

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/03/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165530</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/03/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN HAVEN HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>252 INDIAN HILLDS DRIVE GLENWOOD, IA 51534</b>	
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F 000	INITIAL COMMENTS  Correction date <u>7-4-20</u>  A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on 6/10/20. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.  Resident Census-61  The following deficiencies relate to investigation of complaint #90676-C.  Complaint #90676-C was substantiated.  See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.  Amended 8/19/20	F 000		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/03/2020

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 686	Continued From page 1 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and also failed to ensure residents with pressure ulcers received necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for 3 of 5 residents reviewed (Residents #1, #2, and #4). On 2/20/20, Resident #1's admission assessment documented the resident had multiple small red areas to her left hip and left back. On 2/28/20, the physician wrote an order for Duoderm to the open area on the resident's back and directed staff to change it every 48 to 72 hours. Facility staff failed to apply the Duoderm until 3/2/20, and then it was discontinued due to an allergy on 3/4/20. On 3/15/20, staff identified some shearing abrasions on the resident's back, and on 3/18/20, an abrasion to her left lower back. The chart contained skin assessments for 2/29/20, 3/7/20, 3/21/20, 3/27/20 and 4/4/20, but no comprehensive skin assessment(s) after 4/4/20. On 4/10/20, the physician saw the wounds and ordered a wound culture and a consult with the wound clinic. The facility cultured the wounds on the 4/12/20. On 4/17/20, the physician assessed the resident's wounds, reviewed the labs and then ordered staff to transfer the resident to the hospital for intravenous antibiotics. The resident was subsequently admitted to the hospital for a pressure ulcer infection (pseudomonas and providencia). The resident's record contained no indication to show the facility made an attempt to refer the resident to the wound clinic per physician order between 4/10/20 and 4/17/20.	F 686			

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F 686	<p>Continued From page 2</p> <p>According to the physician, the resident died of sepsis related to the wound infection. These findings constitute an immediate jeopardy (IJ) to resident health and safety. The facility reported a census of 61 residents.</p> <p>Findings include:</p> <p>1. The significant change in status Minimum Data Set (MDS) dated 2/27/20 revealed that Resident #1 readmitted to the facility on 2/20/20. The MDS documented the resident as at risk for pressure ulcers and had moisture associated skin damage but no pressure ulcers. The MDS also documented she required extensive assist of 2 staff for bed mobility, transfers and eating and was totally dependent on staff for locomotion, toilet use and hygiene.</p> <p>Resident #1's Face Sheet revealed the resident had diagnoses that included cerebral infarction, aphasia, dementia, and morbid (severe) obesity.</p> <p>The Clinical Admission Assessment dated 2/20/20 documented the resident had multiple small red areas to her left hip and left back.</p> <p>The resident's Care Plan dated 2/21/20 documented a risk for pressure ulcers and directed staff to reposition the resident frequently to prevent pressure ulcers, however, it failed to include parameters or direct staff how frequently the resident should be assisted to reposition. The Care Plan also directed staff to assess the resident's skin weekly. Review of the Care Plan revealed it failed to contain any interventions for pressure relieving devices for the bed or chair, and lacked any documentation to show that the</p>	F 686			

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F 686	<p>Continued From page 3</p> <p>resident refused to get out of bed or be assisted with repositioning.</p> <p>The Braden Scale form dated 2/22/20 assessed the resident as at a moderate risk for pressure related skin breakdown.</p> <p>The Progress Notes dated 2/28/20 revealed the physician made facility rounds and gave an order for Duoderm to the open area on the resident's back and directed staff to change it every 48 to 72 hours.</p> <p>Record review revealed an order dated 3/4/20 that directed staff to discontinue the Duoderm to resident's lower back due to an allergy and then start border gauze daily.</p> <p>The Treatment Administration Record (TAR) for February 2020 did not contain the Duoderm order. The order was included on the March 2020 TAR, but not signed off as applied until 3/2/20. The March 2020 TAR also contained staff initials that signified they had completed the treatment on 3/5/20 and 3/8/20, which was after the physician had ordered staff to discontinue the Duoderm.</p> <p>An email from the Environmental Services Manager revealed the facility applied a low air loss mattress to the resident's bed on 3/12/20.</p> <p>The Progress Notes dated 3/15/20 at 10:04 PM documented the resident had some shearing abrasions on her back from the brief and chux.</p> <p>The Progress Notes dated 3/18/20 at 4:34 PM documented the resident had a 0.2 cm by 0.1 cm abrasion to her left lower back.</p>	F 686		

