and spoke to no one.
-On 11/3/19 at 10:00 a.m., the on call nurse speaks to LPN #2 to inform her the message was relayed to the provider and she would receive a call in a few minutes.
-On 11/3/19 at 10:08 a.m., a call to Unit III resulted in no answer with no one picking up.
-On 11/3/19 at 10:16 a.m., a call to Unit III resulted in orders given to LPN #2 to change sliding scale to AC and HS.
-There was no call registered to the (on call) service nurse on 11/3/19 at 1:30 p.m. by LPN #2 as she indicated in her nurse's notes that she made at that time.
-On 11/3/19 at 3:06 p.m., the log indicated LPN #2 called the (on call) nurse that the blood sugars were reading "HI" and the (on call) nurse text the provider this information on 11/3/19 at 3:15 p.m. On 11/3/19 at 3:29 p.m., the provider ask the (on call) nurse if the resident was symptomatic and were vital signs okay? There is not indication that the provider got the information if the resident was stable. On 11/3/19 at 3:38 p.m., the (on call) nurse responds that "Family just took her to the ER."

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The Medical Director presented to this surveyor a copy of the text on 11/13/19 at 10:16 a.m. that the provider received- "BS=597 got Humalog 5 units every 6 am and HS, sliding scale only for every HS, Lantus 18 units every HS." Orders given to LPN #2 were to "Change sliding scale to AC and HS." The Medical Director stated, "Either the information about the resident's current insulin orders were read incorrectly to the on call nurse, or the on call nurse interpreted them incorrectly. Bottom line, the resident was already on sliding scale AC and HS, so the resident did not receive orders that would have helped bring her blood sugar levels down." The Medical Director also said if the LPN thought the response times were too slow she could have escalated to a higher level by calling the DON or Administrator. The Corporate Nurse stated, "When the sugars kept going up, I wonder why she did not access the RN nurses in the facility and if she thought she was not getting through to the on call service, she could have called the DON, ADON, Unit Manager or Administrator."

During the above interview, the Medical Director stated five years ago, based on hurricane preparations, he devised an "On Call Protocol" that worked so well, he requested they be posted at every nurse's station, visible to all nurses. The protocol addressed instructions for non-urgent issues, life threatening emergency issues and urgent issues. He stated Resident #4 would have fallen in the category for urgent issues with the following instructions:
"-Call (phone number to the on call service) and choose the correct prompt for your facility and you will be connected directly to our on-call LPN's cell phones (we have eliminated our previous

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answering service to reduce delays).
-You may reach his/her voicemail if she is on the phone with another facility. Please leave a detailed message including your name, facility, unit/call back number, reason for your call and we will return your call promptly.
-Our on call provider should return your call approximately within 1 hour. Please call our on-call LPN again if you don't receive a call back from our provider within 1 hour.
-Please contact our on-call supervisor at (phone number) if you don't receive a call within 15-20 minutes of your second attempt.
-Please notify your DON/Administrator to contact the facility's medical director if our on-call supervisor can't be reached to address your concerns."

On 11/13/19 at 3:27 p.m., an interview was conducted with LPN#2. She stated she tried to call the physician's on call service after the 6:30 a.m. FSBS of 460, after the 7:34 a.m. rechecked FSBS of 596 and did not receive a call back until 9:50 a.m. at which time the on call nurse asked her to check to see how much insulin the resident was on, and when she came back to the phone, the on call nurse had hung up on her. She stated when she called the on call nurse back, the nurse told her she had to relay the information to the physician and she would return the call to her. LPN #2 stated the on call nurse relayed the order from the physician to start sliding scale Humalog AC and HS. When asked by this surveyor if she questioned the order in that the resident was already on Humalog AC and HS, she stated,"Oh, is there something wrong with the order? I don't see what is wrong with the order." LPN#2 did not recognize, until brought to her attention by the surveyor, that she had not obtained any further

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insulin orders that would have a positive effect at lowering the resident's blood sugars. The LPN further stated the FSBS read "HI" at 12:00 p.m. and she placed a call to the on call doctor at 1:30 p.m., with no return call from the on call service, and at 2:53 p.m. when the FSBS read "HI" again. She stated that she was continuously calling the on call service and they were not calling her back. She said, "The daughter called and said the resident called her to tell her she felt sick. I told her I was waiting for the on call to call me back, but she said she wanted (Resident #4's name) to go to the hospital, so I called 911 so the daughter would not take her in her car."

