STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. BUILDING _____ B. WING _____	C 03/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER	1200 WEST NISHNA ROAD SHENANDOAH, IA 51601

(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 4/3/20 and 4/12/20 The following deficiencies are the result of an investigation of complaints 87083-C, 87404-C, 87521-C, 87597-C, 89273-C and 89296-C was conducted February 12 - March 19, 2020. All of the complaints were substantiated. See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.	F 000	This plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. F684 1. Resident #2 discharged from facility on February 15, 2020. 2. The Director of Nursing/Designee completed an audit on April 3, 2020 of current residents that have blood sugar orders and daily weights to identify if any other residents may be affected. 3. Director of Nursing/Designee educated licensed nurses on following orders as prescribed by the physician, including the monitoring of blood sugars and weights as ordered on April 3, 2020. 4. The Director of Nursing/Designee will complete audits 3 days/week for 4 weeks. Then weekly times 8 weeks to ensure weights and blood sugars continue to be completed and documented as required. The results of these audits will be taken to the facility Quality Assurance/Performance Improvement Committee monthly for three (3) months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up. Compliance: 04/03/2020	04/03/2020
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident, physician and staff interview, the facility failed to provide care and treatment in accordance with professional standards of practice for 1 of 3 residents reviewed (Resident #2). On 1/24/20, Resident #2 admitted to the facility from the hospital with diagnoses that included diabetes, coronary artery disease, heart failure, high blood pressure, and atrial fibrillation (irregular heartbeat). During her stay at the facility, she was hospitalized on 1/28/20, returned to the facility on 2/5/20, and sent to the hospital again on 2/16/20.	F 684		

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

Administrator 4/9/2020

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 684	Continued From page 1 The facility failed to administer scheduled medications as prescribed, failed to monitor blood sugar levels as prescribed, and failed to monitor the resident's weight as prescribed, which was verified by the resident's Primary Care Provider (PCP) in an interview on 2/24/20. The facility reported a census of 28 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 1/27/20, Resident #2 had diagnoses that included: coronary artery disease, heart failure, high blood pressure, renal (kidney) insufficiency, diabetes, encephalopathy (disease that alters brain function or structure), atrial fibrillation (irregular heart rhythm), and an implanted cardiac defibrillator. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated the resident displayed no cognitive deficits. The MDS documented the resident required either supervision or extensive assistance of one staff for activities of daily living (ADLs). The MDS also documented the resident required insulin injections and anticoagulant medication (blood thinner). Review of a care plan with a revision date of 2/17/19 revealed a diagnosis of diabetes and directed staff to administer medication as ordered. According to the care plan, education staff should provide education to the resident, family, and/or caregiver regarding the importance of compliance to prevent complications of the disease. The care plan also directed staff to monitor the resident's dietary compliance. The after Visit Summary related to the resident's	F 684		

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F 684	Continued From page 2 1/12/20 - 1/24/20 hospitalization directed the resident's blood sugar goal should range between 100-180. Check before meals and at bedtime unless the resident's Primary Care Provider (PCP) orders something different, and refer (Resident #2) to Nutritional Services for diabetes and failed nurse education. Hospital Discharge Medication Orders: 1. Apixaban 5 mg tab by mouth (po) twice a day (BID) for irregular heart rhythm. Give next at bedtime (HS) 1/24/20. 2. Aspirin 81 mg tablet po daily (QD) for heart health. Give next dose in a.m. on 1/25/20. 3. Calcium/Vitamin D 500 mg/200 units tablet po BID for osteoporosis. Give next dose at HS on 1/24/20. 4. Carvedilol 6.25 mg tablet po BID with meals for blood pressure and heart rate. Next dose due evening 1/24/20. 5. Ezetimibe 10 mg tablet po at HS for cholesterol with next dose due at HS on 1/24/20. 6. Famotidine 20 mg tablet po BID for heartburn with next dose due in the evening on 1/24/20. 7. Ferrous Sulfate 325 mg tablet po QD with breakfast as iron supplement with next dose due 1/25/20 in a.m. 8. Furosemide 20 mg tablet po QD for edema (swelling) with the next dose due 1/25/20 in a.m. 9. Glargine (Lantus) insulin 10 units QD with breakfast for type 1 diabetes with the next dose due on 1/25/20 in a.m. 10. Lispro (Humalog) insulin 4 units 3 times daily (TID) with meals for type 1 diabetes with next dose due in the evening of 1/24/20. 11. Isosorbide 60 mg/24-hour tablet po QD for chest pain with next dose due on 1/25/20 in a.m. 12. Pravastatin 40 mg tablet po at HS for	F 684		