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F 686	<p>Continued From page 4</p> <p>Record review revealed staff had completed skin assessments on 2/29/20, 3/7/20, 3/21/20, 3/27/20 and 4/4/20. The chart lacked documentation that showed staff had done a comprehensive skin assessment after 4/4/20.</p> <p>The Weekly Skin Assessment dated 2/29/20 revealed Resident #1 had excoriations on her mid-back (with no open areas or skin breakdown); a "knot" on her right hip; an intact perineal area, and 3 red spots in a line across her right buttocks. The skin assessment form failed to contain any measurements.</p> <p>The Weekly Skin Assessment dated 3/7/20 documented staff noted excoriated areas to the resident's backside, abdominal folds and groin. No other skin breakdown or measurements had been documented.</p> <p>The Weekly Skin Assessment dated 3/21/20 revealed Resident #1 had excoriated areas to her backside, abdominal folds and groin with no other skin breakdown or measurements documented.</p> <p>The Weekly Skin Assessment dated 3/27/20 documented the resident had excoriations and an open area on her back with lotion applied to the areas. No other skin breakdown or measurements had been documented.</p> <p>The Weekly Skin Assessment dated 4/4/20 revealed Resident #1 had excoriations on her mid and lower back with no other skin breakdown or measurements documented.</p> <p>The Progress Notes dated 4/10/20 revealed the physician saw the resident and ordered a referral</p>	F 686			

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F 686	<p>Continued From page 5</p> <p>to the hospital wound care clinic, cultures to the wounds on her back, and labs (a complete blood count and comprehensive metabolic panel).</p> <p>The Progress Notes dated 4/12/20 revealed the facility obtained the wound culture and noted the wounds were tender with a yellowish center and a red edge. The chart failed to contain any documentation of the wounds from 4/12/20 to 4/17/20 with no referral to the wound care clinic found.</p> <p>The Progress Notes dated 4/17/20 revealed the physician assessed the resident's wounds and reviewed the cultures and labs in the facility, and then ordered staff to transfer the resident to the hospital for intravenous antibiotics. The resident was subsequently admitted to the hospital for a pressure ulcer infection (pseudomonas and providencia).</p> <p>The Skin Integrity and Wound/Pressure Injury Policy for the facility directed staff to monitor pressure ulcers daily measure all areas of impaired skin integrity weekly. It also specified that nurses were to update the care plan with the nursing interventions needed.</p> <p>During an interview with the resident's son on 6/15/20 at 1130 AM he stated his mom, Resident #1, was never the same after her stroke and it caused her to decline. When asked about her skin condition the son became tearful and reported the facility never told him about any open areas and he was not aware of the pressure ulcers until her physician sent her to the hospital on 4/16/20.</p> <p>During an interview with the physician on 6/15/20</p>	F 686		

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F 686	<p>Continued From page 6</p> <p>at 12:05 PM he stated Resident #1 admitted to the hospital due to a stroke and "it was all downhill after that." The resident became depressed, stopped eating and became "failure to thrive." The physician added the resident had been a bigger lady and all of sudden she wasn't able to move, so she developed the pressure areas. When asked about the cause of death he stated it was sepsis (pseudomonas) from the wound infections. The physician added he did not know about the pressure wounds until 4/10/20, and he then ordered wound cultures and a referral to a wound specialist and the resident was subsequently hospitalized on 4/16/20.</p> <p>During an interview with the Director of Nursing (DON) on 6/15/20 at 12:20 PM, she stated staff are to complete a formal skin assessment weekly at a minimum for open areas and pressure ulcers are to be assessed daily. She reported the skin assessments she had provided through 4/4/20 were all the facility had for Resident #1.</p> <p>In a subsequent interview with the DON on 6/29/20 at 3:00 PM, she stated she expected the nurses to complete a full assessment of Resident #1's wounds per facility policy.</p> <p>During an interview with the Dietician on 6/15/20 at 12:32 PM, she stated she was aware Resident #1 had documentation of excoriation and shearing but did not know anything about pressure wounds. She reported that typically if a resident develops a pressure ulcer the facility should contact her within 48 hours for an intervention.</p> <p>During an interview on 6/25/20 at 11: 25 AM with a nurse that cared for the resident at the hospital,</p>	F 686		

