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| {E 000} | Initial Comments<br><br>. | {E 000} | | |
| {F 000} | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid revisit to the standard survey conducted 11/05/2019 through 11/08/2019, was conducted 01/07/2020 through 01/08/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey.<br><br>The census in this 130 certified bed facility was 107 at the time of the revisit survey. The survey sample consisted of 12 resident reviews. | {F 000} | | |
| {F 657} SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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 657} | | 1/15/20 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 01/17/2020

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 657} | Continued From page 1<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, clinical record review, and facility documentation review, the facility staff failed to revise the care plan for one resident (Resident #15) in a sample size of 12 residents.<br><br>The findings included:<br><br>For Resident #15, the facility staff failed to update/revise the care plan after the removal of an external fixator.<br><br>Resident #15, an 82-year old male, was initially admitted to the facility on 09/30/2019 and readmitted to the facility on 12/15/2019. Diagnoses included but not limited to right above knee amputation.<br><br>Resident # 15's most recent Minimum Data Set with an Assessment Reference Date of 10/17/2019 was coded as a discharge assessment. The Brief Interview for Mental Status was not coded. Cognitive skills for daily decision-making were coded as modified independence (some difficulty in new situations only). Functional status for bed mobility was coded as requiring extensive assistance from staff. Transfers and locomotion on unit were coded as total dependence on staff for performance. | {F 657} | Resident #15 comprehensive care plan was revised to reflect resolution of external fixator.<br><br>All patients have the potential to be affected by the alleged deficient practice.<br><br>Administrator educated nursing supervisors, unit managers, ADON, MDS, DON, Social Services, and Activities Director on company care plan procedure for initiation and episodic care plan revisions generally; and specifically following patient readmission to facility within 30 days of an index admission.<br><br>DON or designee to audit Care Plan 3 times weekly x 4 weeks, then weekly x 3 months. All findings reported monthly to QAPI committee for process improvement. | |

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On 01/07/2020, the care plan was reviewed. An active focus initiated on 11/06/2019 and revision date of 11/06/2019 documented, "[Resident #15's name] requires the use of an external fixator R/T [related to] fracture. Interventions associated with this focus initiated and revised on 11/06/2019 documented, "[Resident #15's name] external fixator care will be done as per order; check skin integrity around pin site q shift [every shift]; keep splint/immobilizer clean and dry; monitor for pain, swelling, spasms; notify MD/RP [medical doctor/responsible party] of any changes."

On 01/08/2020 at 9:25 AM, Resident #15 was observed sleeping in his bed with the head of the bed elevated approximately 45 degrees. Resident #15 had a right above knee amputation and no external fixator was observed on any limb.

On 01/08/2020 at approximately 11:00 AM, an interview with Employee C, the MDS (minimum data set) coordinator was conducted in her office with other facility staff present. Employee C confirmed that she was responsible for revising care plans. When asked if Resident #15 had an external fixator, Employee C referred to Resident #15's electronic health record and reviewed physician orders. Employee C confirmed that Resident #15 did not have an external fixator. When asked if the care plan had been revised to reflect this, the facility staff in the office provided another copy of the care plan and stated that the external fixator focus was resolved. A review of the updated electronic care plan had a resolution of 01/08/2020 (current survey day). Employee C also stated that if a care plan focus has been resolved, the care plan would be revised/updated by the unit manager.

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| {F 657} | Continued From page 3 | {F 657} | | |

On 01/08/2020 at approximately 11:15 AM, an interview with Registered Nurse C (RN C), a unit manager, was conducted in her office. When asked when the external fixator was removed, RN C stated that Resident #15 arrived from another facility with an external fixator but there were complications and Resident #15 went to the hospital in December and the external fixator was removed at that time. RN C and this surveyor then observed the hospital records from that encounter on the electronic health record. Excerpts of the Discharge Summary dated 12/15/2019 documented that due to poor healing, septic knee, infected hardware, "underwent above knee amputation on 12/08/19" and "discharged to a skilled nursing facility on 12/15/2019." When asked if the care plan should have been updated/revised to reflect this change, RN C stated I would have to speak with the MDS coordinator about it. RN C then stated "we go by" the baseline care plan and provided a copy. The baseline care plan dated 12/16/2019 and one item under the header "Skin Issues" it was documented a right above knee amputation surgical site.

On 01/08/2020 at 12:10 PM, the DON was asked how long the baseline care plan is in effect, the DON stated that the baseline care plan is in effect until the MDS assessment is transmitted (to CMS) and then the care plan in the electronic health record goes into effect.

On 01/08/2020 at approximately 12:20 PM, the MDS Coordinator provided a copy of Resident #15's assessment transmission dated 12/22/2019.

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| {F 657} | Continued From page 4 | {F 657} | | |

In addition to the active focus on the care plan for the external fixator, there was an active focus on the care plan in the electronic health record initiated on 11/06/2019 and revised on 12/23/2019 which documented, "[Resident #15's name] has surgical wound infection/ right AKA [above knee amputation]." All interventions associated with this focus were initiated on 11/06/2019 and documented, "Reduce exposure to other residents while infection is active; Administer antibiotics as per MD orders; Maintain universal precautions when providing resdient [sic] care; monitor temperature/pulse." A daily wound assessment of the right above knee amputation site was not included in the interventions as ordered.

An excerpt of a physician's order dated 01/05/2020 documented, "Daily wound assessment. Document abnormalities in progress notes...management site: Right AKA."