During the aforementioned interview with LPN #2, she was asked by this surveyor if she was having such great difficulty contacting the physician and/or needed further guidance, could she have called her nurse manager, the Registered Nurse (RN) supervisor who was in the building at the time, the Director of Nursing (DON), the ADON or the Administrator. The LPN responded she did not get the Unit III Manager's phone number until later, after the issues with Resident #4. She stated she could not disturb the RN supervisor because she was on another unit and she currently did not know the phone numbers of the DON, ADON or the Administrator and she did not currently know where to find them.

Random checks for the "On Call Protocol" was conducted on each of the four units:
-On 11/14/19 at 10:50 a.m., Unit I did not have the "On Call Protocol" posted at the nurse's station, but LPN #3 stated she had the protocol memorized and was able to verbalized the protocol. She also stated she has not had a problem contacting the on call even on the

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weekends. She stated she could not speak for a newly hired employee although she felt during orientation, they should be made aware. She stated if she had any concerns regarding the resident's declining health, she would call the unit manager or DON and if the situation became dire, she would not delay, but call 911 and contact the physician later.

-On 11/14/19 at 11:00 a.m., Unit II did not have the "On Call Protocol" visible at the nurse's station. LPN #4 said, "I have seen it before, but I don't know where I saw it. Maybe it is in the "Big Blue Book." After a 20 minute search, LPN #4 found the protocol taped behind other documents. She said if she assessed the resident to be in trouble, even without a call back from the physician, she would definitely consult with another nurse, possibly call the DON and 911.

-On 11/14/19 at 11:15 a.m., Unit III LPN #5 stated she worked for the facility for 10 years and it was usually the same physician and the number was posted at the nurse's station, but she said never saw a document titled "On Call Protocol." She stated, "It may be in the little black book," but it was not found. She said she could call the nursing supervisor, ADON or DON if she was unsure of what she should do in case a resident was becoming gravely ill and check with the doctor later.

-On 11/14/19 at 11:30 a.m., the "On Call Protocol" was clearly visible in a sheet protector posted at the nurse's station near the telephone. A Unit IV LPN (#6) stated, "If the physician or Nurse Practitioner (NP) is not in the building, I would call the on call service, leave a message for a return call, check with the nurse supervisor, and if the

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situation worsens, I would call 911."

The Administrator, DON, ADON and all Unit Manager's personal cell phone numbers were posted on the inside door cabinet or in the nursing office area on all four units.

On 11/14/19, at 1:55 p.m., neither LPN #1 or LPN #2's (both hired 9/9/19) orientation "Skills Competency Validation Record" could be located. LPN #1 had a "Medication Pass Observation" check sheet document, but LPN #2's could not be located. The DON and Corporate Nurse said all of the aforementioned orientation "Skills Competency Validation Record" and "Medication Pass Observation" must be filled out before completing orientation. They stated the medication pass observation check off document was also completed on an annual basis. The "New Hire Orientation Agenda for the Nursing Department" was reviewed that indicated on day 1 nurse's were introduced to their departments. The DON and Corporate Nurse stated that new hires are with a mentor for 5 days to check off all skill competency areas and could be extended if necessary. They stated they were sure the nurse's were oriented during this time on the "On Call Protocol" and where to find all the administrative cell phone numbers.

The hospital records indicated Resident #4 presented in the local Emergency Department (ED) on 11/3/19 at 4:14 p.m. with high blood sugars with complaints of nausea, vomiting and abdominal pain. The patient reported she was "not getting insulin administered when I needed it." The resident's serum (blood) glucose level was 724 (74-106=normal). The urine glucose level was 250 (elevated), ketones were 40

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(abnormal). The resident was admitted to the hospital and diagnosed with diabetic ketoacidosis and started on protocol with an insulin drip. The hospital history and physical (H&P) dated 11/3/19 indicated the resident was accompanied by her daughter and she herself called ambulance services to transport her mom to the hospital because she states, "I just knew she was in DKA." The daughter reiterated, as evidenced in the H&P that there were issues with the patient receiving her insulin in a timely manner. The hospital H&P indicated the resident had nausea, vomiting, abdominal pain, felt fatigued and lethargic. The H&P also indicated the resident was being admitted to the ICU and treated with "a life threatening illness."

