STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175464	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES INDEPENDENCE	**1000 MULBERRY, PO BOX 627 INDEPENDENCE, KS 67301**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents, with 24 residents with blood sugar monitoring and three residents sampled for review. Based on interview and record review, the facility failed to notify the resident's physician when the resident had a high glucose reading from 06/19/2020 to 06/22/2020. Findings include: - The signed Physician order [REDACTED].) The Annual/Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. The resident's functional status was documented as the resident required total assistance with eating He required a feeding tube that included 50% or more of calories and 501 cubic centimeter (CC) of fluids. The Activity of Daily Living Functional/Rehabilitation Care Area Assessment (CAA), dated 06/01/2020, R1 was alert and oriented to person, place, time and situation. He had a BIMS score of 15. Resident was admitted to the hospital with [REDACTED]. He was totally dependent upon staff for nutrition via Percutaneous endoscopic gastrostomy (PEG) tube (a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.) The Discharge MDS, dated [DATE], documented the resident had unplanned admission to an acute hospital. The Care Plan for Diabetes Mellitus with uncontrolled blood sugars, dated 05/25/2020, instructed staff R1 was to have blood sugar tested five times a day. Fax (blood sugar) BS to Primary Care Physician (PCP) daily every night shift after last feeding of the night. Updated 06/22/2020 instructed to notify the PCP if blood sugar is below 70 or above 350. Monitor blood sugars as ordered and report any unusual fluctuations to the physician. Observe for signs and symptoms (excessive thirst, excessive appetite, excessive voiding, altered level of consciousness, mood changes, excessive perspiration, weight changes, circulatory changes) of hypo/[MEDICAL CONDITION] and report changes to charge nurse and physician as needed. Review lab results and notify physician of any abnormalities. On 06/19/2020, R1 was seen by the PCP. Review of the clinical records revealed there was a new order for BS to be checked five times a day, every third day for one month. On Friday, 06/19/2020 at 23:05 PM, the resident's BS was High, as indicated on the glucometer, that indicated the resident's blood sugars was over 600. On Saturday, 06/20/2020 at 06:56 AM, LN G performed the resident's blood glucose test. The glucometer indicated High. At 07:05 AM, she faxed the blood glucose reading to the physician. Staff lacked telephone notification of the high blood glucose. Review of the clinical record lacked telephone notification to the physician when staff were aware of the resident's elevated blood sugars after two high readings on 06/19/2020 at 23:05 PM and on 06/20/2020 at 07:00 AM. The next time the blood sugar was checked was on 06/22/2020 at 08:05 AM, two days later, when blood sugars continued to read High until On 07/27/2020 at 09:17 AM, LN H stated when a glucometer read High, this meant the resident's blood sugar was over 600. When a blood sugar is out of parameters, the expectation would be to call and notify the physician with the change of condition. On 07/27/2020 at 12:30 AM, Administrative Nurse D stated it would be her expectation that the physician be notified by phone and not faxed when blood sugars are out of parameters. On 07/28/2020 at 10:13 AM, Consultant Staff GG stated his expectation was for staff to notify him, by phone, with any blood sugars out of parameters. The facility's Diabetic Hypo/Hyperglycemic Protocol, revised 12/2017, documented if a resident has a blood sugar greater than 400 mg/dl, or physician ordered parameters, the physician would be notified. The Procedure for an Elevated Blood Sugar included to Contact the physician for additional orders if blood sugar remained above 400 mg/dl. If the resident does not have an order for [REDACTED]. The resident became lethargic and the physician ordered for him to be transferred to local hospital for treatment of [REDACTED]. All diabetic residents were audited to ensure parameters were in place. Emergency Quality Assurance Performance Improvement (QAPI) meeting held to review action plan including education completed and audits. Audits will be completed on all diabetic residents to ensure parameters and physician notifications are being followed. Residents care plan has been reviewed and updated.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents, with 24 residents with blood sugar monitoring and three residents sampled for review. Based on interview and record review, the facility failed to monitor and report blood sugars that were out of parameters for Resident (R) 1. The facility placed the resident in immediate jeopardy when the glucometer (instrument used to calculate blood glucose) panel read High, which indicated a blood sugar (BS) over 600 mg/dl (milligrams/deciliter) from 06/19/2020, until R1 was sent to the hospital on [DATE] at 12:15 PM for treatment of [REDACTED]. Ketosis is the accumulation of substances called [MEDICATION NAME] and [MEDICATION NAME] bodies in the blood. Acidosis is increased acidity of the blood.) and septic shock (a condition sometimes occurring in [MEDICAL CONDITION], in which the blood pressure falls and the organs of the body fail to receive sufficient oxygen). Findings include: - The signed Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required total assistance with eating. He required extensive two-person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. He required a feeding tube (a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) that included 50% or more of his calories and 501 cubic centimeter (CC) of fluids. The Activity of Daily Living Functional/Rehabilitation Care Area Assessment (CAA), dated 06/01/20, revealed R1 was alert and oriented to person, place, time, and situation. He had a BIMS