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F 686	<p>Continued From page 7</p> <p>she stated Resident #1 was very ill when she was admitted. The nurse reported Resident #1 was septic and received many fluid boluses and intravenous antibiotics, and added it was obvious where the infection was coming from when they rolled her over for the skin assessment and found the wounds on her lower back and coccyx area. She reported she had been a nurse for eleven years and she had never seen anything so severe; the area was open and deep and when they rolled her it would crack open and bleed and drain purulent foul smelling drainage. She stated they were unable to stage the wound due to the amount of slough and purulent drainage present, and the resident would moan in pain with any repositioning or wound care.</p> <p>During an interview with the Administrator on 6/29/20 at 2:30 PM she stated she had found with auditing that staff had not been completing weekly skin assessments consistently for all residents. She reported when she became aware of the problem, the facility immediately began to put a plan in place so it would not happen again.</p> <p>The facility abated the Immediate Jeopardy on 6/25/20 by:</p> <p>a. Upon hire of the new care coordinators they were educated on their responsibilities in the Skin Integrity Management Programs to include a weekly assessment of any identified skin issue by the Care Coordinator documented in the 2020 Wound Tracking Form spreadsheet. This form was reimplemented effective week of 4/27/20.</p> <p>b. Facility review notes dated 5/1/20 revealed wound counts looked higher but that was due additional wounds being identified and tracked</p>	F 686		

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F 686	<p>Continued From page 8 following implementation.</p> <p>c. All nurses were re-educated regarding wounds in an inservice on 5/21/20.</p> <p>d. Facility review notes dated 5/29/20 documented the facility continued to work on a Performance Improvement Plan for wounds and working on more effective documentation of the progression of the wound and healing.</p> <p>e. 6/25/20 Ongoing compliance with the 2020 Wound tracking form will be monitored by the DON or designee each week and wound trends are reviewed by Cottage at each monthly QAPI meeting. Any compliance concerns will be reported immediately to the Administrator and reviewed by the QAPI team.</p> <p>1. According to the MDS Resident #4 demonstrated intact cognition and was totally dependent on two staff for bed mobility, transfers and toilet. The MDS documented the resident was incontinent of urine and stool. The MDS revealed the resident had the following diagnoses: diabetes mellitus, multiple sclerosis, insomnia, diabetic neuropathy, vitamin d deficiency, restless leg syndrome, and tension type headaches. The recent MDS it documented the resident as at risk for developing skin injuries and had one or more unhealed pressure ulcers at a stage 3.</p> <p>Review of the resident's care plan revealed the resident was at risk for skin breakdown to impaired mobility and incontinence. The care plan identified the resident with a stage 3 pressure area on her left ischium with treatments</p>	F 686		

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F 686	Continued From page 9 per physician order. The care plan directed staff, in part, to: observe skin and any wounds for changes such as redness, tenderness, foul drainage, heat and notify the doctor if noted and conduct weekly skin checks per facility protocols.  The Braden Scale documented the resident as at moderate risk for skin injury.  Review of the resident's progress notes reported the resident's the resident's ulcer measured 0.4 cm x 0.6 cm on 3/11/20. On 4/8/20, the resident's ulcer deteriorated with measurements of 1.8 cm x 2.0 cm x 0.1 cm.  Review of the weekly skin assessments showed the staff failed to perform skin assessments weekly as ordered. The resident's record lacked weekly assessments from 3/28/20 to 4/8/20 and 4/15/20 to 4/29/20.	F 686		
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 record review and family, physician, and staff interviews, the facility failed to ensure residents were free from significant medication errors for 1 of 1 residents reviewed (Resident #1). On 9/4/20, the facility received Resident #1's hospital discharge orders which contained an order for apixaban (generic Eliquis, which is an anticoagulant medication used to treat and prevent blood clots and to prevent stroke). Resident #1 received the medication from 9/5/20	F 760		

