STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00372803. Complaint IN00372803 - Unsubstantiated due to lack of evidence. Survey dates: April 25, 26, 27, 28, and 29, 2022. Facility number: 000059 Provider number: 155697 AIM number: 100266560 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 8 Medicaid: 46 Other: 14 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 9, 2022.	F 0000		
F 0658 SS=E Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, record review, and	F 0658	**F658**	05/29/2022

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

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	interview, the facility failed to ensure nursing services met professional standards of care for administration and documentation of insulin and blood glucose levels, pressure ulcer interventions, and change of condition. This deficient practice had the potential to affect all 68 residents residing in the facility. Findings include: 1. Standards of practice were not followed, related to blood glucose level monitoring and administration of insulin as ordered by the physician. Residents 24, 36, 33, and 29 had multiple incidents of missing documentation of ordered blood glucose levels and administration of insulin. Cross Reference F684. 2. Resident 51 developed a facility acquired pressure ulcer. Skin assessments conducted by nursing staff were inaccurate, and the wound was not identified until it had progressed to a stage 3. Cross Reference F686. 3. Resident 36 was experiencing changes in respiratory status. The clinical record lacked documentation of appropriate monitoring, assessment, and follow-up by nursing staff. Cross Reference F695 3.1-35(g)(1)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Residents 24, 29, 33, and 36 are receiving blood glucose checks and insulin administration per physician orders. · Routine skin assessments are documented accurately for Resident 51. · Resident 36 received appropriate interventions to manage acute respiratory symptoms, and is being monitored for further respiratory symptoms. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents receiving blood glucose monitoring and insulin administration, receive routine skin monitoring, or have a change in condition have the potential to be affected by the alleged deficient practice. · An audit was completed by DNS and IDT to identify all residents that receive blood glucose monitoring and insulin administration to ensure orders have been followed. · An audit was completed by DNS and IDT to identify all residents with a change of condition to ensure appropriate follow up and MD notification has been completed.	

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			· All residents routine skin assessments were reviewed for accuracy by DNS and IDT. · All nursing staff have been educated by DNS/designee on the Change of Condition Policy which includes appropriate follow up assessments and MD notification. · All licensed nursing staff have been educated by DNS/designee on the Blood Glucose Monitoring Policy and Procedure which includes following physician orders and documentation. · All nursing staff have been educated by DNS/designee on the Skin Management Program which includes accuracy of routine skin assessments. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:** • All nursing staff have been educated by DNS/designee on the Change of Condition Policy which includes appropriate follow up assessments and MD notification. • All licensed nursing staff have been educated by DNS/designee on following Blood Glucose Monitoring Policy and Procedure which includes following physician orders and documentation. • All nursing staff have been educated by DNS/designee on the Skin Management Program which	

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			includes accuracy of routine skin assessments. · Audit of all medical records of current residents will be completed daily by DNS/designee to ensure any changes of condition receive appropriate follow up assessment and notification of MD. · Audit of all medical records of current residents will be completed daily by DNS/designee to ensure blood glucose monitoring and insulin administration are documented for all residents with these physician orders. · Audit of all medical records of current residents will be completed daily by DNS/designee to ensure to ensure that routine skin assessments accurately identify all skin impairment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: QA** DNS/designee will complete Change of Condition, Skin Management, and Diabetic Monitoring QA tools weekly for 8 weeks, monthly for 6 months and quarterly for 2 quarters. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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			Attachments: A, B, C, D, E, F, G May 29, 2022	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 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. Based on record review and interview, the facility failed to ensure insulin was administered and blood glucose levels were obtained and documented as ordered by the physician for 4 of 29 residents reviewed for Quality of Care. (Resident 24, 29, 33, and 36) Findings include: 1. The clinical record for Resident 24 was reviewed on 4/29/22 at 3:04 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus with hyperglycemia, chronic pancreatitis related to diabetes mellitus, and stage 3 chronic kidney disease. The Quarterly MDS (Minimum Data Set) assessment, dated 3/1/22, indicated the resident was cognitively intact and received insulin. The care plan, dated 11/6/19, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnoses of	F 0684	**F684** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Residents 24, 29, 33, and 36 are receiving blood glucose checks and insulin administration per physician orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents receiving blood glucose monitoring and insulin administration, have the potential to be affected by the alleged deficient practice. · An audit was completed by DNS and IDT to identify all residents that receive blood	05/29/2022

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	diabetes mellitus type 1. The interventions included, but were not limited to, document abnormal findings and notify MD (Medical Doctor), laboratory tests as ordered, medications as ordered, monitor blood sugars as ordered, and observe for symptoms of hyperglycemia and hypoglycemia. The physician's order, dated 1/3/22, indicated staff were to administer 20 units of Basaglar KwikPen insulin twice daily at 6:30 a.m. and 8:00 p.m. The physician's order, dated 7/12/21, indicated to administer insulin lispro three times daily at 6:30 a.m., 11:30 a.m., and 4:30 p.m., per sliding scale as follows: If blood sugar was less than 60, call MD. If blood sugar was 0 to 199, give 0 units. If blood sugar was 200 to 250, give 3 units. If blood sugar was 251 to 300, give 6 units. If blood sugar was 301 to 350, give 9 units. If blood sugar was 351 to 400, give 12 units. If blood sugar was greater than 400, give 15 units. If blood sugar was greater than 400, call MD. The physician's order, dated 11/4/19, indicated to perform a blood glucose level check as needed for signs or symptoms of hypoglycemia or hyperglycemia. The review of the MAR (Medication Administration Record) for January 2022 indicated the following: The order for insulin lispro sliding scale lacked documentation of blood glucose levels and administration of sliding scale insulin on January 1 at 11:30 a.m., January 2 at 11:30 a.m., January		glucose monitoring and insulin administration to ensure orders have been followed. · All licensed nursing staff have been educated by DNS/designee on following Blood Glucose Monitoring Policy and Procedure which includes following physician orders and documentation. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:** · All licensed nursing staff have been educated by DNS/designee on following Blood Glucose Monitoring Policy and Procedure which includes following physician orders and documentation. · Audit of all medical records of current residents will be completed daily by DNS/designee to ensure blood glucose monitoring and insulin administration are documented for all residents with these physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: QA** DNS/designee will complete the Diabetic Monitoring QA tools weekly for 8 weeks, monthly for 6 months and quarterly for 2 quarters. The results of this audit will be reviewed by the QAPI	