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F 684	Continued From page 3 cholesterol with next dose due at bedtime on 1/24/20. A fax sent to the PCP dated 1/25/20 requested the PCP to specify any other orders for Resident #2 in to hospital discharge. ordered: a diabetic, low salt diet, weights 3 times per week (M-W-F), and blood sugar checks 4 times a day before meals and at bedtime. The January 2020 Medication Administration Record (MAR) documented: a. Staff gave the 1st dose of Aspirin 81 mg. on 1/26/20 instead of 1/25/20. The MAR revealed no administration of ordered medication on 1/28/20. Staff wrote "insulin not required." b. Staff gave the 1st dose of Ezetimibe 10 mg at HS on 1/25/20 instead of 1/24/20. c. Staff gave the 1st dose of Ferrous Sulfate 325 mg in a.m. on 1/26/20 rather than 1/25/20. d. Staff gave 1st dose of Furosemide 20 mg in a.m. on 1/26/20, not 1/25/20 as ordered. e. Staff gave the 1st dose of Glargine Insulin 10 units in a.m. on 1/26/20 instead of 1/25/20. The MAR revealed the staff administered Glargine in the a.m. of 1/27/20 with a blood sugar level of 453. f. Staff gave the 1st dose of Isosorbide 60 mg/24 hour in a.m. on 1/26/20 instead of 1/25/20 as ordered. g. Staff gave the 1st dose of Pravastatin 40 mg at HS on 1/25/20, not 1/24/20. The MAR revealed staff failed to give the medication on 1/24/20 because the medication was on order. h. Staff gave the 1st dose of Apixaban 5 mg in a.m. of 1/26/20 instead of HS on 1/24/20. The MAR recorded staff did not give it in the a.m. of 1/25/20 because staff did not schedule it. The	F 684		

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F 684	Continued From page 4 resident did not receive the medication in evening on 1/25/20 due to medication not available, or on 1/28/20 with no explanation documented by staff. i. Staff gave the 1st dose Calcium/Vitamin D 500 mg/200 units in the evening on 1/25/20 instead of bedtime on 1/24/20. The MAR revealed the medication had been omitted the evening of 1/24/20 and the morning of 1/25/20 because staff did not schedule it on the MAR, 1/26/20 due to not available, and 1/28/20 with no explanation given. j. Staff gave the 1st dose of Carvedilol the evening of 1/25/20 instead of the evening of 1/24/20 as ordered. The MAR revealed staff failed to give the medication on 1/24/20 in the evening due to medication on order and 1/28/20 with no explanation recorded. According to the MAR, the resident did not receive the medication 1/25/20 in the a.m. because staff did not schedule it on the MAR to be given. k. Staff gave the 1st dose of Famotidine on the evening of 1/25/20 rather than the evening of 1/24/20 as ordered, because staff did not schedule it, 1/25/20 due to medication unavailable, 1/28/20 with no explanation, and 1/29/20 due to resident "hospitalized." The MAR also revealed medication not given in a.m. on 1/25/20 because staff failed to list the order on the MAR at that time. l. Staff gave the 1st dose Furosemide on 1/25/20 in the evening rather than 1/24/20 as ordered. The MAR revealed the resident did not receive the medication in the evenings on 1/24/20 due to not scheduled, 1/25/20 due to not available, and 1/28/20 with no explanation. According to the MAR, the resident did not receive the medication on the mornings of 1/25/20 because they had not scheduled it to be given yet.	F 684		

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F 684	Continued From page 5 m. Staff administered the 1st dose of Lispro Insulin 4 units at lunch on 1/25/20 (blood sugar 483) instead of on the evening of 1/24/20 as ordered. The MAR revealed the resident did not receive the Lispro on the evening of 1/24/20 and morning of 1/25/20 because staff failed to schedule it on the MAR, and on 1/28/20 with no explanation. n. According to the MAR, staff checked the resident's blood sugar at 4:00 p.m. on 1/24/20 as ordered. The MAR documented a blood sugar level of 378 at 9:00 p.m. on 1/24/20. The MAR revealed staff failed to check her blood sugar at 11:00 a.m. on the mornings of 1/25/20 because they did not add it to the MAR to direct staff to check it. Review of the January 2020 Treatment Administration Record (TAR) documented staff failed to check Resident #2's weight on Monday, 1/27/20 because staff did not schedule it to be done. An EMAR Orders Administration Note dated 1/24/20 at 5:00 p.m. noted Resident #2 admitted to the facility. The author wrote she documented her entry "after some time" without a specific time of admission. According to the note, the resident reportedly broke her wrist, some ribs and her pelvis after she fell at home and a diabetic specialist followed her for diabetes. Health Status Notes revealed: a. On 1/25/20 at 11:19 a.m., staff documented they entered all of Resident #2's medications into the computer. The nurse contacted the pharmacy and they reported they would deliver all medication that night.	F 684		