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F 760	<p>Continued From page 10</p> <p>to 9/9/19, but then it was discontinued with no order found in the medical record to do so. On 10/8/20, the pharmacy faxed the physician to inform them the facility had not started the medication as ordered and asked if the physician wanted the facility to resume it. The physician faxed back on 10/9/20 with an order for the facility to give the medication. According to the Medication Administration records, the facility failed to restart the resident's Eliquis until 2/20/20. The progress notes showed on 2/16/20, the resident began exhibiting slurred speech and confusion; the facility notified the physician and obtained an order to send the resident to the Emergency Room and she was admitted to the hospital with a subacute infarct (stroke). Hospital records showed she failed the bedside swallowing study (a test to assess swallowing ability), was aphasic (language or speaking impairment), and weaker on the left side. Due to these findings, an immediate jeopardy (IJ) was identified to resident health and safety. The facility reported a census of 61 residents.</p> <p>Findings include:</p> <p>The quarterly Minimum Data Set (MDS) dated 12/9/19 documented Resident #1 had clear speech, was able to make self understood and scored a 15/15 on her Brief Interview of Mental Status (BIMS). It revealed she required extensive assist of 2 staff for bed mobility, transfers, dressing and toilet use; extensive assist of 1 person for personal hygiene; limited assist of one person for locomotion on the unit and was able to eat with supervision and set up help only. It revealed she had diagnosis to include anemia, hypertension, depression and chronic obstructive</p>	F 760			

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F 760	<p>Continued From page 11</p> <p>pulmonary disease. The MDS did not include a diagnosis of stroke or any swallowing disorders.</p> <p>Record review of Discharge Documents dated 9/4/19 for Resident #1 revealed orders for new medications to include apixaban 5 milligrams 1 tablet by mouth two times a day for 90 days and apixaban 5 milligrams 2 tablets by mouth two times a day.</p> <p>New Prescription Form dated 9/4/19 and noted 9/5/19 revealed a prescription for apixaban 5 milligrams 1 tablet by mouth twice a day for 90 days was faxed to the pharmacy.</p> <p>Faxes dated 10/8/19 and 10/9/19 documented the resident was not started on the apixaban and the facility sent a fax to the physician to clarify if they should follow the order or discontinue it. The physician documented continue with the order, apixaban 5 milligrams 1 tablet by mouth twice a day.</p> <p>The facility had sent Physician Orders with current orders as of December 1, 2019 and current orders as of February 1, 2019 to the physician for recertification, but the documents failed to list apixaban as a routine medication.</p> <p>The Medical Administration Record (MAR) dated September 2019 revealed Resident #1 received Eliquis (apixaban) 5 milligrams 2 tablets twice a day from 9/5 to 9/9/19, but then it was discontinued. Further review of the MARs revealed staff failed to resume the order for Eliquis until 2/20/20, however, clinical record lacked an order to discontinue the Eliquis.</p> <p>Record review of the Progress Notes dated</p>	F 760			

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F 760	<p>Continued From page 12</p> <p>2/16/20 at 4:24 AM revealed Resident #1 exhibited slurred speech, threw her plate on the floor, yanked on her oxygen tubing and thought she was at a different place. The clinical record did not contain documentation of a full assessment or physician and family notification at that time.</p> <p>The Progress Notes dated 2/16/20 at 1:08 PM revealed the resident had shown increased confusion, garbled speech and an inability to make her needs known. Staff assessed the resident, notified the family and physician, and transferred the resident to the hospital via ambulance at 1:00 PM.</p> <p>The History and Physical (H &amp; P) from the hospital dated 2/16/20 documented Resident #1 sent to the emergency room for altered mental status since the night before, but the nurse stated she had been told at 11:00 AM. The H &amp; P revealed facility staff reported resident as normally alert and oriented, however the resident could not follow any commands or respond appropriately at that time. The head scans done at the hospital diagnosed Resident #1 with an acute to subacute left parietal and temporal infarct with an overall poor prognosis.</p> <p>Record review of the Hospital Progress Note dated 2/18/20 documented no anticoagulation listed on the residents nursing home MAR, she failed the beside swallow study, was aphasic, and weaker on the left side.</p> <p>The Hospital Progress Note dated 2/19/20 revealed the resident was supposed to be on anticoagulation both for recent pulmonary emboli as well as chronic atrial fibrillation, but was off of</p>	F 760		