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	5 and 6 at 6:30 a.m., January 8 at 11:30 a.m., January 21 at 6:30 a.m., January 26 at 6:30 a.m. and 11:30 a.m., and January 29 at 6:30 a.m. The order for Basaglar KwikPen 20 units twice daily lacked documentation of administration of insulin or blood glucose levels on January 5 and 6 at 6:30 a.m., January 19 at 8:00 p.m., January 21 at both 6:30 a.m. and 8:00 p.m., January 26 at 6:30 a.m., January 27 at 8:00 p.m., and January 29 at 6:30 a.m. On January 3 at 6:30 a.m., the resident's blood glucose level was documented as 488 mg/dl (milligrams per deciliter) and he required 15 units of sliding scale insulin. The review of the MAR for February 2022 indicated the following: The order for insulin lispro sliding scale lacked documentation of blood glucose levels and administration of sliding scale insulin on February 19, 24, and 26 at 6:30 a.m. The review of the MAR for March 2022 indicated the following: The order for insulin lispro sliding scale lacked documentation of blood glucose levels and administration of sliding scale insulin on March 3, at 6:30 a.m., March 5 at 11:30 a.m., March 6 at 6:30 a.m., March 8 at 6:30 a.m., March 12 at both 6:30 a.m. and 11:30 a.m., March 17 at 4:30 p.m., and March 24 at 4:30 p.m. The order for Basaglar KwikPen 20 units twice daily lacked documentation of administration of insulin or blood glucose levels on March 1 at 8:00 p.m., March 3 at 6:30 a.m., March 6 at 6:30		Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Attachments: B, D, G May 29, 2022	

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	a.m., March 8 at 6:30 a.m., March 12 at 6:30 a.m., March 29 at 8:00 p.m., and March 31 at 8:00 p.m. On March 8 at 11:30 a.m., the resident's blood glucose level was 557 mg/dl and he required 15 units of sliding scale insulin lispro and an additional 10 units of NovoLog. The review of the MAR for April 2022 indicated the following: The order for insulin lispro sliding scale lacked documentation of blood glucose levels and administration of sliding scale insulin on April 6 at 6:30 a.m., April 15 at 6:30 a.m., April 16 at 11:30 a.m., and April 23 at 6:30 a.m. The order for Basaglar KwikPen 20 units twice daily lacked documentation of administration of insulin or blood glucose levels on April 6 at 6:30 a.m., April 8 at 8:00 p.m., April 15 at 6:30 a.m., April 23 at 6:30 a.m., April 26 at 8:00 p.m., and April 28 at 8:00 p.m. During an interview, on 4/29/22 at 10:43 a.m., LPN (Licensed Practical Nurse) 8 indicated Resident 24 received insulin. They monitored his blood glucose levels and had parameters to notify the physician of any blood glucose levels above 400 mg/dl or below 60 mg/dl. He was on sliding scale insulin, and it was to be administered per his sliding scale orders as required. During an interview, on 4/29/22 at 2:31 p.m., the Director of Nursing (DON) indicated if the MAR had a blank spot, it indicated missed medication administrations. Not administering insulin would cause the blood glucose level to raise. There			

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	should not be any holes on the MAR. 2. The clinical record for Resident 36 was reviewed on 4/16/22 at 1:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus with diabetic chronic kidney disease chronic kidney disease, stage 5, end stage renal disease, muscle weakness, coronary artery disease, obstructive sleep apnea, chronic diastolic (congestive) heart failure, hypertension, paroxysmal atrial fibrillation, acute and chronic respiratory failure with hypercapnia. The Quarterly MDS assessment, dated 12/17/21, indicated the resident was cognitively intact. The care plan, dated 7/16/21 and last revised 3/22/22, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The interventions included, but were not limited to, resident received Humalog QID (four times a day) and Lantus q HS (bedtime), diet as ordered, monitor intakes, and offer replacements for 50% or less consumption, document abnormal findings and notify the physician, laboratory tests as ordered, medications as ordered, monitor blood sugars as ordered and observe for symptoms of hypoglycemia: such as sweating, tremor, tachycardia, pallor nervousness, confusion, slurred speech, lack of coordination, and staggering gait. The physician's orders included the following: Humalog U-100 Insulin (insulin lispro) solution; 100 unit/mL per sliding scale; If blood sugar is less than 60, call MD. If blood sugar is 0 to 199, give 0 units. If blood sugar is 200 to 250, give 11 units. If blood sugar is 251 to 300, give 13 units.			

