STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175235	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF LARNED	**1114 W 11TH STREET LARNED, KS 67550**

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 49 residents with 13 sampled including one for PASRR (Pre-Admission Screening and Resident Review). Based on observation, interview, and record review the facility failed to follow the recommendations of the Level II PASRR for Resident (R) 15 which recommended instruction and education on R15's medication administrations. Findings included: - Review of R15's Physician order [REDACTED]. have low self-esteem and an overall feeling of inadequacy), and nightmare disorder (which often portray the individual in a situation that jeopardizes their life or personal safety). Review of the Significant Change Minimum Data Set ((MDS) dated [DATE] documented R15 with a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS noted R15's [DIAGNOSES REDACTED]. The resident received antianxiety and antidepressant medications daily during the seven day look back period. Review of the Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/26/19 documented staff were to monitor, document, and report as needed any changes in cognitive function, specifically changes in: the residents decision making ability, memory, recall and general awareness, difficulty expressing herself, difficulty understanding others, level of consciousness, or mental status. The staff would cue, reorient, and supervise the resident as needed. The Activities of Daily Living (ADL) function/Rehabilitation Potential CAA dated 12/26/19 documented the nursing staff were to continue to assist the resident with ADLs and allow the resident to do what she could for herself. Review of the Care Plan dated 02/19/20 documented R15 required extensive assistance of one to two staff with all ADL's. The staff were to administer her medications as ordered. The care plan lacked any mention of training on medication administration or side effects. Review of R15's PASRR determination letter dated 11/15/18 documented the facility were to educate the resident on her medication regimen, the need for each medication, the impact it had on her health and mental health, and the impact that occurred when it was not taken as prescribed. Observation on 03/03/20 at 08:26 AM revealed Certified Medication Aide (CMA) M administered R15's medication with no instruction or education to R15 regarding the administered medications. On 03/03/20 at 08:31 AM CNA N revealed she had no knowledge of any training needed for the resident. On 03/03/20 at 11:02 AM CMA M stated she did not teach the resident about medications and said most of the time R15 just took them without asking any questions. On 03/04/20 at 08:47 AM Licensed Nurse (LN) H stated she did nothing with PASRRs. She stated she saw them in some of the resident's charts but never had anything to do with obtaining them. On 03/04/20 at 08:49 AM Social Services staff X confirmed the facility had not initiated the recommendations from the above mentioned PASRR letter. On 03/04/20 at 08:53 AM Administrative Staff A confirmed the facility missed implementing the recommendations from the above mentioned PASRR letter. Administrative Staff A stated he expected the facility to address the recommendations of each PASRR letter. The facilities undated PASRR requirements policy documented the PASRR was completed to determine provision of appropriate and needed services to individuals who have been diagnosed with [REDACTED].each center should follow the PASRR and Level II state specific requirements. The facility failed to incorporate the recommendations from the PASRR level II determination letter into R15's care plan to include education on medication administration and side effects of those medications.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 49 residents with 13 sampled including one for PASRR (Pre-Admission Screening and Resident Review). Based on interview and record review the facility failed to renew in a timely manner the PASRR determination letter for Resident (R) 15. Findings included: - Review of R15's Physician order [REDACTED]. have low self-esteem and an overall feeling of inadequacy), and nightmare disorder (which often portray the individual in a situation that jeopardizes their life or personal safety). Review of the Significant Change Minimum Data Set ((MDS) dated [DATE] documented R15 with a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS noted R15's [DIAGNOSES REDACTED]. The resident received antianxiety and antidepressant medications daily during the seven day look back period. Review of R15's PASRR determination letter dated 11/15/18 documented it had been determined that you would benefit from a temporary stay of 12 months in order to better meet your care needs. Should you get to the end of your temporary stay period and it appears you will need more time, another assessment will be needed. Your nursing facility must contact KDADS (Kansas Department for Aging and Disabilities) care manager.The assessment and this letter are valid for 12 months from the date of this letter. On 03/04/20 at 08:48 AM Licensed Nurse (LN) G stated she did nothing with PASRRs. On 03/04/20 at 08:49 AM Social Services staff X confirmed the facility had not renewed the above mentioned PASRR letter. She stated she currently had no way of tracking the renewals but would put one in place. On 03/04/20 at 08:53 AM Administrative Staff A stated he expected the facility to address the recommendations of each PASRR letter. The facilities undated PASRR Requirements policy documented the PASRR was completed to determine provision of appropriate and needed services to individuals who have been diagnosed with [REDACTED].each center should follow PASRR and level II state specific requirements. The facility failed to renew the PASRR level II determination letter for R15 in a timely manner as directed in the letter.
F 0646 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 49 residents with 13 sampled including one for PASRR (Pre-Admission Screening and Resident Review). Based on interview and record review the facility failed to inform the state mental health authority in a timely manner of Resident (R)15's significant change on 12/26/19. Findings included: - Review of R15's medical record from November 2019 through (NAME)2020 revealed a lack of notification to the state mental health authority regarding R15's significant change of 12/26/19. Review of the PASRR Determination Letter for R15 dated 11/15,2018, indicating the resident had appropriate [DIAGNOSES REDACTED]. On 03/04/20 at 08:49 AM Social Services staff X stated she did not know of the need to inform anyone of the significant changes in the residents. On 03/04/20 at 08:53 AM Administrative Staff A stated he expected the facility to follow the guidelines regarding notifications and PASRR. The facilities undated PASRR Requirements policy documented the PASRR was completed to determine provision of appropriate and needed services to individuals who have been diagnosed with [REDACTED].each center should follow PASRR and level II state specific requirements. The facility failed to notify the state mental health authority promptly after R15's significant change on 12/26/19.