On 11/14/19 at 2:21 p.m., a telephone interview was conducted with the complainant. She stated the resident called her sister who lived in the same city as the nursing facility and stated to her, "Please come get me, I am sick and I have been nauseous and throwing up all day. I fell like I am dying." The complainant stated the resident knew when her blood sugars were high and felt she wasn't being administered her insulin correctly. She stated her sister jumped in the car and on the way she called 911, gave them the necessary information, and was assured by them it was an emergent situation and would immediately dispatch the EMTs to the facility. She stated her sister was in the building as the EMTs arrived and she packed up the resident's belongings and accompanied the resident to the ED. When asked if her sister wanted to transport the resident in her car and was told by LPN #2 that she should not because the "ambulance can get her there faster," the complainant responded that it was never her sister's intention to take the

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resident to the hospital in the car; that was why she called 911.

During the above interview with the complainant she stated she spoke with the Unit III Manager to complain about the nurse's failure to adequately treat the high blood sugars and that the family was not informed. She stated the Unit III Manager told her she would pass her concerns on to the DON. The complainant stated the DON called her and stated the facility followed protocol and that the nurse called the physician and was waiting for the physician to call back. She stated the DON stated, "We did everything right." The complainant stated the Administrator called and stated he looked over everything and felt it was the hospital's fault that they released the resident from the hospital too soon due to her sugars being out of control. The complainant stated she knew for a fact that the resident's blood sugars were manageable when she was discharged from the hospital on 10/31/19 and that she would always require insulin to treat her type 1 diabetes for the rest of her life. She stated, "I felt pushed aside by the Administrator."

On 11/14/19 a previous interview was conducted with the Admissions Director at approximately 1:15 p.m. She stated the process to assure the facility can accept and care for a potential admission included completion and review of the "Center Admission Alert" paperwork. Review of this paperwork indicated the resident was being admitted for skilled services that would include occupational and physical therapy. The Admission's Director stated, "Her medicals were reviewed and she was deemed appropriate for skilled services by our facility on 11/1/19."

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The Department of Police records indicated two 911 calls were made on 11/3/19. The first 911 call was made by the resident's daughter asking that they send the resident out due to blood sugars reading high and the second 911 call was made by the nursing facility. An interview with the Central Records Department indicated, which was corroborated through review of the Service Detail Report, that information about the two calls were merged due to it was going to the same location.

On 11/14/19 at 3:45 p.m., a debriefing was conducted with the Administrator, DON and the Corporate Nurse. The Administrator stated although the orientation checklists could not be located for both LPN #1 and #2, he was sure they received proper orientation. An opportunity was provided for further questions and/or clarification. No further information was provided prior to survey exit.

*DKA is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones.

The condition develops when your body can't produce enough insulin. Insulin normally plays a key role in helping sugar (glucose), a major source of energy for your muscles and other tissues enter your cells. Without enough insulin, your body begins to break down fat as fuel. This process produces a buildup of acids in the bloodstream called ketones, eventually leading to DKA if untreated. Untreated diabetic ketoacidosis can lead to unconsciousness and death.

The warning signs and symptoms (S&S) of DKA can develop quickly, sometimes within 24 hours

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and include:

Excessive thirst
Frequent urination
*Nausea and vomiting (Resident #4's S&S)
*Abdominal pain (Resident #4's S&S)
*Weakness or fatigue (Resident #4's S&S)
Shortness of breath
Fruity-scented breath
Confusion
*High blood sugar level (hyperglycemia) (Resident #4's S&S)
*High ketone levels in the urine (Resident #4's S&S)

Seek emergency care if:

Blood sugar levels are consistently higher than 300 milligrams per deciliter (mg/dL) and you have multiple signs and symptoms of diabetic ketoacidosis.