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	If blood sugar is 301 to 350, give 15 units. If blood sugar is 351 to 400, give 17 units. If blood sugar is greater than 400, give 20 units. If blood sugar is greater than 400, call MD. Subcutaneous, four times a day with a restart date of 3/7/22. Insulin glargine insulin pen; 100 unit/mL (3 mL) 25 units; subcutaneous at bedtime with a start date of 4/26/22. Insulin glargine insulin pen 100 units/ml 55 units subcutaneous four times a day with a start date of 12/13/21 and discontinue date 2/25/22. Humalog U-100 Insulin 100 units/ml 7 units subcutaneous, three times a day was restarted on 3/7/22. The clinical record lacked documentation indicating the resident's blood sugars and insulin were given as ordered on the following dates: Humalog 7 units three times a day was not given on: 1/5/22 at 6:30 a.m. 1/7/22 at 11:30 a.m. 1/15/22 at 11:30 a.m. 1/21/22 at 6:30 a.m. 1/22/22 at 11:30 a.m. 1/26/22 at 6:30 a.m. 1/29/22 at 11:30 a.m. 1/30/22 at 11:30 a.m. and 4:30 p.m. 3/8/22 at 6:30 a.m. 3/27/22 at 11:30 a.m. 4/8/22 at 4:30 p.m. 4/10/22 at 11:30 a.m. 4/11/22 at 11:30 a.m. 4/15/22 at 11:30 a.m. and 4:30 p.m. 4/18/22 at 4:30 p.m.			

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	4/19/22 at 4:30 p.m. 4/23/22 at 11:30 a.m. and 4:30 p.m. 4/25/22 at 4:30 p.m. Lantus insulin 55 units subcutaneous at bedtime was not given on 1/7/22 at 8:00 p.m. 1/17/22 at 8:00 p.m. 1/21/22 at 8:00 p.m. 2/4/22 at 8:00 p.m. Humalog administer per sliding scale was not given on: 1/5/22 at 6:30 a.m. 1/7/22 at 11:30 a.m. The resident blood sugar at 8:30 a.m. was 500 mg/dl. An order from the physician indicated to recheck the blood sugar in 1 hours. The clinical record lacked documentation the blood sugar was taken. 1/10/22 at 8:00 p.m. 1/11/22 at 8:00 p.m. 1/12/22 at 8:00 p.m. 1/12/22 at 6:30 a.m. 1/17/22 at 11:30 a.m. and 4:30 p.m. 1/21/22 at 6:30 a.m. 1/22/22 at 11:30 a.m. 1/29/22 at 11:30 a.m. 1/31/22 at 11:30 a.m. and 4:30 p.m. 2/2/22 at 11:30 a.m. 2/4/22 at 11:30 a.m. 2/4/22 at 11:30 a.m. 2/5/22 at 11:30 a.m. 2/6/22 at 11:30 a.m. 2/7/22 at 11:30 a.m. 2/8/22 at 4:30 p.m. and 8:00 p.m. 3/8/22 at 6:30 a.m. 3/9/22 at 8:00 a.m. 3/12/22 at 11:30 a.m. 3/15/22 at 8:00 a.m. 3/18/22 at 8:00 p.m.			

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	3/21/22 at 8:00 p.m. 3/22/22 at 11:30 a.m. and 4:30 p.m. 3/23/22 at 8:00 p.m. 3/24/22 at 8:00 p.m. 3/25/22 at 8:00 p.m. 3/27/22 at 11:30 a.m. and 8:00 p.m. 3/31/22 at 8:00 p.m. 4/10/22 at 11:30 a.m. 4/11/22 at 11:30 a.m. 4/15/22 at 11:30 and 4:30 p.m. 4/17/22 at 4:30 p.m. 4/23/22 at 11:30 a.m. and 4:30 p.m. 4/25/22 at 4:30 p.m. and 8:00 p.m. During an interview, on 4/29/22 at 1:39 p.m., LPN 8 indicated the resident's blood sugar before giving insulin. The blood sugar and insulin amount would be documented in the MAR. You would still chart in the MAR even if you did not give insulin. Each square on the MAR should be filled in and not left blank. If left blank that indicates the blood sugar was not taken and the insulin was not given. 3. The clinical record for Resident 33 was reviewed on 4/27/22 at 1:58 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, alcohol-induced chronic pancreatitis, dementia with behavioral disturbance, schizoaffective disorder, vitamin D deficiency, hereditary and idiopathic neuropathy, cognitive communication deficit. The Quarterly MDS assessment, dated 3/16/22, indicated the resident was severely cognitively impaired. The care plan, dated 7/13/16 and revised on 3/22/22, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to the use of glucose			

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	lowering medication and a diagnosis of diabetes mellitus. The interventions, dated 7/13/16, indicated to document abnormal findings and notify the MD. Monitor blood sugars as ordered. Observe for symptoms of hyperglycemia or hypoglycemia. The physician's orders included, but were not limited to the following: Insulin lispro insulin pen; 100 unit/mL; amount: per sliding scale; If blood sugar was less than 60, call MD. If blood sugar was 61 to 149, give 0 units. If blood sugar was 150 to 199, give 3 units. If blood sugar was 200 to 249, give 6 units. If blood sugar was 250 to 299, give 8 units. If blood sugar was 300 to 349, give 11 units. If blood sugar was 350 to 400, give 13 units. If blood sugar was greater than 400, give 13 units. If blood sugar was greater than 400, call MD. Subcutaneously four times a day 6:00 a.m., starting 1/28/20 and restarted on 1/10/21 and 7/25/21, open ended. Accucheck as needed for signs or symptoms of hyper or hypoglycemia. Notify MD if blood sugar was less than 60 or greater than 400 as needed, starting 1/28/20. The MAR lacked documentation of blood sugar readings and insulin administration on the following dates and times: 4/29/21 no reading at 8:00 p.m. 5/4/21 no reading at 8:00 p.m. 7/1/21 no reading at 8:00 p.m. 7/8/21 no reading at 8:00 p.m. 8/5/21 no reading at 8:00 p.m. 8/26/21 no reading at 8:00 p.m. 9/2/21 no reading at 8:00 p.m.			