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F 684	Continued From page 6 b. On 1/25/20 at 11:53 p.m., staff documented the resident's medication arrived during her shift and she gave 4 units of Humalog at bedtime. The nurse noted resident's heartbeat irregular and lung sounds diminished, with swollen lower legs and ankles. c. On 1/26/20 at 10:45 p.m. documented the resident as an insulin dependent diabetic. The nurse noted that the resident's lungs were diminished and she had swollen lower legs and ankles. d. On 1/28/20 at 2:54 a.m. documentation an order that directed a diabetic, low salt diet, weight 3 times weekly, and check blood sugars before meals and at bedtime. e. On 1/28/20 at 11:20 a.m., the resident displayed shortness of breath and her lungs sounded "tight". The nurse also documented administered 2 puffs from a breathing treatment. According to the documentation, the resident reported only slightly improved symptoms with continued shortness of breath. The nurse obtained a physician's order to give a stat, one-time dose of Lasix (water pill) and reassess the resident in 3 hours. f. On 1/28/20 at 11:43 a.m. documented Lasix 40 mg given as ordered. The nurse documented the resident's heart rate at 104 beats per minute with a blood oxygen level at 96% on 2 liters of supplemental oxygen. The nurse coached the resident to pursed lip breathe and take slow, calming breaths through her nose. g. On 1/28/20 at 4:25 p.m., the resident's condition seemed to improve that afternoon. The nurse documented the resident continued with shortness of breath and rapid breathing and the nurse awaited the physician's return call. h. On 1/28/20 at 4:46 p.m. documented the nurse obtained an order to send the resident to the ER	F 684		

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F 684	Continued From page 7 (Emergency Room). The document titled Weight Summary showed Resident #2's January weights as 135 lbs. on 1/26/20 at 12:11 p.m. and 135 lbs. on 1/27/20 at 8:15 a.m. The After Visit Summary regarding hospitalization for acute on chronic systolic heart failure between 1/29/20 - 2/5/20 identified a goal to keep the resident's blood sugar level in the 100-180 range and to check her blood sugar before meals and at bedtime unless instructed by her doctor. The physician described the resident's discharge condition as stable. The summary directed the resident should follow-up with her PCP in 1 to 2 weeks and any of the following should be reported; temperature, severe uncontrolled pain, extreme fatigue, difficulty breathing, persistent nausea and vomiting, and signs of infection. The physician ordered daily weights after the resident's first void and before breakfast and report a gain of 3 lbs. in 24 hours or 5 lbs. pounds from discharge hospital weight. Also, contact provider if resident showed signs/symptoms of fluid overload: weight gain, shortness of breath, difficulty breathing with exertion, cough, new/increased swelling in lower legs, shortness of breath while lying flat, new or increased oxygen needs, and increased fatigue or weakness. The summary directed a resident with Type 1 diabetes should receive insulin and make all efforts to receive a consistent carbohydrate diet. The 2/5/20 Hospital Discharge Medication Orders directed: 1. Apixaban 5 mg tablet po BID with the next dose due at bedtime that night.	F 684		

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F 684	Continued From page 8 2. Aspirin 81 mg tablet po QD with the next dose due the next morning. 3. Calcium/Vitamin D 500 mg/200 units po BID with the next dose due that evening. 4. Carvedilol 6.25 mg tablet po BID with meals with the next dose due that evening. 5. Ezetimibe 10 mg tablet po at HS with the next dose due at bedtime that night. 6. Famotidine 20 mg tablet po BID with the next dose due at bedtime that night. 7. Ferrous Sulfate 325 mg tablet po QD with breakfast with the next dose due the next morning. 8. Glargine insulin 6 units injected QD with breakfast for Type 1 diabetes the next dose due the next morning. 9. Lispro insulin 3 units injected TID with meals for type 1 diabetes with the next dose due the next afternoon. 0. 10. Isosorbide 60 mg/24 hour po QD with the next dose due the next morning. 11. Pravastatin 40 mg po at HS with the next dose due at bedtime that night 12. Ropinirole 0.25 mg tablet, 3 tablets po HS with the next dose due at bedtime that night. 13) Torsemide 20 mg tablet po QD with the next dose due the next morning. A Health Status Note dated 2/5/20 at 1:30 p.m. documented the resident re-admitted from the hospital. A Health Status Note dated 2/6/20 at 4:43 a.m. documented the resident's bedtime blood sugars 448. The nurse obtained an order to administer 15 units of insulin now. A follow up test revealed the resident's blood sugar results as 339. An EMAR Orders Administration Note dated	F 684		

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F 684	Continued From page 9 2/5/20 at 6:15 p.m. documented Ropinirole 0.25 mg. as unavailable. An EMAR Orders Administration Note dated 2/8/20 at 10:31 p.m. directed staff to weigh the resident daily and contact the PCP with 2 lb. gain in one day or a 5 lb. gain in a week k related to heart failure. The nurse documented they had not checked the Resident's weight before breakfast; therefore it would not be accurate. A phone order dated 2/9/20 at 9:25 a.m., noted by the nurse on 2/13/20, directed staff to inject Glargine 10 units QD for Type 1 diabetes. A phone order dated 2/9/20 at 9:28 a.m., noted by the nurse on 2/13/20, directed staff to inject Lispro 5 units TID for Type 1 diabetes. A phone order dated 2/9/20 at 9:30 a.m., noted by the nurse on 2/13/20, directed staff to inject Lispro 5 units one time only for a blood sugar reading of 562 until 2/9/20 at 11:59 p.m. A Health Status Note dated 2/9/20 at 9:34 a.m. revealed staff contacted the on-call doctor to report a blood sugar level of 562. The nurse obtained a new order to increase Glargine insulin to 10 units every morning and increase Lispro insulin to 5 units with each meal and 5 extra units "now". An EMAR Orders Administration Note dated 2/9/20 at 10:31 p.m. revealed the resident's weight had not been checked before breakfast. The Doctor's Orders and Progress Notes dated 2/11/20 at 2:04 p.m. contained orders as follows:	F 684		

