

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

PRINTED: 09/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>F684 9-18-2020</i>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2020
NAME OF PROVIDER OR SUPPLIER CHARITON SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1214 NORTH SEVENTH STREET CHARITON, IA 50049		
(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 Correction date: <u>9/23/20</u> The following deficiency relates to the Focused Infection Control Survey and complaint #92853 conducted by the Department of Inspection and Appeals on August 24 - 26, 2020. Complaint #92853-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. F 580 Notify of Changes (Injury/Denial/Room, etc.) SS=D 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 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)	F 000			
		F 580			

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

TITLE

(X6) DATE

Adeline Hughes *Administrator* *9-23-2020* 09/18/2020

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 580	Continued From page 1 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 record review and interview, the facility failed to notify the Responsible Party of a medication change for 1 of 4 sampled (Resident #1). The facility reported a census of 41. Findings include: 1. The Minimum Data Set assessment dated 5/29/20, listed Resident #1 had diagnoses of diabetes and falls. Resident #1 required setup assistance for eating and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and	F 580			

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F 580	Continued From page 2 bathing. Resident #1 had a Brief Interview for Mental Status score of 13 indicating intact cognition. A Care Plan entry dated 7/9/20 directed staff to communicate with the resident's family regarding her needs. A Physician's Order dated 5/30/20 directed staff to administer Clonidine 0.1 milligrams by mouth every 6 hours for elevated blood pressure. Review of the Clinical Record revealed a lacked of documentation to reflect the facility notified Resident #1's Responsible Party of the order for Clonidine. During an interview on 8/26/20 at 10:15 a.m., the Director of Nurses stated the facility should notify the family of resident changes. During an interview on 8/26/20 at 11:00 a.m., the Director of Nurses stated they did not have a policy regarding family and physician notification and stated they followed the federal standard of practice.	F 580			
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.	F 684			

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F 684	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide timely assessments and intervention when residents had blood glucose levels outside of normal parameters, failed to administer insulin according to the manufacturers recommendations, and failed to recheck a blood glucose level when requested for 2 of 4 sampled. Resident #1 requested to have her blood glucose rechecked and the Nurse declined. The staff later found Resident #1 unresponsive with a blood glucose level of 30 and administered two doses of glucagon prior to transferring to the Emergency Department. The facility reported a census of 41. Findings include: The Minimum Data Set (MDS) assessment dated 5/29/20 documented Resident #1 had diagnoses of diabetes and falls. Resident #1 required setup assistance for eating and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. Resident #1 had a Brief Interview for Mental Status score as "13" indicating intact cognition. The Care plan entry dated 5/22/20 revealed Resident #1 had diabetes and directed staff to administer insulin medications as ordered, monitor blood glucose as ordered, and monitor for side effects such as low blood sugar, headache, weakness, sweating, and fainting. According to the American Diabetes Association@ www.diabetes.org a normal blood glucose ranged from 80 to 130 milligrams	F 684			

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F 684	Continued From page 4 (mg)/deciliter (dl). Review of the Weights and Vitals Summary from June 23, 2020 to July 20, 2020, Resident #1 had the following blood glucose readings below 60 mg/dl and exceeding 350 mg/dl: a. On 6/25/20, 347 mg/dl. b. On 6/27/20, 12 mg/dl. c. On 6/28/20, 353 mg/dl. d. On 6/30/20 at 4:45 a.m., 51 mg/dl. e. On 6/30/20 at 7:53 a.m., 481 mg/dl. f. On 7/1/20, 384 mg/dl. g. On 7/2/20 at 8:32 a.m., 52 mg/dl. h. On 7/2/20 at 12:41 p.m., 404 mg/dl. i. On 7/4/20, 50 mg/dl. j. On 7/9/20, 54 mg/dl. Review of the Clinical Record revealed a lack of Physician notification and assessments and intervention for the above abnormal blood glucose levels. A Physician's Order dated 6/23/20 directed staff to keep a food diary for 7 days and to send to the physician on 7/1/20. The Clinical Record lacked documentation of a food diary every shift for 7 days and lacked documentation submitted to the Physician for	F 684			