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	155697	A. BUILDING 00 B. WING	04/29/2022

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	9/7/21 no reading at 8:00 p.m. 9/16/21 no reading at 8:00 p.m. 9/22/21 no reading at 8:00 p.m. 10/3/21 no reading at 6:00 a.m. 10/5/21 no reading at 8:00 p.m. 10/14/21 no reading at 6:00 a.m. or 8:00 p.m. 11/2/21 no reading at 8:00 p.m. 11/4/21 no reading at 8:00 p.m. 8/9/21 no reading at 8:00 p.m. 11/16/21 no reading at 8:00 p.m. 11/23/21 no reading at 8:00 p.m. 11/24/21 no reading at 8:00 p.m. 12/3/21 no reading at 8:00 p.m. 12/6/21 no reading at 4:30 p.m. 12/11/21 no reading at 11:30 a.m., or 8:00 p.m. 12/12/21 no reading at 6:00 a.m. 12/15/21 no reading at 11:30 a.m. 12/25/21 no reading at 8:00 p.m. 12/30/21 no reading at 8:00 p.m. 1/1/22 no reading at 11:30 a.m. 1/2/22 no reading at 11:30 a.m. 1/6/22 no reading at 8:00 p.m. 1/8/22 no reading at 11:30 a.m. 1/19/22 no reading at 8:00 p.m. 1/21/22 no reading at 8:00 p.m. 1/26/22 no reading at 6:00 a.m. or 11:30 a.m. 2/5/22 no reading at 4:30 p.m. 2/15/22 no reading at 8:00 p.m. 2/17/22 no reading at 4:30 p.m. or 8:00 p.m. 4/16/22 no reading at 11:30 a.m. 4/20/22 no reading at 6:00 a.m. 4/21/22 no reading at 8:00 p.m. 4/24/22 no reading at 6:00 a.m. 4/25/22 no reading at 6:00 a.m. or 8:00 p.m. 4/26/22 no reading at 8:00 p.m. 4/28/22 no reading at 8:00 p.m. During an interview, on 4/29/22 at 10:05 a.m., LPN 8 indicated the resident's blood sugars ran in the high 300s usually. She documented the			

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	blood sugars in the MAR. A box would pop up in the medication area, for the blood sugar readings. 4. The clinical record for Resident 29 was reviewed on 4/29/22 at 1:03 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with foot ulcer, diabetic neuropathy, and diabetic (poly) neuropathy. The Quarterly MDS assessment, dated 3/4/22, indicated the resident was cognitively intact. The care plan, dated 9/10/21, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to the use of glucose lowering medication and/or diagnosis of diabetes mellitus. The interventions included, but were not limited to, document abnormal findings and notify MD, laboratory tests as ordered, medications as ordered, and monitor blood sugars as ordered. The physician's orders included, but were not limited to the following: Insulin Lispro insulin pen; 100 unit/mL; amount: per sliding scale; If blood sugar was less than 60, call MD. If blood sugar was 61 to 149, give 0 units. If blood sugar was 150 to 199, give 3 units. If blood sugar was 200 to 249, give 6 units. If blood sugar was 250 to 299, give 8 units. If blood sugar was 300 to 349, give 11 units. If blood sugar was 350 to 400, give 13 units. If blood sugar was greater than 400, give 13 units. If blood sugar was greater than 400, call MD. Subcutaneously four times a day 6:00 a.m., starting 2/17/22 and was open ended. Accucheck as needed for signs or symptoms of hyper or hypoglycemia. Notify the MD if blood			

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	sugar was less than 60 or greater than 400 as needed, starting 9/22/21 and was open ended. The MAR lacked documentation of blood sugar readings and insulin administration on the following dates and times: 3/4/22 no reading at 6:00 a.m.,12:00 p.m. and 8:00 p.m. 3/7/22 no reading at 8:00 p.m. 3/8/22 no reading at 6:00 a.m. and 8:00 p.m. 3/12/22 no reading at 4:00 p.m. and 8:00 p.m. 3/14/22 no reading at 12:00 p.m. and 8:00 p.m. 3/18/22 no reading at 6:00 a.m. and 8:00 p.m. 3/21/22 no reading at 12:00 p.m. 3/22/22 no reading at 12:00 p.m. and 4:00 p.m. 3/24/22 no reading at 4:00 p.m. 3/26/22 no reading at 4:00 p.m. 3/30/22 no reading at 8:00 p.m. 4/1/22 no reading at 12:00 p.m. and 8:00 p.m. 4/7/22 no reading at 8:00 p.m. 4/8/22 no reading at 4:00 p.m. 4/10/22 no reading at 12:00 p.m. 4/11/22 no reading at 12:00 p.m. 4/12/22 no reading at 8:00 p.m. 4/15/22 no reading at 12:00 p.m. 4/17/22 no reading at 8:00 p.m. 4/18/22 no reading at 4:00 p.m. 4/19/22 no reading at 4:00 p.m. and 8:00 p.m. 4/23/22 no reading at 4:00 p.m. The Blood Glucose Monitoring policy, dated February 2015, was provided by the DON on 4/29/22 at 12:57 p.m. The policy included, but was not limited to, "... Residents who have a physician's order to obtain routine capillary blood glucose will have a physician's order specifying the blood glucose parameters requiring physician notification... The physician will be notified when the resident's blood glucose is outside the physician stated			

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	parameters or if the resident is experiencing signs or symptoms of high or low blood sugar... Blood glucose results will be documented on the Capillary Blood Glucose Monitoring Tool or on the medication administration record." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §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 new ulcers from developing. Based on, observation, record review, and interview, the facility failed to ensure interventions and assessments were implemented to prevent the development or worsening of new pressure ulcers for 1 of 4 residents reviewed for pressure ulcers, which resulted in the development of a stage III pressure ulcers to the residents right buttock. (Resident 51) Findings include: During an observation of wound care for Resident 51, on 4/28/22 at 9:45 a.m., the wound care nurse cleansed the wound to the resident's	F 0686	**F686** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Residents #51 is provided preventive treatments/measures based on identified risks to prevent further skin breakdown, and accuracy of routine skin assessments is ensured.	05/29/2022