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F 684	Continued From page 10 1) Obtain daily weights for 2 weeks and fax results to the PCP's attention on Thursdays. 2) Give insulin after meals, never before. Hold meal time insulin if Resident #2 eats less than 25% of her meal. 3) The Resident reported she is not receiving evening meal insulin on a regular basis. She is Type 1 diabetic and requires regular timely insulin administration to avoid death. 4) Please ensure Resident #2 is on a no added salt and diabetic diet. She needs both; not one or the other. 5) Administer 5 units of Lispro once "now" for a blood sugar reading of 528. Re-check her blood sugar in 2 hours and call the PCP with the results. Staff documented on the order that they called the PCP at 4:30 p.m. to clarify and received an order to re-check the Resident's blood sugar and administer 5 units if it measured higher than 400. The nurse documented the Resident's blood sugar level as 193 at that time. A Health Status Note dated 2/11/20 at 5:12 p.m. documented receipt of a fax from the resident's PCP regarding the residents diet, insulin, and weights and an order to administer 5 units of Lispro for a blood sugar level of 528. The order directed staff to re-check the blood sugar in 2 hours and notify PCP of results. The nurse documented that she had not given the 5 units of Lispro because she had not observed a blood sugar result that high on her shift. The nurse consulted the PCP to know to do since she had not given the 5 extra units of Lispro, had not re-checked in 2 hours or called back. The PCP ordered her to check Resident #2's blood sugar "now" and administer 5 units of Lispro if the blood sugar level was over 400. The PCP also ordered her to call him back after re-checking the	F 684		

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F 684	Continued From page 11 Resident's blood sugar in 2 hours. The nurse documented Resident #2's blood sugar as 193. A phone order dated 2/12/20 at 8:15 a.m., noted by the nurse on 2/13/20, directed staff to inject Lispro 5 units additional STAT (immediately) for high blood sugar. A phone order dated 2/12/20 at 8:17 a.m., directed the resident to receive Lispro 5 units one time only after breakfast until 2/12/20 at 11:29 a.m. for a high blood sugar reading. A Health Status Noted dated 2/12/20 at 8:20 a.m., documented a blood sugar reading of 500 before breakfast. The nurse obtained an order to administer 5 units of insulin in addition to the scheduled dose, and another 5 units after the resident ate breakfast. The PCP also ordered the nurse to call with the blood sugar results before lunch. A Health Status Noted dated 2/12/20 at 10:39 a.m., the nurse documented resident's blood sugar still high. She then notified the PCP of uncontrolled blood sugars. Fax correspondence dated 2/12/20 at 1:25 p.m. notified the PCP the resident had lost 11 pounds. The nurse documented the resident's 1/26/20 weight as 135 pounds and her 2/5/20 weight as 124 pounds. The nurse also notified the PCP that the resident consumed anywhere between 0-50% of her no added salt (NAS) diet. The PCP documented that he attributed her weight loss to treatment of acute heart failure and ordered the facility to "please perform her ordered daily weights".	F 684		

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F 684	Continued From page 12 The Doctor's Orders and Progress Notes dated 2/13/20 noted the resident's weight as 136.8 pounds. The PCP ordered: 1. Change Glargine to 12 units QD. 2. Change Lispro to 7 units TID after consumption of 50% of the resident's meals. 3. Torsemide 20 mg by mouth once "today". 4. Fax the resident's blood sugar log to the PCP on 2/19/20. A Health Status Note dated 2/13/20 at 1:25 p.m. documented the resident's PCP saw her on routine rounds. The nurse documented she discussed blood sugar management and new dosing with the PCP, and he wanted to get her blood sugar levels down into the 200's. An EMAR Orders Administration Note dated 2/13/20 at 7:17 p.m. noted Ezetimibe 10 mg was unavailable. A Health Status note dated 2/14/20 at 3:49 p.m. documented the nurse called the PCP after getting 3 consecutive "HI" blood sugar readings. The nurse obtained an order to give 6 units fast acting insulin (Humalog) and recheck blood sugar in 2 hours. A Health Status Note dated 2/14/20 at 11:53 p.m. documented that the resident had eaten an ice cream snack, potatoes for lunch and a cookie. The nurse noted that she observed 4 consecutive "HI" results when she tested the resident's blood sugar level. According to the nurse's documentation, another RN obtained an order to administer 5 units of Humalog "now" and recheck it in 2 hours; at which time the resident's blood sugar measured 577. The nurse documented that	F 684		