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F 684	Continued From page 5 review on 7/1/20. A Progress Note dated 7/13/20 1:35 p.m., revealed the resident's blood sugar was 343 mg/dl. The facility obtained an order for 15 units of Novolog (insulin) if the resident ate and 10 units if the resident didn't eat. The resident did not eat and the nurse administered 10 units. A Weights and Vitals summary 7/13/20 at 2:43 p.m., documented Resident #1 had a blood glucose level of 109 mg/dl. On 7/13/20 at 4:28 p.m., Resident #1 had a reading of 102 mg/dl. The Medication Administration Audit Report dated 7/13/20 at 4:33 p.m. revealed Resident #1 received Novolog per sliding scale. The July 2020 Medication Administration Record (MAR) dated 7/13/20 revealed Resident #1 had an afternoon blood glucose level of 102 mg/dl and received 5 units of insulin per sliding scale. The MAR directed staff to administer 5 units for blood sugars between 71-150 mg/dl. A facility meal intake record indicated on 7/13/20, the resident ate 76-100% of breakfast and refused lunch. The record stated "not applicable" for the supper entry. The Progress Note dated 7/13/20 6:32 p.m. revealed a Nurse Aide summoned the Nurse to Resident #1's room due to Resident #1 slouched forward in her recliner, unresponsive, and diaphoretic (sweating profusely). The Staff checked Resident #1's blood glucose level and obtained a reading of 30 mg/dl. The Staff administered an injection of glucagon (medication to raise blood glucose) and informed	F 684			

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F 684	Continued From page 6 the physician. The Physician directed staff to administer another dose of glucagon if the resident did not respond. The Progress Note dated 7/13/20 6:40 p.m., documented the Nurse administered a second dose of glucagon due a blood glucose reading of 48 mg/dl. The Progress Notes dated 7/13/20 7:42 p.m., revealed Resident #1 transferred to the Emergency Department. The Emergency Department report dated 7/13/20 revealed Resident #1 had a blood glucose reading in the 400 mg/dl range at lunchtime and the physician ordered of 10 units of regular insulin and to recheck the reading. The facility called the Physician at 6:32 p.m. and stated the resident was unresponsive and had a blood glucose reading of 30 mg/dl. The Physician ordered Glucagon and Resident #1 did not respond well. The resident transferred to the Emergency Department unresponsive but aroused when her blood glucose level raised. In the emergency room, the resident's blood sugar was 101 mg/dl. The report stated that the resident did not eat any food for lunch or dinner and stated a facility CNA asked the resident's nurse to check the resident's blood sugar but she did not and went on break instead. Resident #1 transferred from the Emergency Department to another hospital for further cardiac workup. A handwritten statement dated 7/13/20 composed by Staff C (Registered Nurse) documented Staff B (Nurse Aide) informed Staff C that she asked Staff A (Registered Nurse) to check Resident #1's blood glucose level twice prior to finding Resident	F 684			

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F 684	Continued From page 7 #1unresponsive. Staff A sat at the Nurses Station eating and stated she was "too busy". The facility lacked documentation of an investigation carried out related to the concern submitted by Staff C. The Novolog Patient Information sheet provided by the facility on 8/26/20, stated Novolog acted fast and a meal should eaten within 5-10 minutes after injection. The Blood Glucose Monitoring policy dated January 2015 directed staff to notify the physician for blood glucose levels below 60 mg/dl or above 200 mg/dl. The Diabetic Management of Hypo/Hyperglycemia policy dated January 2015 instructed the facility to establish blood glucose parameters with the physician including at what level to treat and when to notify in order to identify serious complications. The Grievance/Concern Investigations policy dated June 2019 stated investigation forms were intended to assist in making concerns known in order to take action and follow up. During an interview on 8/25/20 at 9:12 a.m., the Dietary Manager stated the evening meal was at 5:00 p.m. and this would be the earliest they would serve. During an interview on 8/25/20 at 7:54 a.m., Staff E (Licensed Practical Nurse) stated she worked the day shift on 7/13/20 and the resident's blood sugar was high. She stated the physician gave an order to give her a dose of insulin. She didn't	F 684			