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	right buttocks with normal saline and patted it dry. She applied Santyl to the open wound and packed the wound with gauze soaked in normal saline. She applied optifoam and covered it with a dressing. The wound was approximately the size of a quarter. Granulation tissue (healthy tissue) with no drainage or no foul odor covered the wound bed. The wound NP (Nurse Practitioner) indicated the wound continued to tunnel. The clinical record for Resident 51 was reviewed on 3/27/22 at 10:49 p.m. The diagnoses included, but were not limited to, dementia, malnutrition, muscle weakness, unspecified lack of coordination, dysphagia, and chronic obstructive pulmonary disease, The Quarterly MDS (Minimum Data Set) assessment, dated 3/25/22, indicated the resident was severely cognitively impaired. She required extensive assistance for bed mobility, extensive assistance with dressing and personal hygiene, and supervision with eating. The care plan, dated 11/1/21, indicated the resident was at risk for impaired skin integrity. Pressure ulcer to the right buttock. The interventions included, but were not limited to, assess for pain, treat as ordered, notify physician of unrelieved or worsening pain, assess wound weekly, documenting measurements and description, turn and reposition every 2 hours, encourage the resident to eat at least 75% (percent) of meals, incontinent care as needed, low air mattress on the bed, notify physician of worsening or no change in wound or for signs of infection, registered dietician to assess routinely, pressure reduction cushion in the wheelchair, supplements as ordered, and wound healing vitamins as ordered.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affected by the alleged deficient practice. ·All residents with potential to develop pressure wounds will have IDT review of orders and care plans for preventative measures for pressure ulcers. ·Skin assessments will be completed by DNS/designees to compare with most recent routine skin assessment to ensure accuracy. ·All nursing staff will be educated by DNS/designee on Skin Management Program Policy which includes the use of preventative measures for pressure ulcer development and accuracy of routine skin assessments **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · All nursing staff will be educated by DNS/designee on Skin Management Program Policy which includes the use of preventative measures for pressure ulcer development and accuracy of routine skin	

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	The Weekly Skin and Vital Signs Assessment, dated 10/27/21 and 11/5/21 indicated the resident's skin was warm, dry and pink, non-tenting and no edema. No open areas were documented. The IDT notes, dated 11/1/21, indicated a suspected deep tissue. A new wound with skin injury to the right buttock. The pressure wound was a stage III. The Wound Management Report, dated 11/1/21, indicated the resident had a stage III pressure wound to the right buttock. The length was 3cm (centimeters) in a head-to-toe direction. The width from side to side was 2.5 cm and the depth could not be measured at that time. The wound was covered by 75% granulation tissue and 25% yellowish slough. The surrounding tissue was dark purple or rusty discoloration, and the erythema was blanchable. Serous drainage was clear, amber in color and the thin and watery. The physician's order, dated 2/4/22 indicated the wound NP (Nurse Practitioner) to evaluate and treat, low air mattress check settings every shift, and weekly skin assessment. The physician's order, dated 12/2/21 and discontinued on 12/24/21, indicated staff were to cleanse the wound bed to the right buttock with wound cleanser, pat dry and apply medihoney to the wound bed and cover with a foam dressing. The physician's order, dated 2/16/22 and discontinued on 4/26/22, indicated staff were to apply Dakin's solution 0.125%, 1 application topical. Cleanse the wound to the right buttock		assessments. · DNS/designee will round each shift to ensure preventative measures for pressure ulcers are in place per plan of care for all at risk residents. · DNS/designee will review routine skin assessments for accuracy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: QA** DNS/designee will complete Skin Management QA tool weekly for 8 weeks, monthly for 6 months and quarterly for 2 quarters. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Attachments: C, D, F May 29, 2022	

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	with wound cleanser. The physician's order, dated 2/26/22 and discontinued on 4/12/22, indicated staff were to use Silverasorb apply to the wound bed and apply a dry dressing. The physician's order, dated 11/1/21 discontinued on 12/2/2, and 2/24/22 to 3/10/22, indicated staff were to apply Santyl ointment, 250 units/grams, 1 application topical, cleanse open area to the right buttock with normal saline, pat dry, and thick nickel amount of Santyl to wound bed, cover with foam dressing daily and as needed for soilage or dislodgement. The physician's order, dated 3/10/22 and discontinued on 3/17/22, indicated staff were to cleanse right buttock with normal saline, and pat dry. Apply Puracol Powder with Hydrogel to wound bed and cover with a dry dressing. The physician's order, dated 4/12/22 and discontinued on 4/26/22, indicated staff were to cleanse the right buttock with normal saline, and pat dry. Apply wound vac at 125mmhg. Apply white foam to undermining, followed by black foam to the wound base and track the pad to the hip. During an interview, on 4/28/22 at 9:45 a.m., the wound NP indicated the wound was slow to heal due to the resident's nutritional status, weight loss, smoking, and staying up in wheelchair. The wound was stable except for tunneling. She was unsure at this time what stage the pressure wound was on 11/1/21. Her wound care notes for 11/1/21 indicated the wound was a stage III when found.			