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F 684	Continued From page 13 administered the scheduled insulin and the resident did not eat much for her evening meal, but stated she felt "so much better". The resident slept most of the evening before her blood sugar was checked again; at which time it measured 270. A Health Status Note dated 2/15/20 at 2:45 a.m. documented a blood sugar reading of "HI" and the resident with decreased responsiveness. The nurse documented the resident's vital signs as temperature 99.6 F., respirations 24 (breaths per minute) and shallow, blood pressure 112/60 and oxygen level 94%. She described the resident as being weak and unable to ambulate. Documentation revealed the resident had not been given the after meal insulin, so she administered it. After consulting an on-call doctor, the nurse rechecked the blood sugar in 20 minutes per order; which she documented as "HI". The nurse documented the resident did not respond to her but whimpered throughout their encounter. The resident could not answer questions. An order was obtained to send the resident to the ER. EMAR Orders Administration Note dated 2/15/20 at 7:51 p.m. documented staff missed checking Resident #2's blood sugar before supper. The nurse documented the current reading as "HI". A phone order dated 2/16/20 at 12:37 a.m. authorized the facility to send the resident to the ER immediately for persistent hyperglycemia with continued decreased level of consciousness. A Health Status Note dated 2/16/20 at 4:13 a.m. documented the resident was admitted to the hospital for further observation.	F 684		

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F 684	Continued From page 14 A review of the February 2020 MAR revealed: 1. Staff administered the 1st dose of Aspirin 81 mg. by mouth for heart health on the morning of 2/8/20 instead of 2/6/20 as ordered. The MAR revealed the resident did not receive the medication on 2/6/20 and 2/7/20 due to hospitalization (resident was readmitted on 2/5/20). 2/9/20, 2/10/20 and 2/11/20 doses were not administered without an explanation and 2/14/20 due to the resident refusal. 2. Staff administered the 1st dose of Ezetimibe 10 mg. by mouth for cholesterol at bedtime on 2/5/20 as ordered. The MAR documented the resident did not receive the medication on 2/13/20 because the medication was not available. 3. Staff faxed daily weights to PCP on Thursday 2/13/20 related to congestive heart failure as ordered on 2/11/20. 4. Staff administered Glargine 10 units on the mornings of 2/9/20 through 2/13/20 as ordered (MAR initialed for both 8 and 10 units on 2/9/20) on 2/9/20. 5. Staff administered Glargine 12 units for type 1 diabetes on the mornings of 2/14/20 and 2/15/20 as ordered on 2/13/20. 6. Staff administered the 1st dose of Ropinirole 0.25 mg. for restless leg syndrome at bedtime on 2/6/20 instead of 2/5/20 as ordered. Medication documented as being unavailable. 7. Staff did not administer the dose of Calcium/Vitamin D 500 mg./200 units on 2/8/20, 2/9/20, 2/12/20 and 2/13/20 with no explanation or due to the medication being unavailable. 8. Staff administered Lispro 4 units TID at lunch on 2/5/20 instead of 3 units as ordered on 2/5/20. Staff administered 3 units in the evening of 2/5/20	F 684		

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F 684	Continued From page 15 and TID on 2/6/20 through the morning dose on 2/9/20; at which time they discontinued that dose with a blood sugar level of 562. 9. Staff administered Lispro 15 units one time only on 2/5/20 at 10:00 p.m. for a blood sugar reading of 448. 10. Staff administered Lispro 5 units one time only on 2/8/20 at 9:29 a.m. for a high blood sugar reading. 11. Staff administered Lispro 5 units one time only on 2/9/20 at 9:41 a.m. for a blood sugar reading of 562. 12. Staff administered Lispro 5 units TID at lunch on 2/9/20 through the lunch dose on 2/11/20 as ordered on 2/9/20. 13. Staff administered Lispro 5 units TID (if Resident #2 ate at least 25% of her meal) starting in the evening on 2/11/20 through the lunch dose on 2/13/20; at which time they discontinued that dose with a blood sugar level of 459. 14. Staff administered Lispro 5 units immediately on 2/12/20 at 8:25 a.m. for a high blood sugar reading. 15. Staff administered Lispro 5 units one time only after breakfast on 2/12/20 at 9:08 a.m. for a high blood sugar reading. 16. Staff administered Torsemide 20 mg in addition to Resident #2's normal dose immediately for edema on 2/13/29 at 4:45 p.m. 17. Staff administered Lispro 7 units TID at lunch (if Resident #2 ate at least 50% of her meal) starting at supper on 2/13/20 through the lunch dose on 2/15/20. 18. Staff administered Lispro 6 units one time only on 2/14/20 at 5:36 p.m. 19. Staff checked the resident's blood sugar before meals and at bedtime starting at 4:00 p.m. on 2/5/20 through 11:00 a.m. on 2/15/20. The MAR lacked documentation of a blood sugar	F 684		

