STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

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F 000	INITIAL COMMENTS Correction date 07/18/2019 The following deficiencies are related to the investigation of complaints #84082-C, #84083-C and of facility-reported incident #84132-I on July 10 - 17, 2019. Both the incident and the complaints were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, facility staff failed to note and implement an insulin order for one of four residents reviewed (Resident #3). The facility identified a census of 77 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 4/19/19, Resident #3 had a diagnosis of diabetes mellitus and received a daily insulin injection. The resident's Care Plan contained a focus area dated 1/3/19 that addressed the resident's diabetes. The Care Plan instructed staff to administer Resident #3's diabetic medications as	F 658		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 1 ordered by his doctor, and to monitor for and document side effects and effectiveness. The Medication Administration Record (MAR) for June 2019 instructed staff to administer Levemir FlexTouch insulin 14 units subcutaneously once a day for diabetes starting 4/22/19. A Nurses Note dated 7/4/19 at 12:22 p.m. and composed by Staff A, RN (Registered Nurse) documented a facsimile (fax) returned with Resident #3's labs (laboratory results). The fax dated 7/3/19 documented the resident's A1C test (a measure of blood sugar levels over time) looked really good and he may be running low (blood sugars) a lot of the time. The resident's physician recommended reducing the resident's Levemir insulin to 12 units daily. Staff A noted the order on 7/4/19 at 12:25 pm. The Medication Error Report dated 7/10/19 documented Resident #3 had an order received on 7/4/19 with a recommendation to reduce his Levemir insulin from 14 units to 12 units. The MAR was not changed. Staff changed the MAR on 7/8/19 and notified the doctor. A risk management note attached to the Medication Error Report recorded that review of the resident's lab work on 7/8/19 revealed it contained a recommendation to reduce his Levimer to 12 units. The nurse who addressed the order stated she faxed the doctor to see if she wanted the recommendation as an order. The writer of the report told the nurse that this is the resident's primary doctor and the order should be changed at the time of processing the order. The nurse stated that she could not find the fax but would fax the doctor.	F 658		

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F 658	Continued From page 2 During interview on 7/16/19 at 11:10 a.m., the Director of Nursing (DON) stated he wrote the entry on the risk management note. The DON stated he looked for the fax Staff A said she sent asking if the recommendation was an order, but could not find it. Review of the resident's blood sugar readings revealed the following results: 6/27/19 - 99, 6/30/19 - 93, 7/4/19 - 176, 7/7/19 - 99, 7/11/19 - 100 and 7/4/19 - 91.	F 658		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and physician interviews, the facility to ensure a resident remained free of significant medication errors for 1 of 4 residents reviewed (Resident #1). On 7/4/19, Resident #1 received medication that was not ordered for her. Due to this error, the resident experienced a life-threatening drop in blood sugar and blood pressure which required treatment in the Emergency Room (ER) and a subsequent 5 day stay in the Intensive Care Unit (ICU). This caused an Immediate Jeopardy (IJ) to resident health and safety. The facility identified a census of 73 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 4/3/19, Resident #1 had	F 760		

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F 760	Continued From page 3	F 760		

diagnoses that included diabetes mellitus and high blood pressure. The MDS documented she had no memory or cognitive impairment, as evidenced by a brief interview for mental status score of 15/15. The assessment documented the resident did not require insulin injections.

Resident #1's care plan, updated on 4/8/19, contained no interventions related to diabetes management. The care plan documented she received a regular diet with ground meat.

The Medication Administration Record (MAR) dated 7/1 - 7/31/19 documented Resident #1 had no orders for insulin or oral antidiabetic medications. The MAR instructed staff to apply an Aspercreme Lidocaine 4% patch to the resident's back every day for pain: apply the patch to the lumbar 5 vertebral areas, on for 12 hours and then off for 12 hours. The MAR recorded the patch as applied on 7/4/19.

A Nurses Note dated 7/4/19 at 9:41 am documented an RN (or registered nurse, Staff A, pool nurse) entered the resident's room around 7 a.m. to check her pain level and apply a patch to the resident's back. Resident #1 was alert and oriented x 3 (to person, place and time) and rolled over on request for placement of the patch. Resident #1 had no complaints at the time. A CNA (certified nursing assistant) approached Staff A 10 minutes later stating the resident was concerned about multiple shots she got in her right upper arm. Staff A re-entered the room and told the resident she put applied a patch; no shots were given. Resident #1 told Staff A it wasn't you; okay. The resident got up in her wheelchair per her usual routine and a CNA assisted her to the bathroom. The CNA then approached Staff A to

