STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366443	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELPRE LANDING NURSING AND REHABILITATION	1915 HILL STREET BELPRE, OH 45714

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 0684 **Level of harm** - Minimal harm or potential for actual harm **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** Based on closed medical record review and interview the facility failed to provide adequate care and services to ensure diabetes management including the administration of medications and blood glucose monitoring was completed timely following admission and failed to effectively implement the facility policy and procedure related to an incident of [MEDICAL CONDITION] for Resident #200 who was assessed to have an elevated blood glucose level of 564. This affected one resident (#200) of three residents reviewed for quality of care and treatment. Findings include: Review of Resident #200's closed medical record revealed the resident was admitted to the facility on [DATE] at 2:45 P.M. and discharged from the facility to the hospital on [DATE] at 6:18 P.M. The resident did not return to the facility following this hospitalization . The resident had [DIAGNOSES REDACTED]. Review of the admission packet paperwork, dated 07/24/20 revealed orders were verified with the physician on 07/24/20 at 3:00 P.M. physician's orders [REDACTED].M. and 6:00 P.M. The resident also did not receive the insulin regular human solution 100 units/ml 22 unit sq before her dinner meal on the evening of admission on 07/24/20. Accucheck (blood (sugar) glucose) monitoring was ordered four times daily before meals and at bedtime. Record review revealed no evidence the resident's accucheck was completed on 07/24/20 before the dinner meal as ordered. Review of the care plan, dated 08/06/20 revealed the resident was at risk for hyper/hypoglycemic episodes related to type two diabetes mellitus. The goal was for the resident to be free of hypo/[MEDICAL CONDITION]. Interventions included to be alert to medications that may cause changes in blood sugar (i.e. steroid therapy, some antibiotic therapies), blood sugar as needed for symptoms of hyper/[DIAGNOSES REDACTED], diet as ordered, follow facility procedures for hypo/[MEDICAL CONDITION] episodes, insulin as ordered, monitor blood sugar as ordered, monitor meal intake and oral hypoglycemics as ordered. On 08/18/20 at 1:30 P.M. interview with the Director of Nursing (DON) confirmed the resident's orders were verified with the physician on 07/24/20 at 3:00 P.M. The DON revealed she was the one who entered the new orders into the computer for Resident #200 at the time of her new admission. She stated she just noticed that in their computer system, if you put orders in after a certain time, orders to be given that day do not show up until the next scheduled dose which was the A.M. dose on 07/25/20. The DON revealed the order for insulin was entered in the computer at 4:46 P.M., [MEDICATION NAME] was entered into the computer at 5:24 P.M. and the accucheck order was entered into the computer at 5:48 P.M. She said therefore the insulin, [MEDICATION NAME] and accucheck did not show up for the nurse to give at the time of the dinner meal on 07/24/20. She confirmed the accucheck was not completed as ordered, insulin was not given as ordered and the [MEDICATION NAME] was not given as ordered. At the time of the interview, the DON revealed the medications were available in the facility (contingency stock) to be given and it was just that they didn't show up on the Medication Administration Record [REDACTED].M. revealed the resident complained of slurred speech, requesting to go to the emergency room . Blood sugar was 564 (elevated), temperature 99.3, blood pressure 160/78, pulse 94 beats per minute, respirations 24 per minute and oxygen saturation 91% on room air. The note indicated the nurse practitioner text. 911 called. Report called to emergency room . Message left for sister to call. The note indicated the resident left the facility at 6:30 P.M. The resident did not return to the facility after being sent to the hospital. On 08/18/20 at 1:56 P.M. during an interview with the administrator, the administrator was asked to verify Resident #200 did not receive her scheduled [MEDICATION NAME] and insulin or accucheck on 07/24/20 following her admission. The administrator verified the medications were not administered and accucheck not completed because the computer kicked it to the next does due to the time the medications were entered into the computer system and the nurse would not have been able to see that these medications and monitoring were due the evening meal on 07/24/20. The administrator also confirmed these medications were available in the facility. When asked if the physician was notified the medications were not given, she stated no. When asked if there was any additional information related to LPN #2 sending a text message to the nurse practitioner regarding the resident on 07/25/20, the administrator revealed there was no evidence. On 08/18/20 at 2:39 P.M. telephone interview with Nurse Practitioner #1 revealed she was not contacted by LPN #2 on 07/25/20 regarding Resident #200's high blood sugar or that the resident was going to the emergency department. She said in fact, she was reviewing notes the day after this incident on 07/26/20 and saw this nurse had documented she text me. However, she did not. She stated she sent a message to the DON to notify her she saw this in the progress notes and she wanted her to know the nurse didn't text her about this incident. She stated the nurses were supposed to be using a system called third eye on the weekends and after hours. When asked what third eye was, she stated this was a group of physicians who were on call and Belpre Landing had an iPad that was used for telemedicine after hours. She stated this nurse had text her earlier that day (07/25/20) for a different resident and she stated she didn't respond because she was not supposed to be contacting her. She stated the DON responded that she would take care of it. On 08/19/20 at 12:21 P.M. interview with Licensed Practical Nurse (LPN) #2 revealed she was the nurse caring for Resident #200 on 07/25/20 at the time she had the change in condition/elevated blood sugar. The LPN stated she told the resident she was going to call the physician and get some orders and the resident stated that never worked, she didn't want it. The LPN revealed the resident stated she wanted to go to the emergency room and wouldn't let her do anything for her. The LPN revealed when she told the resident she was going to get an order for [REDACTED]. When asked what she text her and/or what the nurse practitioner's response was, (if any) no additional information was provided. There was no evidence the facility provided any type of treatment for [REDACTED]. The facility policy and procedure for [MEDICAL CONDITION] (ketoacidosis), dated 01/18/01 and revised 04/2002 revealed the purpose was to outline and maintain the facility's procedure as it related to [MEDICAL CONDITION] (ketoacidosis/random blood sugar greater than 200). The responsibility of licensed staff included the prevention of [MEDICAL CONDITION], 1. Provide insulin or oral hyperglycemic agent as ordered. 