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F 760	<p>Continued From page 13 it for some time.</p> <p>The facility Progress Notes care facility dated 2/20/20 revealed Resident #1 returned to the facility with aphasia, an inability to speak except for yes/no questions, and could not grip with her left hand.</p> <p>The Progress Notes dated 2/22/20 documented the resident was staying in bed and required assistance to eat due to left side hemiparesis (weakness or paralysis on the left side). The note added the resident had been restarted on Eliquis.</p> <p>According to the significant change in status MDS dated 2/27/20, Resident #1 had diagnoses that included anemia, hyperlipidemia, depression, chronic obstructive pulmonary disease, and cerebral infarction. The MDS documented Resident #1 had unclear speech, was rarely/never understood, and demonstrated moderately impaired cognitive skills for daily decision making. The MDS also documented she required extensive assist of 2 staff for bed mobility, transfers, and eating and was totally dependent on 2 staff for locomotion on the unit, toilet use, and personal hygiene. The MDS revealed Resident #1 had swallowing disorders of coughing or choking during meals or when swallowing medications.</p> <p>During an interview with the resident's son on 6/15/20 at 1130 AM, he stated in September of 2019 the physician started his mother on Eliquis due to having blood clots. He reported he had assumed she had been on it the entire time she was at the facility, but staff had called him on 2/16/20 to report they were sending his mother to the hospital due to stroke symptoms, and he later</p>	F 760		

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F 760	<p>Continued From page 14</p> <p>found out that she hadn't been on the Eliquis at the facility. The son added that his mother was never the same after the stroke and it caused her decline.</p> <p>During an interview with the physician on 6/15/20 at 12:05 PM, he stated Resident #1's issues stemmed from having atrial fibrillation (quivering or irregular heartbeat). He stated the resident was on Eliquis and at one point the nurse coordinator and pharmacy asked if she needed to continue it. He told the nurse coordinator the resident needed to stay on the medication but it was either missed by the facility or pharmacy and she did not receive the medication. He stated the weeks went by, she was off the Eliquis and then staff notified him 2/16/10 of the resident's slurred speech. He stated that he expected staff to notify him as soon as they noted such a significant change (the slurred speech and confusion) The physician reported Resident #1 admitted to the hospital for a stroke and, "It was all downhill after that. She became depressed, was not eating, and showed a "failure to thrive."</p> <p>During a subsequent interview with the physician on 6/16/20 at 11:50 AM he was informed that Resident #1 went 5 months without her anticoagulant Eliquis and he stated that it didn't matter if she went a few weeks or a few without the blood thinner, it put her at a significantly higher risk for a stroke.</p> <p>During an interview with the Director of Nursing on 6/15/20 at 12:20 PM she stated that with a significant change such as slurred speech and confusion the nurse should notify the nurse coordinator, physician, and family right away.</p>	F 760			