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	During an interview, on 4/29/22 8:32 a.m., the DON indicated resident 51 had a lot of issues going on health wise. Her Braden Scale for Predicting Pressure Sore on admission indicated the resident was at high risk for pressure wounds. The pressure wound should have been found and documented before it was found at a stage III. During an interview, on 4/29/22 at 10:00 a.m., the Wound Care Nurse Caroline LPN (Licensed Practical Nurse) indicated a pressure injury should be found before it's a stage III. On 11/5/21 the weekly skin assessment indicated the resident's skin was intact. The pressure wound was documented on 11/1/21 as a stage III. She indicated the skin assessments need to be accurate. The Skin Management Policy, dated 7/21, provided on 4/28/22 at 12:50 p.m., by the DON, included, but was not limited to, "...It is the policy of [Name of Corporation] to ensure that each 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 a resident with pressure ulcers receives necessary treatment and services, consistent with professional standard of practice, to promote healing, prevent infection, and prevent new ulcers from developing..." 3.1-40(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited			

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	range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure ROM (Range of Motion) devices were applied as recommended for 1 of 3 residents reviewed for Range of Motion. (Resident 34) Findings Include: During an observation on 4/25/22 at 1:06 p.m., Resident 34 was lying abed. His right hand was contracted, with a thick, yellow, scaly build up to the palm of the residents hand. The resident indicated he had a palm protector, he was supposed to use but couldn't get it on himself and had trouble getting anyone to put it on him. During an observation on 4/26/22 at 8:28 a.m., the resident was lying abed with no splint in place to his contracted right hand. During an observation on 4/27/22 at 1:54 p.m., the resident was lying abed with no splint in place	F 0688	**F688** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 34 no longer resides in the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** ·All residents with recommendations for splints have the potential to be affected by the alleged deficient practice. ·An audit was completed by DNS to identify all residents with recommendations for splints, to	05/29/2022

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	to his contracted right hand. During an observation on 4/28/22 at 9:03 a.m., the resident was lying abed with no splint in place to his contracted right hand. During an observation on 4/29/22 at 9:01 a.m., ., the resident was lying abed with no splint in place to his contracted right hand. The clinical record for Resident 34 was reviewed on 4/27/22 at 10:30 a.m. The diagnoses included, but were not limited to, lumbago with sciatica to the right side, spondylosis with radiculopathy, peripheral vascular disease, abnormal posture, hereditary and idiopathic neuropathy, need for assistance with personal care, muscle weakness, and chronic pain syndrome. The Significant Change MDS (Minimum Data Set) assessment, dated 3/14/22, indicated the resident was cognitively intact and did not identify any functional limitation in range of motion to the resident's upper extremities. The nurse's note, dated 2/18/22 at 12:15 p.m., indicated a Journey meeting had been held with hospice for the resident. His extremities had contractures. The nurse's note, dated 3/17/22 at 12:21 p.m., indicated a Journey meeting was held with hospice. Hospice had ordered a splint for the resident per his request, and had provided education to staff on donning and doffing the splint. The clinical record lacked documentation of any orders to don or doff the splint, to monitor the hand for any signs of skin breakdown, any		ensure that devices have physician orders, are care planned for use, and are currently using the device. ·All nursing staff have been educated by DNS/designee on splint use and policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · All nursing staff have been educated by DNS/designee on splint use and policy. · DNS/designee will complete daily audit to ensure residents utilizing splints have the devices available and are utilizing per order, with follow up notifications completed for any refusals. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: QA** DNS/designee will complete Range of Motion QA tool weekly for 8 weeks, monthly for 6 months and quarterly for 2 quarters. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Attachments: D, H, I	

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	refusals of care, education on refusal of the splint, or a care plan to address the resident's contractures and splint use or refusal. During an interview, on 4/28/22 at 11:12 a.m., LPN (Licensed Practical Nurse) 8 indicated she wanted to say the resident had a splint, she felt like he used to use one but she was not sure, she would have to check and see. During an interview, 4/28/22 at 11:57 a.m., Hospice Nurse 10 indicated the resident's arms were contracted. They had gotten a splint for him, and it should be in his room still. The resident had requested it, and then decided he didn't like it. During an interview, on 4/28/22 at 2:38 p.m., the RDCS (Regional Director of Clinical Services) indicated the resident should have had an order to place and remove the splint, and to monitor the skin. Any refusals of the splint should have been documented. During an interview, on 4/29/22 at 8:20 a.m., the DON (Director of Nursing), indicated they did not receive an order from hospice for donning or doffing the splint. If they had gotten an order, they should have had an order to don and doff the splint, to monitor the site for breakdown. The resident had not had been wearing the splint. 3.1-42(a)		May 29, 2022	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who			

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	155697	A. BUILDING 00 B. WING	04/29/2022

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	needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review, and interview, the facility failed to ensure interventions and assessments were implemented to prevent the development or worsening of respiratory symptoms for 1 of 3 residents reviewed for respiratory care. (Resident 36) Findings include: The clinical record for Resident 36 was reviewed on 4/26/22 at 1:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus, stage 5 chronic kidney disease, end stage renal disease, muscle weakness, coronary artery disease, obstructive sleep apnea, chronic diastolic (congestive) heart failure, hypertension, paroxysmal atrial fibrillation, acute and chronic respiratory failure with hypercapnia. The Quarterly MDS (Minimal Data Set) assessment, dated 12/17/21, indicated the resident was cognitively intact. The care plan, dated 3/22/22, indicated the resident was the resident was at risk for fluid imbalance due to decreased mobility, weakness, diabetes mellitus, congestive heart failure and chronic kidney disease. The interventions included, but were not limited to administer medications as ordered, document and notify physician of signs and symptoms of fluid volume deficit: dry mucous membranes, thirst, weight loss, decrease blood pressure, weak/rapid pulse,	F 0695	F-695 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 36 received appropriate interventions to manage acute respiratory symptoms, and is being monitored for further respiratory symptoms. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? · All residents with a change in condition have the potential to be affected by the alleged deficient practice. · An audit was completed by DNS and IDT to identify all residents with a change of condition to ensure appropriate follow up and MD notification has been completed. · All nursing staff have been educated by DNS/designee on the Change of Condition Policy which	05/29/2022