The facility staff provided a copy of their policy entitled, "Plan of Care Overview." Under the header "Policy", it was documented, "It is the policy of this facility to provide resident-centered care that meet the psychosocial, physical, and emotional needs and concerns of the residents."

In summary, Resident #15's care plan was not updated/revised timely to accurately reflect changes in condition, physician's orders, and plan of care.

On 01/08/2020 at approximately 4:00 PM, findings were shared with the administrator and the DON and they had no further information or documentation to offer.

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| {F 842} | Continued From page 5 | {F 842} | | |
| {F 842} SS=D | Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | {F 842} | | 1/15/20 |

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,

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| {F 842} | Continued From page 6<br>medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain an accurate clinical record for one resident (Resident #14) in a sample size of 12 residents.<br><br>The findings included:<br><br>For Resident #14, the facility staff failed to | {F 842} | For resident #14, the facility staff documented administration of medication of insulin outside of administration acceptable timeframe.<br><br>For resident #14, the patient's attending Physician was notified and ordered to hold insulin administration if not already provided. Medication error form | |

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{F 842} Continued From page 7

accurately document administration times for insulin.

Resident #14 was admitted to the facility on 09/20/2019. Diagnoses included but not limited to diabetes.

Resident #14's most recent Minimum Data Set with an Assessment Reference Date of 10/10/2019 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of no cognitive impairment. The number of days that insulin injections were received during the 7-day look-back period was coded as 7 meaning 7 days.

On 01/08/2020, the Medication Administration Record (MAR) was reviewed for insulin administration with a date range of 12/10/2019 through 01/07/2020.

As per physician orders, insulin documented on the MAR, "Insulin Lispro Solution 100 units/ml [a rapid-acting insulin]. Inject as per sliding scale:
If [blood glucose] 150-200 = 1 unit
201-250 = 2 units
251-300 = 3 units
301-350 = 4 units
Call MD if BS [blood sugar] < [less than] 60 mg/dL or > [greater than] 350 mg/dL, subcutaneously before meals and at bedtime for DM [diabetes mellitus]."

The scheduled times of administration for this medication were 8:00 AM, 11:00 AM, 4:00 PM, and 9:00 PM.

Of the 106 administrations of insulin in that date

{F 842}

completed. Resident suffered no adverse affects from this medication documentation error.

Residents reviewed for resident records identifiable information to identify those residents that have potential to be affected. All diabetic residents with active insulin orders have the potential to be affected by the alleged deficient practice.

The responsible nurse was educated by the DON on medication administration and documentation standards. Additionally, all licensed nurses were educated on the 7 rights of medication administration.

Medication error rates will be monitored by the QAPI committee for benchmarking and process improvement. Staff Development/ Quality Nurse will audit medication administration weekly x 4 weeks, then monthly x 3 with all findings reported to the QAPI committee monthly.

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| {F 842} | Continued From page 8 | {F 842} | | |

range, there were 29 instances which the insulin was given greater than 1 hour after the scheduled administration, 12 instances which the insulin was given greater than 2 hours after the scheduled administration time, 8 instances which the insulin was given greater than 3 hours after the scheduled administration time, 2 instances which the insulin was given greater than 4 hours after the scheduled administration time, 2 instances which the insulin was given greater than 5 hours after the scheduled administration time, 1 instance which the insulin was given greater than 6 hours after the scheduled administration time, 1 instance which the insulin was given greater than 7 hours after the scheduled administration time, and 2 instances which the insulin was given greater than 8 hours after the scheduled administration time.

On 01/08/2020 at approximately 12:45 PM, an interview with Registered Nurse B (RN B) was conducted. When asked about the expectation of administering insulin on the sliding scale, RN B stated that the dose should be given "once you find out what the blood sugar value is." When asked about the expectation for documenting medication administration, RN B stated that it should be documented right after it is administered. When shown the multiple late administrations, RN B stated that it appeared the nurses "forgot to document it." RN B went on to say that if an emergency happened or the nurse got busy, the nurse is supposed to document a late entry and put the actual administration time. As an example, RN B and this surveyor observed the MAR for 12/17/2019. The actual administration times beside the scheduled times of administration (8:00 AM, 11:00 AM, 4:00 PM, 9:00 PM were 4:49 PM (received 1 unit

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subcutaneously, blood sugar: 179), 4:48 PM (received 2 units subcutaneously, blood sugar: 216), 4:45 PM (received 2 units subcutaneously, blood sugar: 234), and 12:00 AM (received 3 units subcutaneously, blood sugar: 253), respectively. When asked about the accuracy of the clinical record, RN B stated, "No, it's not accurate" and went on to say that "this can be confusing" because cannot tell when it was actually given.

On 01/08/2020 at approximately 1:45 PM, an interview with the DON was conducted. When asked about the expectation for acceptable time range parameters for medication administration, the DON stated medications can be given up to one hour before or after scheduled administration time. When asked why it was important to document administration timely, the DON stated that if it wasn't documented timely, someone looking at [the MAR] would not know if it was already given.

The administrator provided a copy of a PowerPoint presentation their nurses recently completed entitled, "Seven Rights of Medication Administration." Under the header, "Nine Types of Documentation Errors", the list of errors included, "Adding entries later on."

The facility provided a copy of their policy entitled, "Medication Administration." In Section IV entitled, "Documentation" it was documented,
"a. Documentation of medication will be current for medication administration
b. Documentation of medications will follow accepted standards of nursing practice."

On 01/08/2020 at approximately 4:00 PM, the

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| {F 842} | Continued From page 10 administrator and DON had no further information or documentation to offer. | {F 842} | | |