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F 760	<p>Continued From page 15</p> <p>During an interview with the Community Care contact of the pharmacy, on 6/16/20 at 11:58 AM she stated the pharmacy received an order for Eliquis on 9/4/19 for 2 tabs twice a day which was dispensed to the pharmacy. The pharmacy faxed the physician on 10/8/19 to clarify the Eliquis order and got a verbal confirmation from the physician's nurse on 10/9/19 to continue 1 tab twice a day. They didn't dispense any more at that point because the order on 9/4/19 was for 90 days. She stated that was all the information she could provide.</p> <p>During an interview with Staff A LPN on 6/16/20 at 4:40 PM she stated all of the incoming orders are sent to the pharmacy and it is their responsibility to put them on the medication administration record (MAR). The nurse will then chart the orders in the progress notes and notify the family of any changes. Once the pharmacy inputs the orders into the MAR they are alerted to review and approve or reject the orders in the quickmar system. We then note the orders and give them to our nurse coordinator to review. When asked if she recalled why Resident #1 never received her anticoagulant for 5 months she stated that when the pharmacy was entering all the meds into the system they entered 2 medication orders. She stated that she rejected one of them but the pharmacy reported she accepted the discontinued order and rejected the active order so it never pulled through.</p> <p>During an interview with Staff B LPN on 6/16/20 at 9:42 PM she stated that when she gets an order at the facility she will send it to the pharmacy and they put it into the MAR. She will document it in the nurse notes, notify the family, and the order will go to her nurse coordinator for</p>	F 760		

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F 760	<p>Continued From page 16</p> <p>review. She reported the meds are in bubble packs and she personally checks the cart at the end of each med pass to make sure everything is given. She also stated that if the nurse doesn't give something then the box on the MAR in the system will stay blue which will alert you to give it.</p> <p>During an interview with the pharmacist responsible for the facility on 6/17/20 at 10:15 AM he stated he had been researching the med error and he found that on 9/4/19 Resident #1 readmitted back to the nursing home and they received all the discharge orders from the hospital. She had a new order for Eliquis 10 milligrams twice a day for 7 days with an ending date of 9/9/19. He stated that order was entered into the MAR and accepted by the nursing staff so the medication was dispensed to the facility. On 9/10/19 Eliquis 5 mg twice a day for 90 days was supposed to start. That order was entered into the MAR and accepted. He stated the pharmacy got a duplicate order faxed to them the next day. They reviewed it with the original and that it had looked like they had the end date wrong for the order. They wrote to discontinue the first order and put a second order in. The nurse at the facility accepted the discontinue order thinking it was the active order and rejected the active order. He stated that it showed up as active on their end so they never caught it but the nurse rejected it so it was never activated on the facility end of the order. He stated there was some liability on the pharmacy for the error but it was a miscommunication on the part of the facility as well.</p> <p>The facility abated the Immediate Jeopardy on 6/25/20 by implementing the following:</p>	F 760			

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F 760	Continued From page 17  a. On 6-24-20 the Physician Orders Process was reviewed and revised to include a required notation by each Care Coordinator going forward to document the review. The SBAR process was also reviewed and revised to ensure timely follow-up of an identified need for Physician communication.  b. The re-education on the process was completed with all facility nurses on 6-25-20. All nurses unable to attend were educated via telephone 1:1. The nurses were provided the education materials in print upon arrival for their next shift.	F 760			

The following constitutes Glen Haven Village's response to the regulatory deficiencies noted from the inspection completed 07/03/20. The facility does not admit to truth or accuracy of the statements or allegations contained in the statement of deficiencies; however the facility remains committed to the delivery of high quality health care and services and will continue to make whatever changes and improvements that may be necessary to satisfy those objectives.

Please consider this response our credible allegation of compliance, effective July 4, 2020

**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer**

1. Resident # 1 passed away at the hospital on 4-21-20. Resident #4 skin assessment was completed on 4-25-20 by RN Jana Lewis and has continued according to policy with the addition of the Care Coordinator weekly wound tracking rounds. Resident #4 does not have any current open areas and continues on prevention protocols per facility policy.
2. Week of 4-27 all residents of the facility received a skin assessment and treatment review to ensure all skin integrity issues were being adequately addressed in accordance with physician orders.
3. The facility reviewed and revised the facility protocols for the Skin Integrity Management Programs. Upon hire of the new care coordinators they were educated on their responsibilities in the Skin Integrity Management Programs to include a weekly assessment of any identified skin issue by the Care Coordinator documented in the 2020 Wound Tracking Form spreadsheet. This form was reimplemented effective week of 4-27-20 and now includes a review of current treatments.

The facility also added an additional Care Coordinator to the team on 6-1-20 to lessen their caseloads from 3 cottages to 2 to allow for more thorough oversight.