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F 684	Continued From page 8 remember the specifics but she was to give a lower dose of insulin if the resident did not eat lunch. The resident did not end up eating so Staff E gave her the lower dose. Staff E stated when she administered insulin, she tried to make sure the resident ate within 15-20 minutes. She stated she informed the evening nurse coming on shift that the resident's blood sugar was high and she did not eat. She stated the evening meal began at 5:00 p.m. and would not be earlier than this. During an interview on 8/24/20 at 3:51 p.m., Staff B (Nurse Aide) stated on 7/13/20 4:20 p.m. or 4:30 p.m. Resident #1 put her call light on and told Staff B she wasn't feeling very well. Staff B thought the resident's blood glucose level was low and reported this to Staff A (Registered Nurse). Staff B then assisted other residents. At 5:00 p.m., she took Resident #1's dinner tray into her and sat it in her lap as the resident preferred. The resident requested to have her blood glucose level checked. Staff B encouraged the resident to eat something and informed Staff A. Staff B stated Staff A was sitting at the nursing station eating. She stated Staff A said the resident's blood glucose level was fine when she administered her insulin and stated she didn't have time to take it again. According to Staff B, Staff A stated she would go into the resident's room when she had time. Staff B then assisted other residents and when she entered Resident #1's room at 6:15 p.m., the resident was slumped over in her chair and her food was on the floor. Staff B stated it appeared as though she dropped her tray. She tried to rouse the resident and called for a nurse. Staff B stated Staff A was "still on break" but Staff C (Registered Nurse) had just arrived for her shift and she came to the resident's room to assist her. Staff B stated she	F 684			

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F 684	Continued From page 9 remained in the room until the paramedics came to transport her to the hospital. Staff B stated she reported to Staff C that she had informed Staff A of the resident's condition earlier but Staff A did not take action. During an interview on 8/24/20 at 12:08 p.m., Staff C (Registered Nurse) stated she arrived for her shift around 6:30 p.m. on 7/13/20. She stated a Nurse Aide asked for a nurse and she and Staff D (Licensed Practical Nurse) went to the resident's room and she was unresponsive in her recliner. She took her blood sugar and it was very low. They gave her a shot of glucagon and called the doctor. Staff A returned from break and they updated her. During an follow-up interview on 8/25/20 at 9:00 a.m., Staff C stated Staff B reported to her she reported the resident's condition to Staff A and she did not check on the resident. Staff C stated she documented this concern and submitted it to the Administrator. During an interview on 8/24/20 at 3:18 p.m., Staff D (Licensed Practical Nurse) stated on 7/13/20 she heard a nurse was needed in Resident #1's room. She stated she and Staff C went to the resident's room and she was slumped over in her recliner and was unresponsive. She stated they checked her blood sugar and it was around 32 or 34. They gave her a shot of glucagon. She stated Staff A (Resident's #1's nurse) was on break and when she returned they updated her and she took over. She stated Resident #1 was a "brittle diabetic" and she would not give the resident her insulin until she had the tray in front of her. She stated supper trays did not come out before 5:00 p.m.	F 684			

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F 684	Continued From page 10 During a follow-up interview on 8/25/20 at 10:20 a.m., Staff D stated Staff B had informed her she reported the resident's condition to Staff A but Staff A stated she was "too busy". During an interview on 8/24/20 at 1:12 p.m., Staff A stated on 7/13/20 when she gave the resident her insulin, it was dinner time and she had her tray in front of her. She stated she was not sure if she ate anything or not. She stated she was not the nurse who found the resident unresponsive as she was on break at the time. She stated Resident #1 had a high blood glucose level earlier in the day and the doctor ordered a one-time dose of insulin. During an interview on 8/25/20 at 10:48 a.m., the Director of Nurses (DON) stated she received a call on 7/13/20 of the resident's low blood glucose level and the resident was sent to the Emergency Department. She stated earlier her blood glucose level was high. She stated she would want the nurse to make sure she was eating or hold the insulin. She stated she did not remember any staff members reporting any concerns with other staff. During an interview on 8/26/20 at 10:15 a.m., the DON stated she would expect the nurses to double check when inputting blood sugars. She stated there should have been parameters on the Medication Administration Record to direct nurses of when to notify the physician of abnormal blood sugars. She stated moving forward, the facility would do this. She stated the facility should have followed through with getting the resident a mechanical soft diet and acknowledged the food diary was not done. She stated the evening meal	F 684			