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F 684	Continued From page 16 check at 4:00 p.m. on 2/15/20. Documentation revealed the 9:00 p.m. blood sugar reading as 5000. Review of the February 2020 Treatment Administration Record (TAR) revealed it failed to direct staff to weigh the resident after the resident's first morning urination (void) and before breakfast as ordered on 2/5/20. The TAR failed to contain documentation that indicated the staff weighed the resident daily as ordered. The TAR also failed to contain documentation that verified staff faxed the resident's blood sugar log to the PCP on 2/19/20 as ordered. A document titled Weight Summary documented the resident's February weights as follows: 1. 2/12/20 at 8:24 a.m. = 135.1 pounds. 2. 2/13/20 at 9:46 a.m. = 136.8 pounds. 3. 2/14/20 at 8:23 a.m. = 134.7 pounds. 4. 2/15/20 at 12:14 p.m. = 136.5 pounds The 2013 Blood Glucose Testing procedure to monitor blood glucose level directed staff to verify the physician's order for blood glucose testing and reporting parameters and notify the physician if the blood glucose is out of parameter range. The policy also directed staff to document the blood glucose level on the MAR or in progress notes, and also the resident's response to their blood glucose level if out of parameter range. During an interview on 2/24/20 at 12:45 p.m., the Director of Nursing (DON), stated staff are to fax admission orders to the pharmacy as soon as the discharge orders are in the building. The DON described their admission process as "broken." When asked, the DON also stated staff should	F 684		

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F 684	Continued From page 17 check the emergency medication kit (e-kit) for medication on hand to ensure medication can be administered as prescribed. She added staff should call the pharmacy if specific medications are not in the facility/e-kit, and pharmacy can deliver them STAT if necessary. The DON stated the pharmacy delivers by midnight and they are pretty good about getting the medication here in a timely manner. The DON stated she spoke to the doctor about making sure insulin was administered as prescribed and informed him they were working on the processes. During an interview on 2/24/20 at 2:54 p.m. with Resident #2's PCP, he stated he expected the facility to notify him of a high blood sugar reading. The PCP stated he did not write specific orders about when to notify him, but facilities usually have a policy with the threshold somewhere between 300 and 500, and he certainly expected to be notified for any reading over 500. The PCP also stated he would have expected the facility staff to check the resident's blood sugar and administer all medications as ordered, especially after a lengthy hospitalization for congestive heart failure as Resident #2 had prior to her 1/24/20 admission to the facility. The PCP said medication and diet adherence would probably be the greatest factors in preventing re-admission to the hospital, and not tracking blood sugar and not receiving medications as ordered could have potentially contributed to the resident being re-hospitalized after her 1/24/20 admission. The PCP reported uncontrolled diabetes could potentially be a risk factor for developing infection such as pneumonia, and added hyperglycemia (high blood sugar) is an independent predictor for morbidity and mortality in pneumonia. The PCP said hyperglycemia and the resulting	F 684		

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F 684	Continued From page 18	F 684		

complications directly resulted in Resident #2 being hospitalized on 2/15/20. He stated pneumonia and congestive heart failure were factors that contributed to that hospitalization, and the 2/15/20 hospitalization could be directly attributed to blood sugar control. The PCP said he expected staff to followed physician's orders in a timely manner and administer medications as ordered.

In an interview on 3/9/20 at 10:58 a.m., the Nurse Consultant stated the resident's blood sugars had been out of control and she felt relieved that they called the doctor and sent her to the hospital. The Nurse Consultant reported the facility did not accept the resident back after her second hospitalization because her blood sugars were too brittle (variable, hard to manage), and added they had too many temporary agency nursing staff in the building and could not meet Resident #2's needs.

On 3/12/20 at 11:00 a.m. the Dietary Supervisor reported in an interview she had worked as a cook in the facility for a couple of years, left for approximately 9 months, and came back about a week ago as the Supervisor. The Dietary Supervisor stated the difference between a diabetic diet and a regular diet are a smaller scoop size for starches, a smaller or different dessert than a regular diet, and they either do not receive bread and butter or just get a half of a slice. The Dietary Supervisor stated a regular diet also has lower sodium and does not differ from a no added salt diet. The Dietary Supervisor stated the diets are followed carefully as far as she knows. She stated she could only speak for herself because there were no other cooks on the shift she worked but only the cook plates the