Without enough insulin, your body can't use sugar properly for energy. This prompts the release of hormones that break down fat as fuel, which produces acids known as ketones. Excess ketones build up in the blood and eventually "spill over" into the urine.

Diabetic ketoacidosis can be triggered by a problem with insulin therapy. Missed insulin treatments or inadequate insulin therapy can leave you with too little insulin in your system, triggering DKA. The risk of diabetic ketoacidosis is highest with type 1 diabetes. Complications of DKA include abnormal electrolytes that can affect the brain (swelling) heart, muscles and nerves (https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff and complainant interviews and facility documentation review, the facility staff failed to minimize accident hazards sustained from the foot rest brackets on the side of a wheelchair for 1 of 4 residents (Resident #3) in the survey sample, which caused a laceration to the resident's right leg, an evaluation in the Emergency Department (ED), and 16 sutures. The findings include: Resident #3 was admitted to the nursing facility on 7/1/19 with a diagnoses that included, but not limited to, stroke with *hemiparesis. *Hemiparesis is muscular weakness or partial paralysis restricted to one side of the body (https://www.merriam-webster.com/medical/hemiparesis). Resident #3's most recent Minimum Data Set	F 689	Resident #3 discharged from the facility on July 31, 2019. Residents with hemiplegia, use of anticoagulants, and impulsive behaviors placing them at risk for skin tear injuries were reviewed to ensure that the risk is identified and interventions to prevent injury are included in the resident plan of care. Charge Nurses will be educated to identify residents at risk for skin tear injuries to include hemiplegia, use of anticoagulants, and those with impulsive behaviors. Charge nurses will be educated to identify interventions for prevention of injury, to revise care plans as indicated to prevent injury, and to implement the identified interventions. The Unit Managers will monitor skin tear	12/17/19

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(MDS) assessment was an admission dated 7/8/19 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 10 out of a possible score of 15 which indicated the resident was moderately impaired in the necessary skills for daily decision making. He was not assessed to have any behavioral problems, nor did he reject care that would have affected his ability to achieve his goals for health and well-being. The resident was assessed to require extensive assistance from one staff for transfers, dressing and toilet use. He used his wheelchair as the main mobility device. The assessment coded the resident to walk in his room only once or twice during this 7-day assessment period. The resident was occasionally incontinent of bowel and bladder. The assessment coded the resident to have hemiparesis following a stroke that affected his right dominant side. The resident was coded to be on an anticoagulant seven days a week. He was not on any antipsychotic, anti-anxiety, antidepressant or hypnotic medications. The resident was assessed to have speech, occupational and physical therapy. The resident was 76 inches tall (6 feet 4 inches) and 288 pounds.

The care plan dated 7/2/19 identified the resident had deficits in activities of daily living (ADL) self-care performance related to fatigue, he was at risk for falls related to right sided weakness and fatigue and he was on anticoagulant therapy related to chronic atrial fibrillation. The goals the staff set for the resident was that the resident will improve his current level of functioning in ADLs, be free of falls, be free of adverse reactions or discomfort related to anti-coagulant use. Some of the interventions to accomplish theses goals

injuries on a weekly basis to ensure that interventions were implemented for prevention of further injury.

Issues noted will be referred to the Quality Assurance Committee for review and recommendation.

Completion date: December 17, 2019

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for the resident included, staff to assist as needed, encourage use of call bell for assistance, keep environment free of hazards, daily skin inspections related to anticoagulant use. The care plan dated 7/17/19 identified an actual impairment to skin integrity of the right calf related to laceration and that the goal set by the staff was that the resident would have no complications related to the laceration. Some of the interventions to accomplish this goal included to educate resident/family/caregivers of causative factors and measures to prevent skin injury, identify/document potential causative factors and eliminate/resolve where possible. The care plan dated 7/24/19 identified that the resident had a potential for skin tears related to fragile skin and the goal set by the staff for the resident was that identify potential causative factors and eliminate/resolve them when possible, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.

The operational care plan dated 7/2/19 and revised on 7/8/19, 7/1719 and 7/24/19 did not identify or was revised for impulsive behaviors, non-compliance with safety instructions or that he refused care, treatment or staff assistance. Revisions to the care plan to prevent injuries to arms and legs from sharp or hard surfaces were made after the second injury to the right leg, the resident's weaker dominate side on 7/17/19 and 7/24/19.