score of 15. The resident was in the hospital with a [DIAGNOSES REDACTED]. He had a feeding tube placed while in the hospital and received nothing by mouth. R1 needed extensive assistance for bed mobility, transfers with use of a sit to stand lift, wheelchair locomotion, dressing, toilet use, and personal hygiene. He was totally dependent upon staff for nutrition via a feeding tube. The Discharge MDS, dated [DATE], documented the resident had an unplanned admission to an acute hospital. The Care Plan for diabetes mellitus with uncontrolled blood sugars, dated 05/25/20, instructed staff to test R1's blood sugar five times a day and directed staff to fax the BS (blood sugar) to his Primary Care Physician (PCP) daily every night shift after the last feeding of the night. Updated 06/22/20, instructed staff to notify the PCP if the blood sugar was below 70 mg/dl or above 350 mg/dl. Monitor blood sugars as ordered and report any unusual fluctuations to the physician. Observe for signs and symptoms (excessive thirst, excessive appetite, excessive voiding, altered level of consciousness, mood changes, excessive perspiration, weight changes, circulatory changes) of hypo/[MEDICAL CONDITION] and report changes to the charge nurse and physician as needed. On 06/19/20, R1 was

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) seen by the PCP. Review of the clinical records revealed there was a new order for staff to check his BS five times a day, every third day for one month. Review of Faxes sent to the PCP revealed on Friday 06/19/20 at 12:20 AM, Licensed Nurse (LN) G faxed the physician the resident's blood sugars as follows: At 09:23 AM, the resident's BS was 153 mg/dl. At 12:02 PM, the resident's BS was 194 mg/dl. At 08:55 PM, the resident's BS was 340 mg/dl. At 11:05 PM, the resident's BS was High, on the glucometer, that indicated the resident's blood sugar was over 600 mg/dl. On 06/20/20 at 06:56 AM, LN G performed the resident's blood glucose test. The glucometer indicated High. At 07:05 AM, she faxed the blood glucose reading to the physician. The record lacked telephone notification of the high blood glucose. Review of the Clinical Record lacked documentation of follow up blood sugars and assessments related to elevated blood sugars after two high readings on 06/19/20 at 11:05 PM and on 06/20/20 at 07:00 AM. The next time staff checked the blood sugar was on 06/22/20 at 08:05 AM, two days later, when blood sugars continued to read High. On 06/22/20 at 08:26 AM the physician ordered the following: 1. [MEDICATION NAME], 50 units, one time for BS reading of High. 2. Obtain BS before every tube feeding. 3. Fax BS to the physician daily. On 06/22/20 at 10:30 AM, a Nurse's Note recorded the BS reading was High. On 06/22/20 at 10:37 AM, the physician ordered [MEDICATION NAME] 50 units subcutaneous one time only and to hold the resident's tube feeding. On 06/22/20 at 12:15 PM, the Nurse's Progress Note documented R1 transferred to the hospital, related to high blood sugars and lethargy (altered level of consciousness). On 06/22/20, the Facility Investigation documented LN G stated she had taken two BS readings on her shift and both read High on the glucometer. The medical records from the Emergency Department Record documented on 06/22/2020 at 12:28 PM, R1 arrived at the emergency department with [DIAGNOSES REDACTED]. Presenting complaint included the sending facility checked the resident's blood sugar this morning, the first reading was high and he was given 50 units of [MEDICATION NAME]. Rechecked blood sugar at 11:30 AM also read high. They gave 50 units of [MEDICATION NAME]. The resident was typically alert, oriented, and able to transfer himself. He was not able to talk or transfer himself at this time. Emergency Medical System (EMS) personnel stated he was not alert and unable to do a stroke scale (a tool used by healthcare providers to objectively quantify the impairment caused by a stroke). His blood sugar read high and unable to give a number. The resident appeared ill, was lethargic, and oriented to nothing. He received Regular 10 units of insulin and then started an insulin intravenous (IV) drip. On 07/27/20 at 09:17 AM, LN H stated when a glucometer read High, this meant the blood sugar was over 600 mg/dl. When a blood sugar was out of parameters, the expectation would be to call the physician with the results. On 07/27/20 at 12:30 AM, Administrative Nurse D stated it was her expectation that the physician be notified by phone and not faxed with out of parameter blood sugars. On 07/28/20 at 10:13 AM, Physician GG stated his expectation was for staff to notify him, by phone, with any blood sugars out of parameters The facility's Diabetic Hypo/Hyperglycemic Protocol, revised 12/17, documented if a resident had a blood sugar greater than 400 mg/dl, or out of range of physician ordered parameters, the physician would be notified. The procedure for an elevated blood sugar included to contact the physician for additional orders if blood sugar remained above 400 mg/dl. If the resident does not have an order for [REDACTED]. The resident became lethargic and the physician ordered for him to be transferred to local hospital for treatment of [REDACTED]. Failure to closely monitor and notify the physician of the elevated blood sugars increased the resident's likelihood of a serious outcome of diabetic coma. The deficient practice cited as past non-compliance on 06/22/20 at 04:00 PM when the facility completed the following: Immediate nursing education completed for proper notification, following blood sugar parameters [MEDICAL CONDITION] education. All diabetic residents were audited to ensure parameters were in place. Emergency Quality Assurance Performance Improvement (QAPI) meeting held to review action plan including education completed and audits. Audits will be completed on all diabetic residents to ensure parameters and physician notifications are being followed. Residents care plan has been reviewed and updated.