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F 684	Continued From page 19 food. She stated there is no record of what type of diet a resident gets served on any particular day they just follow the order. The Dietary Supervisor stated she can only assume a resident got served the type of diet the physician ordered.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident and staff interview, the facility failed to properly supervise 1 of 3 residents reviewed (Resident #11). The facility reported a census of 28. Findings include: The Minimum Data Set (MDS) assessment with a completion date of 12/6/19 listed diagnoses of mood disorder, hip pain and disorder of bone density and structure. The Brief Interview for Mental Status (BIMS)documented a score of 15 out of 15 which indicated no cognitive deficits. The MDS documented the resident as being independent with most activities of daily living (ADLs); including the ability to self-propel her wheelchair. An observation on 2/13/20 at 8:48 a.m. revealed	F 689	F689 1. Resident #11 was counseled by the Director of Nursing on March 6, 2020 about not allowing another resident to pull her in her wheelchair. She agreed and has not done it since. The resident with the electric wheelchair was also counseled by the Director of Nursing on March 6, 2020 to not pull other residents with his wheelchair. He has not done it since. 2. The Director of Nursing/Designee completed an audit on April 6, 2020 of current residents to identify others who use electric wheelchairs. Residents identified were informed of the expectations of not pulling or pushing other residents with their wheelchair. 3. Department Heads were educated by Administrator on March 25, 2020 related to addressing resident safety issues at the time it is noticed. Also, to inform Director of Nursing or Administrator of incident to monitor and document. The Director of Nursing/Designee educated other nursing staff related to addressing resident safety concerns at the time the concern is identified and complete documentation as required by April 12, 2020. Director of Nursing educated residents that utilize an electric wheelchair, that they are not allowed to pull anyone with their wheelchairs on April 6, 2020. Any resident that starts to use or is admitted with an electric wheelchair will be educated at that time on pulling residents in regular wheelchairs.	

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F 689	Continued From page 20 a resident operating an electric wheelchair with Resident #11 hanging on to his chair and being pulled down the hallway. Resident #11's feet hovered just above the floor and sometimes slid on the floor as he towed her wheelchair from her room and down the hallways past various offices going towards the front of the building-an approximate distance of 142 feet. An observation on 2/20/20 at 10:40 a.m. revealed a resident operating an electric wheelchair while pulling Resident #11 in her wheelchair behind him as she held onto his. Resident #11's feet hovered just above the floor and sometimes slid on the floor as he towed her wheelchair around a corner from the middle hallway to her room-approximately 106 feet. Observation on 2/26/20 at 9:18 a.m. revealed a resident operating an electric wheelchair while towing Resident #11 in her wheelchair behind him as she held onto his. Resident #11's feet hovered just above the floor and sometimes slid on the floor as he towed her wheelchair from the middle of the hallway going past the Director of Nursing's (DON) office, around a corner and all the way to her room-approximately 142 feet. Multiple staff members passed by the two residents without saying anything. A Certified Nurse's Aide (CNA) grabbed onto and walked behind the back of Resident #11's wheelchair while saying "you can tow me too". The CNA hung onto the wheelchair for approximately 106 feet without intervening. Observation on 2/27/20 at 8:40 a.m. revealed a resident operating an electric wheelchair while towing Resident #11 in her wheelchair behind him as she held onto his. Resident #11's feet hovered just above the floor and sometimes slid on the	F 689	4. Director of Nursing/Designee will monitor residents that utilize electric wheelchairs weekly for four (4) weeks and then monthly for two (2) months to ensure residents continue to follow guidelines of not pulling other residents in a wheelchair. Results of these audits will be taken to the facility Quality Assurance/ Performance Improvement Committee monthly for three (3) months for review and recommendations as needed. The Administrator is responsible for monitoring and follow up. Compliance 04/12/2020	04/12/2020

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F 689	Continued From page 21 floor as he towed her wheelchair from her room, down the hallways past various offices and nurse's stations and exited a door to the designated smoking area-approximately 245 feet. Review of a Care Plan with a revision date of 3/26/17 documented Resident #11's risk for falls related to weakness from chemotherapy and antidepressant use. Interventions implemented on 12/19/19 included independent use of a wheelchair throughout the facility. The Care Plan instructed staff to encourage her to ask for assistance when she felt weak or tired and offer to assist her if she appeared fatigued. Review of a document labeled The Behavioral Management Overview dated May 2014 directed: 1. The facility provides individual care and services that promote the highest practicable level of function for each resident. If a resident develops behaviors that are harmful or potentially harmful to themselves or others, a behavior management plan will be implemented. Procedure: 1. Identify and address possible causes of the behavioral symptoms. 2. Develop the care plan. 4. Implement and document individualized goals and interventions. 7. Evaluate effectiveness of interventions. During an interview on 2/13/20 at 9:25 a.m., the resident stated the nurse took over pushing her wheelchair the day this surveyor witnessed another resident towing her behind his electric wheelchair. The resident stated the nurse had	F 689		

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said, "I better push you. The state is here". The resident stated she can self-propel her own wheelchair independently and the nurse did not put the foot rests on her wheelchair from the time she began pushing it until the time she stopped at the front entry. Resident #11 said, "I just let my feet dangle above the floor".

During an interview on 3/12/20 at 8:05 a.m. with the Corporate Nurse Consultant 2, she stated various aspects of supervision, accidents, and hazards are incorporated into their policies. The Consultant stated they do not have a general policy specifically related to resident towing other residents behind an electric wheelchair. The Consultant stated the resident is cognizant and does what she wants to do. The Consultant stated the resident wondered why "it was a big deal" as she had done it for a long time and nothing had happened. The Consultant acknowledged she understood the potential for injury and stated she had observed serious accidents with injuries from residents being pushed in wheelchairs while their feet were dragging on the floor. The Consultant stated staff have grown accustomed to it and did not recognize it as a hazard. She stated they needed to be educated. The Nurse Consultant stated she expected staff to intervene whenever they see residents involved in potentially hazardous situations.