The resident was admitted to the nursing facility with physician orders dated 7/1/19 for *Apixaban (Eliquis) tablet 5 milligrams (mg) two times a day at 9:00 a.m. and 6:00 p.m. for anticoagulation therapy treatment related to chronic atrial

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fibrillation.

*What is ELIQUIS? ELIQUIS is a prescription medicine used to:
Reduce the risk of stroke and blood clots in people who have atrial fibrillation (AFib), a type of irregular heartbeat, not caused by a heart valve problem.

What are the possible serious side effects of ELIQUIS?
This is a list of some of the serious side effects of ELIQUIS.
Bleeding
ELIQUIS can cause bleeding, which can be serious, and rarely may lead to death. This is because ELIQUIS is a blood thinner medicine that reduces blood clotting. While taking ELIQUIS, you may bruise more easily and it may take longer than usual for any bleeding to stop
https://www.eliquis.bmscustomerconnect.com/

The resident was ordered on 7/2/19 to have physical therapy 6-7 times/week for 6 weeks; speech therapy 5-7 days/week for 4 weeks and occupational therapy 6-7 times a week for 8 weeks.

The nurse's notes dated 7/6/19 at 10:10 p.m., indicated the Certified Nursing Assistant (CNA) notified Licensed Practical Nurse (LPN) #7 that Resident #3 had sustained a skin tear while being assisted to bed because he did not allow the CNA to lock the right side of his wheelchair before he stood up which resulted in the leg bracket scrapping his right leg causing a skin tear. The skin tear was treated with normal saline, followed by Bacitracin and a dry dressing. The care plan was not revised with any preventative measures

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to protect the resident's skin from subsequent injuries related to the leg brackets. An in house incident report was generated dated 7/7/19 that reflected the same information. It was added that the "resident appears very impatient and does not allow staff time to perform task." The care plan was not revised to reflect this resident behavior.

The nurse's notes dated 7/9/19 at 9:45 p.m. indicated LPN #7 heard the resident calling out for help. The nurse's notes indicated the resident was found sitting in his wheelchair outside of the bathroom and blood was noted on the floor coming from his left (error, should be right) lateral leg. The nurse's notes indicated the bleeding was controlled by applying pressure, gauze and Kerlix and was able to visualize a sizeable gash to the left lateral leg (error, should be right) above area where resident has skin tear. The resident was sent to the ED via medical transport. An in house incident report was generated dated 7/16/19 that reflected the same information, but referred to the injury occurring to the right leg, not the left leg and also indicated that the resident "was not" sent to the hospital. The incident report noted under "other info" that "Resident does not lock his right side of the wheelchair when using the toilet and w/c (wheelchair) moved and caused injury, resident did not use his call bell for assistance for toileting." The incident report indicated, "No witnesses found."

The ED notes dated 7/10/19 at 12:24 a.m. indicated the resident told the ED physician that he accidentally bumped up against his wheelchair, stated he had a 5 out of a 10 pain level localized to the right lower leg and he was on Eliquis.

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The nurse's notes indicated that the resident returned from the ED on 7/10/19 at 1:40 a.m. with "laceration to right shin with 16 stitches and three steri-strips next to it." The physician orders indicated the right leg sutures were to be removed on 7/30/19.

The nurse's notes evidenced on 7/2/19, 7/9/19,7/21/19, 7/22/19, 7/24/19, 7/25/19 that the resident was found attempting to transfer himself. Care plans did not evidence this behavior.

On 11/12/19 at approximately 11:00 p.m., the Assistant Maintenance Director was interviewed and he stated he only repaired resident equipment that had a functional problem and the therapy department would be the ones to pad any areas on the wheelchairs. He stated he did not have a record of a functional problem with Resident #3's wheelchair.

On 11/12/19 at 1:15 p.m., the Assistant Rehabilitation Director was interviewed. She stated she was not familiar with Resident #3, but said if a resident is in therapy, they have the opportunity to assess the wheelchair and determine if there are any safety needs to include the need for padding, contour cushions, positioning devices and/or determine proper width and height of the wheelchair. She stated with the bariatric patients their legs may be more abducted and place a greater risk at rubbing the foot rest brackets on the wheelchair. She stated they had a room with many devices to protect and pad areas on wheelchairs and sometimes "we are inventive" depending in the resident's individual needs, and also depend on the nursing staff to tell them if they have any safety concerns.