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F 760	Continued From page 4	F 760		

check the resident 5 minutes later. Resident #1 had slumped over in her wheelchair and had unresponsive, dilated pupils. The resident's respiratory rate measured 20 with shallow respirations. Staff A checked the resident's blood sugar and it measured 20 (a very low reading). The resident's blood pressure measured 68/43 (also low), her pulse 95 and regular, and her oxygen saturation measured 95%. Staff gave sugar to the resident on her tongue. Resident #1 spit out small amounts of yellow clear emesis. Staff rechecked her blood sugar and it measured 26. Staff called the physician on-call and received an order to administer Glucagon 1 mg (milligram, to raise blood sugar), obtained the medication from the facility's Emergency kit, and gave it to the resident at 7:48 am. Upon re-check, the resident's blood sugar measured 28. A call was placed to the on-call doctor with receipt of an order to transfer Resident #1 to the ER (Emergency Room). Staff notified the resident's son and the Director of Nursing (DON). Resident #1 left the facility at 8:15 am via ambulance. At that she time communicated one word answers and her pupils were responsive.

Emergency Room records dated 7/4/19 documented Resident #1 had a history of diabetes type 2 and had never needed insulin or took any medications for this. Resident #1 arrived by ambulance due to a blood glucose of 20 and BP of 50/30 with concerns she may have gotten an insulin shot last night or this morning but was not on insulin. It is possible she was given her roommate's insulin by accident; long acting last night or short acting this morning. The resident did not act normally, did not respond to questions and her blood glucose measured 20. The resident received Glucagon at the nursing

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F 760	Continued From page 5	F 760		

home and then medics gave her Glucagon paste and started a dextrose IV (intravenous solution). Upon arrival, Resident #1's blood glucose measured 130 and her BP 70's/30's. She answered easy questions but acted sleepy. Later, the nursing home called the ER and related the patient accidentally received Levemir (insulin) last night but did not know if the resident received any other medications that were not her own.

The History and Physical section of the hospital records recorded it appeared Resident #1 wrongly got her roommate's insulin yesterday evening, 7/3/19. Resident #1 is a diet-controlled diabetic and does not require any insulin or oral medications. This morning, she was not responsive, had a blood sugar of 20 and a systolic blood pressure of 50. When given Glucagon per the nursing home protocol, she reportedly told staff it was the second injection she got since last night, when is when the error became realized. Resident #1 transported to ER and remained hypotensive (with a low blood pressure) despite fluids. Hospital staff started Dopamine to assist in raising her blood pressure and the resident admitted to the Intensive Care Unit.

The Discharge Summary dated 7/9/19 documented Resident #1 slowly improved each day, being slightly more alert and more interactive. She had been off supplemental blood glucose for two days, had improved over five days and was at her mental baseline. Resident #1 returned to the nursing facility on 7/9/19.

During interview on 7/10/19 at 2:30 pm, Staff A stated she saw the resident first on 7/4/19 at roughly 6:45. She went in Resident #1's room,

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	165288	A. BUILDING _____ B. WING _____	C 07/17/2019

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F 760	Continued From page 6	F 760		

asked if she had pain and the resident denied pain. Staff A asked Resident #1 to roll for a pain patch, she obliged, and Staff A changed the patch and did nothing else for her. Staff B, CNA went to get the resident up and called Staff A from the door; the resident said she got a shot in her arm. Staff A went in the room and asked the resident if she remembered application of the pain patch. Resident #1 told her 'you're not the one' and wheeled by; Staff A recalled Staff B being in the room at the time. Staff A reported since this would have been the first or second time she worked the hall, she was unsure if Resident #1 woke up confused or not. Staff A stated she was absolutely sure she did not give the resident a shot. Five or ten minutes later, another CNA asked her to check on Resident #1. The resident was unresponsive, with fixed and dilated pupils, slumped in her chair and with saliva running out of her mouth. Staff A thought the resident was having a stroke. When she checked the resident's blood sugar and the result was 20, she asked another nurse (Staff D) to call the doctor for a Glucagon order. She put sugar in the resident's mouth and obtained Glucagon from the Emergency kit. The resident did not pink up and her blood pressure measured about 60/40, so she asked Staff D to call for ambulance transport. Resident #1 then started to dry heave and she had a respiratory rate of 20 with a pulse oximetry reading of 95% on room air.