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	change in mental status, decreased urine output, abnormal labs, poor skin turgor, encourage fluids, labs as ordered, and record intake. The physician's orders indicated the resident was prescribed the following: - Pulmicort Flexhaler 180 mcg/actuation, 1 puff inhalation for acute and chronic respiratory failure with hypercapnia with a start date of 2/9/22 and a discontinue date of 2/25/22. - Pulmicort Flexhaler 180 mcg/actuation, 1 puff inhalation for acute and chronic respiratory failure with hypercapnia with a start date of 3/9/22. Replace Bipap/Cpap mask/nasal prongs, tubing, and filter every 3 months. The NP (Nurse Practitioner) progress notes, dated 2/4/22, indicated the resident was seen for evaluation related to reports of right lower leg swelling. He was currently on Bumex 2 (milligrams) daily. She would adjust the Bumex orders for 5 days and update laboratory tests following treatment. The nurse's note, dated 2/5/22 at 8:46 a.m., indicated the resident's entire body continued to be swollen. The resident complained of increased episodes of being short of breath. His oxygen saturations were ranging between 91 to 97% (percent on 2 lpm (liters per minute) per nasal cannula. The resident was encouraged to limit fluid and sodium intake. The nurse's note, dated 2/21/22 at 1:15 a.m., indicated the resident continued to have some shortness of breath. The head of his bed was elevated to facilitate with his breathing. His skin		includes appropriate follow up assessments and timely MD notification. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · All nursing staff have been educated by DNS/designee on the Change of Condition Policy which includes appropriate follow up assessments and timely MD notification. · DNS/designee will audit all medical records of current residents daily to ensure any changes of condition receive appropriate follow up assessments and MD notification. How the Corrective action(s) will be maintained to ensure the deficient practice will not recur: QA The DNS/designee will complete the Change of Condition CQI tool weekly for 8 weeks, monthly for 6 months and then quarterly for 2 quarters. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance Attachments: A, D, E May 29, 2022	

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	color was pallor, abdomen was extremely large in size, and his right leg was taunt and swollen. The resident does not get up out of bed much anymore due to difficulty breathing. The clinical record lacked documentation of other intervention or any respiratory assessments. The nurse's note, dated 2/23/22 at 7:00 p.m., indicated the nurse was summoned to the resident's room by the CNA (Certified Nurse Aide). Resident 36 complained of increased difficulty breathing. He had facial swelling and his eyes were shut due to the swelling. He was using his accessory muscles to breath. His O2 saturation ranged between 77 to 80% on 4 lpm per nasal cannula. Orders were received to send the resident to the local hospital due to possible respiratory failure. The NP progress notes, dated 3/9/22 at 12:39 p.m., indicated the resident was seen for an admission assessment after return from the local hospital due to fluid overload and chronic kidney disease. During an interview, dated 4/29/22 at 8:30 a.m., the DON (Director of Nursing) indicated the symptoms should have been addressed when there was a change in condition. The NP and family should have been called when the resident's symptoms worsened. The Resident Change of Condition Policy, dated 11/20/18, provided on 4/28/22 at 12:50 p.m., by the DON, included, but was not limited to, "... It is the policy of this facility that all changes in resident condition will be communicated to the physician and family responsible party, and that			

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	timely and effective interventions takes place..." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	periodically reconciled. Based on observation, record review and interview, the facility failed to ensure insulin pens were appropriately labeled and discarded upon expiration for 2 of 4 medication carts observed for medication storage. (Resident 29) Findings include: 1. During an observation on 4/27/22 at 11:13 a.m., LPN (Licensed Practical Nurse) 6 prepared to administer Resident 29's insulin aspart flexpen 100 units/mL (milliliters) per sliding scale, which had an open date of 2/18/22 on the pen. The pen expired on 3/28/22. LPN 6 had dialed the pen to 12 units when she was asked to check the expiration date. Upon seeing the date, she disposed of the flexpen in the sharps container and obtained the resident's unopened flexpen. The clinical record for Resident 29 was reviewed on 4/27/22 at 1:02 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with foot ulcer, diabetic neuropathy, and diabetic autonomic (poly)neuropathy. The Quarterly MDS (Minimum Data Set) assessment, dated 3/4/22, indicated the resident was cognitively intact. The care plan, dated 9/10/21 and last revised on 3/10/22, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The interventions, dated 9/10/21, included, but were not limited to, document abnormal findings and notify MD, labs as ordered,medications as ordered, monitor blood sugars as ordered, observe for symptoms of hyperglycemia.	F 0755	**F755** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Staff are following policy for expiration of insulin pens for Resident 29 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** ·All residents receiving insulin have the potential to be affected by the alleged deficient practice. ·An audit was completed by DNS and IDT to identify all residents receiving insulin to ensure all insulin devices are labeled with appropriate opened date and are within date parameters ·All licensed nursing staff were educated by DNS/designee on proper insulin pen storage, expiration and disposal. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · All licensed nursing staff were educated by DNS/designee on proper insulin pen storage,	05/29/2022

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	The current physician's orders included, but were not limited to, the following: Insulin aspart U-100 insulin pen; 100 unit/mL (3 mL); amount: per sliding scale; If blood sugar was less than 60, call MD. If blood sugar was 61 to 199, give 0 units. If blood sugar was 200 to 250, give 3 units. If blood sugar was 251 to 300, give 6 units. If blood sugar was 301 to 350, give 9 units. If blood sugar was 351 to 400, give 12 units. If blood sugar was greater than 400, give 15units. If blood sugar was greater than 400, call MD. subcutaneously four times a day, starting 2/17/22. Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); amount: 40 units; subcutaneously, twice a day, starting 4/13/22. The resident's blood sugars for March 2022 indicated an average range of 300 to 400 mg/dl. She received the insulin aspart 4 times daily from 3/29/22 to 4/26/22. The New Order Documentation, dated 3/1/22, indicated an increase of the Lantus to 40 units BID (twice daily), due to abnormal blood glucose. During an interview, on 4/27/22 at 11:13 a.m., LPN 6 indicated the resident's blood sugars were high and she always required insulin. 2. During an observation, on 4/27/22 at 11:22 a.m., an unlabeled Lantus insulin pen, with an open date of 3/24/22, was found in the Front Hall medication cart. The pen expired on 4/21/22. The insulin pen did not contain any pharmacy		expiration and disposal. ·DNS/designee will complete daily audit to ensure that insulin devices are labeled with appropriate opened date and are within date parameters. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur: QA** DNS/designee will complete the Medication Storage Review QA tool weekly for 8 weeks, monthly for 6 months and the quarterly for 2 quarters. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Attachments: D, J, K May 29, 2022	