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F 684	Continued From page 11 was at 5:00 p.m. and not before then. She stated Staff A should not deny care to a resident. During an interview on 8/25/20 at 8:41 a.m., Resident #1's Physician stated Resident #1 had a high blood glucose level around 500 mg/dl and he ordered a dose of insulin. He stated on the evening shift, the resident would not eat and the aide told the nurse to check on her but the nurse did not. He stated by the time the nurse checked on her, her blood sugar was 30 mg/dl. The staff subsequently gave an injection of glucagon but the resident did not respond. He stated if a resident did not eat, nurses should recheck blood sugars. During an interview on 8/25/20 at 10:58 a.m., the Administrator stated as far as she knew no one had spoken to Staff A regarding the concern Staff C submitted regarding her not responding to a resident after a Nurse Aide told her the resident was not doing well. She stated normally they would investigate. During an interview on 8/26/20 at 11:00 p.m., the DON stated they did not have a policy regarding family and physician notification or assessment and intervention and stated they followed the federal standard of practice. 2. The Face Sheet revealed Resident #3 admitted to the facility on 8/19/20 and had diagnoses of diabetes mellitus and congestive heart failure. The Progress Notes dated 8/19/20 revealed Resident #3 had a fall at home with a blood glucose reading of 29 milligrams (mg)/deciliter (dl).	F 684			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2020
NAME OF PROVIDER OR SUPPLIER CHARITON SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1214 NORTH SEVENTH STREET CHARITON, IA 50049		
(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 684	Continued From page 12 The Weights and Vitals Summary dated 8/22/20 at 8:00 p.m., listed a blood glucose reading of 433 mg/dl. Review of the Clinical Record revealed a lack of documentation to reflect the staff notified the Physician, completed further assessments and carried out interventions for the high glucose reading. The Care Plan entry dated 8/20/20 revealed Resident #3 had diabetes and directed staff to monitor blood glucose levels and side effects.	F 684			

Preparation and/or submission of the Plan of Correction is not a legal admission that the violations existed or exist or that the deficiencies herein are correctly cited, and it is not to be construed as an admission against the interests of Chariton Specialty Care or its affiliates, employees, agents, or individuals who drafted/submitted or may be discussed in this Plan of Correction. Rather, submission of this Plan of Correction is to respond to the specific matters addressed in the Statement of Deficiencies related to the alleged deficiencies and demonstrate how the facility's programs, policies, and practices promote its commitment to assure that all residents receive services that are of quality that meet professionally recognized standards of care and that comply with all requirements for licensure and participation.

F580- Credible allegation of compliance date: 9/23/2020

Chariton Specialty Care ensures that physician and family are notified when changes occur

Resident #1 no longer resides in the facility

All residents with potential to be affected are protested thru education and auditing

Professional staff received education related to notification requirements on 8/26/2020

D.O.N or designee is routinely auditing family and physician notification to monitor for compliance

QAPI Leadership Team will review audits routinely thru the next 3 quarters to ensure solutions are permanent.

F684- Credible allegation of compliance date: 9/18/2020

Chariton Specialty Care ensures that timely assessment and intervention occur

Staff A is no longer employed by the facility

Resident #1 no longer resides in the facility

All residents with potential to be affected are protected via policy change & education

The Blood Glucose Monitoring Policy was changed to reflect that each order for blood glucose checks must include physician directed high/low parameters for physician notification. Policy change occurred on 8/26/2020

Each resident with glucose checks and insulin administration had parameter orders prior to surveyor exiting the building on 8/26/2020

Professional staff received education on the policy change, order administration note completion, use of fast acting insulin administration times in relation to meals, grievance policy and assessment of residents when requested by support staff 8/26/2020

Each professional staff member was assigned online education on "Diabetes Care & Management in the Older Adult" on 8/26/2020 thru 9/18/2020.

D.O.N or designee will complete routine audits a minimum of 3 times weekly of blood glucose levels and required notifications, following policy administration times & grievance follow up to monitor ongoing compliance.

QAPI Leadership Team will review audits to ensure that solutions are permanent.