On 7/10/19 at 3 pm, Staff B, CNA stated she cared for Resident #1 on 7/4/19. Sometime between 6:15 and 6:30 am, Staff A turned the resident's call light on after applying a patch because the resident had been incontinent. Staff B finished assisting another resident and saw Resident #1's light on. Resident #1 informed Staff

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F 760	Continued From page 7 B a nurse gave her a shot and she wanted to talk to her. Staff B got Staff A, who went back in Resident #1's room. Staff B stated she showed Staff A a spot on the resident's arm. She did not recall Resident #1's denial of Staff A giving her a shot. Staff B then got Resident #1 out of bed, took her to the bathroom, dressed her, and left the room. Resident #1 put her light on and Staff B moved the resident to the sink for morning cares. Staff B stated when she left the room, Resident #1 appeared fine. About 20 minutes later, Staff B returned to the resident's room and found her slumped in her wheelchair, wheeling back and forth into her bed. The resident wouldn't talk to her. She called another CNA, Staff C on the walkie-talkie, got help and asked her to get the nurse. Staff B recalled the resident sweating profusely and it took approximately 15 minutes for Staff A to get there. While Staff C held Resident #1's head up, Staff A checked her blood sugar and then told Staff B to get a food tray. When Staff B returned, Staff A was giving the resident 1 1/2 spoonfuls of sugar. The ambulance came and the resident transported to the hospital. Staff B thought the resident got a shot, but she did not know who may have given it. An undated written statement by Staff D, LPN (licensed practical nurse) as part of the facility's investigation documented he worked on 7/4/19. When Staff A assessed Resident # 1, she asked Staff D's opinion on why Resident #1 had slumped in the wheelchair. He thought it looked like a blood sugar problem. Staff D asked Staff A what first vital sign she took, and Staff A responded blood sugar. Staff D told Staff A to get an order for Glucagon and send the resident out; he assisted with the Glucagon order and getting Resident onto the stretcher with emergency	F 760		

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	165288	A. BUILDING _____ B. WING _____	C 07/17/2019

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ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

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F 760	Continued From page 8	F 760		

medical technicians (EMTs). He probably told the EMTs Resident #1 got insulin when assisting them and wrote he called the ER later to let staff know he thought insulin was given.

During interview on 7/15/19 at 2:15 pm, Staff C recalled receiving a page from Staff B to help in Resident #1's room. She told Staff A then went into the resident's room. Staff B sat on the bed with Resident #1 in her wheelchair. Resident #1 asked where's that nurse? She gave me a shot. The resident's right shoulder had a red bump. Resident #1 said it had been her nurse. They waited a few minutes, got the nurse, and returned to the room. Resident #1 now drooled and had slumped down in the wheelchair and appeared unconscious. Staff C held the resident's head up, Staff B talked her and Staff A asked them to bring the resident to the nurse's station. The resident's blood sugar measured 20. Staff A told her to get sugar from the kitchen gave the resident a spoonful, and her blood sugar next tested 21. Staff A got Glucagon, injected the resident and a re-test showed her blood sugar measured 'LO' (too low to register). Staff called paramedics. Staff C took Resident #1 towards her room, but the time they got there the EMTs had arrived.

During interview on 7/15/19 at 2:30 pm, Staff F, CNA stated she cared for Resident #1 during the night shift on 7/3/19. She recalled the resident's activity was low that night. Staff F put the resident to bed, assisting her to use the toilet, brushing her teeth, washing her face and helping her to bed. Every night, Resident #1 went to bed at 8:30 pm. She checked on the resident at 9:30 pm and noted she had been incontinent of urine. The resident told Staff F she did not feel well. Staff F checked the resident again at 12:30 pm,

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F 760	Continued From page 9	F 760		

when she said she did not need to use the toilet and then at 12:45 am when the resident had incontinence. At 2:30 am, Resident #1 denied needing to use the toilet and had no incontinence. Staff F concluded her shift on 7/4/19 at 3 am.

During interview on 7/15/19 at 8:20 am, Staff E, RN remembered caring for Resident #1 the evening and night shifts of 7/3/19. She gave Resident #1 her night time medications about 8:20 pm. The resident lay in bed at the time, awake, alert and swallowing well. Staff E asked how the resident was doing, and Resident #1 replied she felt okay. Staff E stated it was the second time she'd given Resident #1 her medications, but she looked the same as when they had first met. The resident had no indications of low blood sugar. Staff E was sure she did not give the resident any injections.

An undated written statement composed by Staff E as part of the facility's investigation documented 7/3/19 had been a very hard night. She gave Resident #1's roommate her bedtime insulin. She had not worked that side of the building before and asked for resident verification from other staff if she did not know who the residents were. She said pictures in the electronic health record help, but she had to ask for verification for insulin. Staff E wrote she got into it with a disrespectful aide and that did not help. By the end of her shift, Staff E felt upset due the shift being non-stop (the EMAR verified Staff F checked the roommate's blood sugar at 8:33 pm and administered long-acting insulin at 8:36 pm). Staff E was sure she did not give Resident #1 any insulin shots.

On 7/15/19 at 3:40 pm, interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 760	Continued From page 10	F 760		

physician who supervised Resident #1's care in the hospital stated that in his opinion, Resident #1 had no other condition while hospitalized that would have dropped her blood sugars so severely. He thought it probable Resident #1 received insulin not ordered for her.