2. Ensure resident/patient was following prescribed diet. 3. Observe resident/patient more closely for and report to physician, any signs of infection, vomiting, diarrhea or other physiologic stresses. 4. Be aware of signs and symptoms including thirst, anorexia, vomiting, abdominal pain, headache, listlessness, hot, dry flushed appearance and visual disturbances. In the event of ketoacidosis and coma: 1. Obtain vital signs and perform a blood sugar fingerstick, 2. Notify physician STAT and follow orders as prescribed. 3. Notify Director of Nursing, 4. Notify family of resident's status. This deficiency substantiates Complaint Number OH 915.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review and interview the facility failed to maintain complete and accurately documented

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) medical records for Resident #200. This affected one resident (#200) of three sampled residents. Findings include: Review of Resident #200's closed medical record revealed the resident was admitted to the facility on [DATE] at 2:45 P.M. and discharged to the hospital on [DATE] at 6:18 P.M. The resident did not return to the facility following the transfer to the hospital. The resident had [DIAGNOSES REDACTED]. Review of a nursing progress note, dated 07/25/20 at 6:10 P.M. revealed the resident complained of slurred speech, requesting to go to the emergency room . The resident's blood sugar was elevated at 564. The progress note revealed Nurse Practitioner text. 911 called. Report called to emergency room . Message left for sister to call. The note indicated the resident left the faciity on [DATE] at 6:30 P.M. Review of the nursing progress note revealed no documentation related to what the nurse practitioner text included and/or whether there was any reply back from the nurse practitioner. On 08/18/20 at 1:30 P.M. interview with the Director of Nursing (DON) revealed she had spoken to Licensed Practical Nurse (LPN) #2, who was the nurse caring for Resident #200 on 07/25/20 at the time she was sent to the hospital. The DON revealed staff always notified her whenever anyone was sent out. The DON stated the LPN told her she offered to call the physician or nurse practitioner and said the resident requested to be sent out. She stated the nurse told her the resident had been snacking and reported she was eating most of the day. She stated the resident stated we would not be able to get her blood sugar down. She confirmed the nurse had not documented the resident refused insulin or why she wanted to go to the emergency department or that the resident was continually eating all day. In addition, the DON also confirmed the LPN did not document what she notified the nurse practitioner of via text, what the nurse practitioner advised her to do or if she even had a response back from the nurse practitioner. On 08/18/20 at 1:56 P.M. during an interview with the administrator, the administrator was asked if there was any evidence LPN #2 text the nurse practitioner including the date/time and what she notified her about. The administrator revealed there was no evidence of the text message. On 08/18/20 at 2:39 P.M. interview with Nurse Practitioner #1 revealed she was not contacted by LPN #2 regarding Resident #200's high blood sugar or that the resident was going to the emergency department on 07/25/20 She said in fact, she was reviewing notes the day after this incident on 07/26/20 and saw this nurse documented she had text her, when in fact she had not. The nurse practitioner stated she sent a message to the DON to notify her she saw this in the progress notes and she wanted her to know the nurse didn't text her about this incident. She stated the DON responded she would take care of it. On 08/18/20 at 2:03 P.M. during an interview with the DON, administrator the LPN #2, the staff were asked why these interviews were so different, the nurse documented she notified the nurse practitioner via text, the nurse practitioner stated she did not receive a text from this nurse about this resident, the nurse practitioner stated she had notified the DON about the discrepancy at the time she saw the note, the DON did not mention this when questioned earlier and stated the LPN had text the nurse practitioner. LPN #2 stated she did text the nurse practitioner and would not have documented that if she hadn't. She stated she thought she used her personal phone to text her but no longer had any evidence of this because her phone always indicated she didn't have enough room so she couldn't keep messages very long. The DON then stated she remembered the nurse practitioner sending her a message that she didn't feel it was appropriate for the nurses to document they text her because that didn't mean she actually got the message or was notified but didn't remember her informing her LPN #2 documented she text her but actually didn't. She stated she educated her staff not to use the word text and instead to document the nurse practitioner was notified. She stated she may have missed the part about the nurse not notifying her. During a follow up interview on 08/19/20 at 8:49 A.M. the DON stated she went back and looked at what the nurse practitioner notified her of and there was a sentence in the message that she had not received notification from LPN #2 as the nurse documented but she didn't see that at the time. On 08/19/20 at 12:21 P.M. interview with Licensed Practical Nurse (LPN) #2 revealed she was the nurse caring for Resident #200 on 07/25/20 at the time she had the change in condition/elevated blood sugar. The LPN stated she told the resident she was going to call the physician and get some orders and the resident stated that never worked, she didn't want it. The LPN revealed the resident stated she wanted to go to the emergency room and wouldn't let her do anything for her. The LPN revealed when she told the resident she was going to get an order for [REDACTED]. When asked what she text her and/or what the nurse practitioner's response was, (if any) no additional information was provided. This deficiency is an incidental finding to Complaint Number OH 915.