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	labeling, resident information, or directions for use. During an interview, on 4/27/22 at 1:33 p.m., the RDCS (Regional Director of Clinical Services) indicated she could not locate which resident the Lantus belonged to. They could have been discharged from the facility. The General Dose Preparation and Medication Administration policy, last revised on 1/1/13, was provided by the Regional Director of Clinical Support on 4/27/22 at 1:10 p.m. The policy included, but was not limited to, "... 3.3 Facility staff should not administer a medication if the medication or prescription label is missing or illegible... Facility staff should verify that the medication name... 4. Prior to administration of medication, facility staff should take all measures required by facility policy... Check the expiration date on the medication..." The Insulin Storage Recommendations, copyrighted 2021, was provided by the RDCS on 4/27/22 at 1:32 p.m. The insulin Aspart indicated an open expiration period of 28 days. The Lantus insulin had an open expiration period of 28 days. 3.1-25(k) (1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(5) 3.1-25(o)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.			

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	§483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			

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	Based on record review and interview, the facility failed to ensure dental services were obtained in a timely manner for 1 of 3 residents reviewed for dental services. (Resident 24) Findings include: The clinical record for Resident 24 was reviewed on 4/27/22 at 10:00 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus and need for assistance with personal care, depressive episodes. The Significant Change MDS (Minimum Data Set) assessment, dated 2/1/22, indicated the resident was cognitively intact and had obvious or likely cavity or broken teeth. During an interview, on 4/25/22 at 11:09 a.m., Resident 24 indicated he had several missing teeth and couldn't get treatment because the facility told him he had the wrong insurance. He was supposed to be getting dentures for three years now. At one point he'd been in the dentist chair, about to have surgery, and they had to take him out because they couldn't get the insurance cleared. The nurse's note, dated 9/24/20 at 10:47 a.m., indicated the resident was seen on 9/22/20 by the dentist and had new orders for extractions. A call was placed to the oral surgeon for an appointment. The dental exam, dated 2/12/21, indicated a referral had been placed for extractions, however with the pandemic the resident had not been able to go. The SSD (Social Services Director) thought he would be able to at some point. Extractions were indicated on teeth 4, 5, 9, 10,	F 0791	**F791** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 24 will have an appointment made to outside dental office for consultation to have teeth extracted as listed by in house dental referral. · Resident 24 has appointment made to see oral surgeon on 6/1/22; resident and/or family notified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affected by the alleged deficient practice. · Audit completed by SSD of all residents in facility to identify immediate dental needs. · All staff educated by SSD/designee on Dental Services policy which includes addressing immediate dental needs. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · All staff educated by SSD/designee on Dental Services	05/29/2022

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	11, 12, 14, 21, 22, 23, 25, 26, 27, and 31. Teeth 2, 3, 8, 19, 20, 4, and 28 would remain and appliances would be fabricated after healing was complete. The nurse's note, dated 2/15/21 at 10:47 a.m., indicated the resident was seen on 2/12/21 by the dentist and the oral surgeons appointment was rescheduled for 4/19/21. The nurse's note, dated 4/19/21 at 4:19 p.m., indicated the resident returned from the dental appointment and his extractions had been unable to be completed because of issues with billing. The resident was open to being removed from the facilities dental program and seeing an outside dentist if necessary. The facility would continue to assist. The dental exam, dated 10/25/21 indicated the resident had root tips present on 4, 5, 9, 10, 11, 12, 14, 21, 22, 23, 25, 26, 27, and 31. His oral hygiene was poor. The resident had natural teeth with poor oral health and several root tips remaining. No pain or infection at the time. The recommendation indicated to continue 6 month exams, and refer to oral surgeon for extractions. The clinical record lacked documentation of any efforts by the facility to assist the resident with his insurance or dental extractions at this time. The dental exam note, dated 3/4/22, indicated the patient had a significant number of broken teeth he would like extracted so he could eat better with dentures. The SSD requested referral for office. A referral was submitted. During an interview, on 4/28/22 at 9:39 a.m., Unit Manager 7 indicated the SSD had given her a		policy which includes addressing immediate dental needs. · SSD/designee will complete daily audit of Facility Activity Report to ensure residents' dental needs are addressed. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur: QA** SSD/Designee will complete the Dental Services QA Tool weekly for 8 weeks, monthly for 6 months and quarterly for 2 quarters. The results of these audits will be reviewed by the QAPI Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Attachments: D, L, M May 29, 2022 -	

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	referral for the resident to have extractions on 3/4/22. They tried to call the Oral Surgeon but he said they could not see the resident until his insurance was changed. During an interview, on 4/28/22 at 9:44 a.m., the SSD indicated she had only been the SSD since January of 2022, and was not aware the resident had extractions ordered back in 2020. She was aware of issues with billing and his extractions. His insurance had prevented him from billing for extractions. The Dental Services/Missing Dentures Policy, last revised 9/2017, provided on 4/28/22 at 11:30 a.m. by the RDCS (Regional Director of Clinical Services), included, but was not limited to, "... Policy... The facility obtains needed dental services, including routine and emergency dental services; assists in providing these services and makes prompt referrals for dental services as needed... 1. The facility will obtain contracted outside dental services to meet the routine and emergency dental needs of each resident..." 3.1-24(a)(3)			