Review of Resident #1's roommate's (Resident #2) clinical record showed she had orders for Detemir insulin 20 units subcutaneously (SQ) every morning and also daily at bedtime. The resident's MDS assessment of 4/24/19 recorded she had a BIMS of 12, indicating moderate memory impairment.

On 7/16/19 at 7:35 am, Resident #2 remembered the morning of 7/4/19. She was out of their room having a bath and did not hear Resident #1 report a nurse gave her a shot. When she returned to the room, her roommate lay in bed, out of it and couldn't say anything. Staff got her up in the wheelchair and the girls were concerned. She recalled receiving her insulin shot a bit late the morning of 7/4/19, due to her shower, and the nurse got a new flex pen to administer the injection. Review of her Progress Notes revealed an entry dated 7/5/19 at 3:12 pm that she remembered receiving her medications and injections the evening of 7/3/19 and both she and Resident #1 were in the room at the time.

On 7/17/19 at 7:40 am, when asked how agency or pool nurses received training, the DON stated that before the medication error, an experienced staff member would tour the facility with the agency or pool nurses. Training was easier if the agency nurse showed familiarity with the electronic health record (EHR). Only one agency nurse had no experience with the EHR and he

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F 760	Continued From page 11	F 760		

had worked with her on it. Most agency and pool staff worked during the day shift, so he asked how they were doing or if anything needed for their work. Contract pool staff agreed to come to the facility for a set time period, like 13 weeks, so their orientation was easier.

The facility abated the Immediate Jeopardy on 7/16/19 by implementing the following:

1) Agency staff will go through general orientation process. An orientation checklist will be performed and completed. This checklist will be kept in a binder/folder for reference as needed to show staff was educated on job requirements/duties. Agency staff will be educated on the 5 rights of medication pass (right resident, right med, right dose, right time, right route) as part of their orientation process.

2) Facility nursing staff will be educated on the proper protocols for insulin administration with resident identification stressed. PCC has pictures but NEED TO ASK RESIDENT IDENTIFICATION if unsure. Ask the resident and or other staff if unsure who resident is. This will also be stressed when passing any medication. This will include the 5 rights of passing medication as well. (right resident, right med, right dose, right time, right route) Educations began 7/11/19 with facility nurses and med aides.

3) Staff will be audited on insulin administration as well as general medication administration ensuring proper resident identification takes place as well as proper technique is maintained. This will be done for general medication administration as well.

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	165288	A. BUILDING _____ B. WING _____	C 07/17/2019

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ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(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 760	Continued From page 12 4) New staff (including Agency staff) will be educated during orientation process prior to caring for residents and passing medications. Education will be provided regarding proper resident identification for all medication administration types followed by medication administration audits as part of their orientation process. This will also include the 5 rights of passing medication (right resident, right med, right dose, right time, and right route) Education began 7/11/19 with facility nurses and med aides and was completed on 7/16/19.	F 760		

F 658

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F 658. This allegation does not constitute guilt but that the facility is in compliance to F 658.

Resident #3 is receiving their physician ordered doses of insulin.

All Resident are receiving their physician ordered doses of insulin.

Facility identified resident #3's insulin order was not accurate on ***7/10/2019***. This was handled as a med error by the facility. Resident #3's ***family*** and Dr. were notified of the error with resident #3's insulin. The error was corrected and the appropriate insulin was continued to be administered. Staff was education on proper order taking as well as the 5 rights of med administration on ***7/16/2019.*** Staff A no longer works at the facility.

Nurse management will review new orders to ensure orders are noted properly. This will include proper notification of pharmacy as well as order entry into the electronic medication administration record, to ensure residents receive their proper insulin doses as well as all other proper medications that their Dr's may have ordered. Nurse Management will audit nurses for proper medication administration techniques which will include insulin. Problems will be corrected as they are observed.

Facility's QA process will monitor that new orders are reviewed and proper medications are present and available for the residents. The QA process will also monitor that audits are completed for med pass techniques which will include insulin administration. Problems will be corrected as they are observed.

F 760

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provision of federal and/or state law.

This is my credible allegation of compliance to F 760. This allegation does not constitute guilt but that the facility is in compliance to F 760.

Resident #1 is receiving only her physician prescribed medications.

All residents are receiving on their physician prescribed medications.

Staff A NO longer works at the facility. Staff was educated on ***7/16/2019*** on medication administration which included proper resident verification methods as well as the 5 rights for medication administration. Facility changed Agency Orientation process to include proper resident identification methods as well as the 5 rights for medication administration on ***7/16/2019.*** Staff will be audited on medication administration techniques which include practicing the 5 rights of medication administration to assist in avoiding potential medication errors.

Nurse management will monitor for correct orders, agency orientation checklist completion, and complete staff audits. Problems will be corrected as they are observed. This will include further education as needed.

Facility's QA process will monitor for agency orientation sheet completion as well as completion of staff audits for medication administration techniques.