On 6-24-20 the Physician Orders Process was reviewed and revised to include a required notation by each Care Coordinator document their review of the order and confirmation that the order was implemented accurately by the front line care team. The SBAR process was also reviewed and revised to ensure timely followup of an identified need for physician communication.

Re-education on the updated physician order and SBAR processes were completed with all facility nurses on 6-25-20. Education was also provided with regard to appropriate nursing interventions when a change of condition or question about a care plan arises. Nurses were coached on choosing the

appropriate method (call or fax) of communication based on critically thinking through the severity of the resident need. Nurses were encouraged to collaborate with Nursing Leadership if unsure of how to respond and reminded, if after hours of the availability of the Nurse Leader on Call. All nurses were also educated and have continued to be coached on the proper documentation of skin issues to include measurements during their routine skin assessments. All nurses unable to attend were educated via telephone 1:1. They will be provided the education materials in print upon arrival for their next shift.

4. The facility management team implemented routine Cottage Rounds twice per week in each cottage allowing the facility IDT to work directly with the front line in order to improve the quality and timeliness of care delivery. This was started on 5-4-20.

The 2020 Wound Tracking Form spreadsheet will be reviewed by the Director of Nursing or designee weekly to ensure adequate treatment and followup is being provided to all identified skin issues. Ongoing compliance and skin outcome trends will be monitored by the QAPI team monthly, any compliance concerns will be reported immediately to the Administrator or designee and reviewed by the QAPI team.

The facility DON or designee will complete two chart audits per week to ensure compliance with Skin Integrity Policy and timely communication and implementation of physician orders and clinical changes. Results will be reviewed by the facility QAPI Team monthly.

#### **F760 Residents are Free from Significant Med Errors**

1. Resident #1's order for Eliquis was restarted on 2-20-20 after the medication error was discovered during a hospitalization.
2. A letter requesting verification and reconciliation was sent out to all resident primary care physicians on 6-25-20 in order to ensure other physician orders have been implemented correctly.

Upon discovery of the failure to administer the Eliquis order on 3-5-20, the Director of Nursing and the Administrator reevaluated the nursing leadership team and added an additional Care Coordinator to the team on 6-1-20 to lessen their caseloads from 3 cottages to 2 to allow for more thorough oversight. The facility also added an LPN to the Nursing Support team to provide an additional

layer of oversight and assist the DON in monitoring the processes managing quality care delivery.

3. On 6-24-20 the Physician Orders Process was reviewed and revised to include a required notation by each Care Coordinator going forward to document the review. The SBAR process was also reviewed and revised to ensure timely followup of an identified need for physician communication. Facility nurses were reeducated on 6-25-20 on the updated physician order and SBAR processes. During the meeting nurses were also educated on appropriate nursing interventions when a change of condition or question about a care plan arises. Nurses were coached on choosing the appropriate method (call or fax) of communication based on critically thinking through the severity of the resident need. Nurses were encouraged to collaborate with Nursing Leadership if unsure of how to respond and reminded, if after hours of the availability of the Nurse Leader on Call.
4. The facility management team implemented routine IDT Cottage Rounds twice per week in each cottage beginning on 5-4-20 in order to assist the front line in identification of change in condition and ensure the response is completed accurately and timely. This was started on 5-4-20.

The facility DON or designee will complete two chart audits per week to ensure compliance with Skin Integrity Policy and timely communication and implementation of physician orders and clinical changes. Results will be reviewed by the facility QAPI Team monthly.

The facility QAPI team in cooperation with the facility pharmacy will also monitor and track the percentages of orders incorrectly entered by the pharmacy to ensure processes between the facility and pharmacy result in accurate and timely implementation of physician orders related to medication administration. Facility will meet monthly with the pharmacy to troubleshoot any future process issues and ensure root cause analysis is completed. .

Ongoing compliance will be monitored by the QAPI team monthly and any compliance concerns will be reported immediately to the Administrator or designee and reviewed by the QAPI team.

**Signed Electronically by Julianne Marriott, Administrator 8-21-20**