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On 11/13/19 at 1:30 p.m., an interview was conducted with the Occupational Therapist (OT) who provided OT services for Resident #3. She stated she went to the resident's room to get him for therapy on the day after the first incident (7/7/19) and asked the resident what happened. She stated the resident said he tried to transfer by himself and scraped his leg on the wheelchair. She stated the day before the first incident the resident was able to transfer from chair to commode with minimum/moderate assist of 1 person and because of is size, he could not use a bedside commode. She said based on his stroke he could use his right leg, but it was weaker than the left leg. She said the goal was to have him propel himself with his arms and legs in the wheelchair without foot rests so that he could be as independent as possible. She stated they were not looking at walking, but wanted the resident to be able to utilize his wheelchair as his the mode of mobility within his environment.

During the above interview, the OT stated on 7/9/19 and 7/10/19 the resident was doing more toward reaching his goal to be able to stand from the wheelchair, use the forward wheel-walker, stand pivot to transfer to the chair with contact guard assist (touching only). She stated neither therapy or nursing thought about the bolsters after the first skin tear to the right leg, but after the second incident with a laceration and sutures, bilateral bolsters with Velcro straps were placed over the brackets/prongs on each side of the wheelchair where the foot rest connected to prevent further injury. She stated it was important to have the resident be as proficient as possible in the use of his wheelchair because the goal was to have him mobile in his wheelchair and not use the foot rest. The OT stated the resident only

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used the foot rest, if he was pushed somewhere by his wife. She said the wife was happy about the bolsters and said the injury to the resident's right leg was in the same place with each incident.

On 11/13/19 at 5:20 p.m., LPN #7 stated she tried to watch Resident #3 the best she could by parking her medication cart outside of his room because he was impulsive at times and confused and she wanted to be able to hear him try to move around, but at times he would manage to stand and try to go the bathroom on his own. The LPN stated, "There was so much blood with the second incident. I left the old dressing from the skin tear with the first incident and applied dressings and pressure over top until we could get him sent out." She verified that the bolsters were placed over the areas on the wheelchair where the foot rest attach after the second incident to prevent further incidents. She stated the resident did not have any further injuries from the wheelchair after the bolsters were applied. When asked why these impulsive behaviors and intermittent episodes of confusion with interventions were not care planned, especially in light of the fact that the resident was on an anti-coagulant twice a day which put the resident at higher risk for bleeding from any injuries, LPN #7 responded, "I am just getting into care planning because I was taught in nursing school that LPN's could not enter anything on the care plan." She could not provide an explanation as to why the brackets were not padded after the first incident, a skin tear, to prevent the second one in the same are which was a significant injury/laceration requiring ED evaluation and sutures.

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On 11/14/19 at 12:07 p.m., a telephone interview was conducted with Resident #3's wife (complainant). She stated she hated that both incidents occurred on the same leg in the same area. She said, "The facility was telling me when I spoke to them around the middle of July that they were not sure how the incident occurred the second time and did not want to say it was because of the wheelchair brackets like with the first incident. They wanted to say it was a scrape on something else like a door jam." She said the only difference was that the first incident was a skin tear and the second one was a laceration that required 16 sutures and they could not take away that it happened and it was ironic that they covered the brackets the next day with no further incidents. She stated, "They should have been proactive instead of reactive."

The facility's procedure titled "Measures to Prevent Skin Tears" (undated) indicated "Pad bed rails and wheelchairs arms, foot plates, and leg supports and follow the care plan. Some patient's move quickly and without warning... Fragile skin is common in older adults."

On 11/14/19 at 3:45 p.m., a debriefing was conducted with the Administrator, Director of Nursing and the Corporate Nurse. The Administrator stated he felt that the second incident may have happened another way since it was not witnessed and felt it was from the door jam and he had fragile skin. An opportunity was provided for the facility to present any further information. No further information was provided before survey exit.

Complaint Deficiency.