During an interview on 3/12/20 at 11:40 a.m. with Staff B, CNA, she stated the facility had never told them to intervene whenever they saw the other resident towing Resident #11's wheelchair behind his electric wheelchair. Staff B stated Resident #11 "hitches a ride" with the other resident because she gets short of breath from

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F 689	Continued From page 23 self-propelling her own wheelchair. Staff B said they call it their "choo choo" train. The CNA acknowledged grabbing onto the back of Resident #11's wheelchair a couple of weeks ago and acting like they were pulling her too. Staff B stated she did not think of it as a big deal. She stated the resident had been towing Resident #11 behind his electric wheelchair for at least the last couple of months if not longer. The CNA stated she did not understand why it was considered a problem other than the fact somebody could get hurt. Staff B stated she realized Resident #11 could get her feet stuck under her wheelchair and get hurt. Staff B stated that today the facility told them to discourage the residents from continuing to do it. During an interview on 3/12/20 at 11:45 a.m. with Staff C, Physical Therapy Assistant (PTA), she stated she has seen the resident towing Resident #11's wheelchair behind his electric wheelchair. Staff C said she had become accustomed to seeing it. Staff C stated the facility has never told them to intervene when they saw it happening. Staff C said she had never intervened nor has she seen other staff intervene. The PTA said she understands how it could be dangerous and how Resident #11 could run into the back of the other resident's electric wheelchair if he stopped suddenly. Staff C stated she believed Resident #11's wheelchair could also tip over. The PTA stated they know not to push a resident in a wheelchair if they do not have their feet resting on the foot rests. Staff C said she still has not been told to intervene if she saw the Resident towing Resident #11 in her wheelchair.	F 689		
F-880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F-880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. BUILDING _____ B. WING _____	C 03/19/2020

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F 880	Continued From page 24 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	F880 1. Resident #6 was assessed by the Director of Nursing initially on March 12, 2020 with no signs and symptoms of infection or GI upset noted. Through a follow-up assessment and chart review on April 8, 2020, the resident continued to have no signs and symptoms of infection or GI upset from incident. Resident # 10 was assessed by the Director of Nursing initially on March 12, 2020 with no signs and symptoms of infection or GI upset noted. Through a follow-up assessment and chart review on April 8, 2020, the resident continued to have no signs and symptoms of infection or GI upset from incident. Staff A received education; counseling related to maintaining infection control during medication administration on March 12, 2020 by Director of Nursing. CMA will have a Medication Administration Skills Checklist completed prior to returning to a med cart 2. Director of Nursing/Designee will perform a Medication Administration Skills Checklist on current nurses and C.M.A.'s prior to April 12, 2020 to ensure infection control is maintained as required during Medication Administration. 3. Director of Nursing/Designee will re-educate licensed nurses and C.M.A.'s on the Medication Administration requirements and expectations, including maintaining infection control during medication administration by April 12, 2020.	

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F 880	Continued From page 25 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to consistently practice acceptable Infection Control standards for 2 residents (Residents #6 and #10) during observation of medication administration. The facility reported a census of 28 residents. Findings include: 1. According to the Minimum Data Set (MDS)	F 880	4. Director of Nursing/Designee will complete (3) Medication Administration observation audits weekly for 4 weeks and monthly for two (2) months to ensure infection control continues to be maintained during medication administration. The results of these audits will be presented to the facility Quality Assurance/ Performance Improvement Committee monthly for three (3) months for review and recommendations as needed. The Director of Nursing is responsible for monitoring and follow up. Compliance 04/12/2020	04/12/2020

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F 880	Continued From page 26 assessment tool dated 1/2/20, Resident #6 had diagnoses that included aphasia (difficulty understanding or speaking), stroke, dementia, and difficulty swallowing. The resident scored 0 of 15 during the Brief Interview for Mental Status (BIMS) test, which meant the resident displayed severe cognitive deficits. The MDS documented the resident was totally dependent on 1 or 2 staff members for most Activities of Daily Living (ADLs). Observation on 3/9/20 at 12:07 p.m. revealed Staff A, Certified Medication Aid (CMA) handling one of Resident #6's pills with her bare hands before she crushed it, mixed it in pudding, and administered it to the resident in a medication cup. 2. According to the MDS dated 2/13/20, Resident #10 had diagnoses that included stroke, depression, and hemiparesis (muscle weakness or partial paralysis on one side) or hemiplegia (paralysis on one side). The MDS documented the resident required extensive assist of 1 or 2 staff members for most ADLs. Observation on 3/9/20 at 12:13 p.m. revealed Staff A handled one of Resident #10's pills with her bare hands before administering it to the resident in a medication cup. During an interview on 3/12/20 at 8:45 a.m. with the Director of Nursing (DON) and the Corporate Nurse Consultant, both acknowledged they considered handling medication with bare hands an unacceptable practice.	F 880		