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

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F 0646 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 49 residents with 13 included in the sample. Based on observation, interview, and record review the facility failed to revise the care plan for Resident (R)29 related to the use of [MED] (anticoagulant medication) to include monitoring for bruising. Findings included: - Review of the Inpatient Discharge Instructions from the local Medical Center dated 01/22/20 revealed R29 had the following Diagnosis: [REDACTED].) Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R29 was independent with all activities of daily living and did not receive an anticoagulant. Review of the Medicare five-day MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognition. R29 was independent with all activities of daily living and received an anticoagulant medication daily during the lookback period. The Care Plan lacked instruction to staff for R29's anticoagulant use and possibility of R29 bruising easily, higher risk of bleeding, and no interventions to prevent bruising were in place. Review of the [MED] Medication Guide as found on the Food and Drug Administration (FDA) website (www.fda.gov) revealed, while taking [MED]: 1) you may bruise more easily. 2) it may take longer than usual for any bleeding to stop. Review of the physician orders [REDACTED]. 2) An order dated 01/22/20 for: [MED] (anticoagulant medication) 5 milligrams (mg), give one tablet by mouth two times a day for [MEDICAL CONDITION]. 3) An order dated 01/22/20 for: Weekly skin assessments, every evening shift, every Monday for skin assessment. 4) An order dated 01/23/20 for: Aspirin 81 mg, give one tablet by mouth one time a day for [MEDICAL CONDITION]. 5) An order dated 01/22/20 for: Weekly skin review. Review of the January 2020 Electronic Treatment Administration Record (ETAR) revealed: 1) Monitoring for signs and symptoms of bleeding related to anticoagulant use every evening shift started on 01/24/20. The staff completed the documentation but did not indicate any new bruising. 2) Weekly skin assessment, every evening shift, every Monday for skin assessment started on 01/27/20. The staff completed the documentation but did not indicate any new bruising. Review of the February 2020 ETAR revealed: 1) Monitoring for signs and symptoms of bleeding related to anticoagulant use every evening shift started on 01/24/20. The staff completed the documentation but did not indicate any new bruising. 2) Weekly skin assessment, every evening shift, every Monday for skin assessment started on 01/27/20. The staff completed the documentation but did not indicate any new bruising. An observation on 03/02/20 at 10:20 AM revealed R29 sat in her recliner crocheting. Her skin on both of her lower arms were exposed and several bruises on both hands and lower arms were visible. Her upper left arm had a blood-soaked gauze bandage in place due to a skin tear. R29 did not have anything in place to help protect her arms from getting bruised. During an interview on 03/04/20 at 09:47 AM, Certified Nurse Aide (CNA) N stated she didn't know if there was anything in the care plan that said anything about R29 bruising or interventions in place to help prevent bruising. During an interview on 03/04/20 at 10:53 AM, Licensed Nurse (LN) H stated R29 received a baby aspirin and [MED]. LN H stated R29 had a skin tear which bled after bumping her arm. LN H stated R29 did not have any problems with bruising. LN H stated they had educated R29 to use pillows to provide padding to her arm while sitting in her recliner. LN H stated skin checks were performed weekly, and this was where any new bruising was noted. LN H said there was not anything specific in the care plan pertaining to R29 bruising, or the use of an anticoagulant. During an interview on 03/04/20 at 11:15 AM, Administrative Nurse D stated it was her expectation there should be something included on the care plan addressing the use of anticoagulants as well as interventions to help prevent bruising. Administrative Nurse D verified there was nothing included in the care plan for R29 concerning the use of anticoagulant medications or anything about bruises. Administrative Nurse D stated any nurse could update the care plan and the MDS Coordinator reviewed the care plans quarterly. The facility did not provide a policy specific to bruising as requested on 03/04/20. The facility failed to revise the care plan for R29 to include information concerning the use of an anticoagulant medication, monitoring for bleeding and bruising, and interventions to help prevent bruising for R29.
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** The facility census totaled 49 residents with 13 included in the sample. Based on observation, interview, and record review the facility failed to ensure Resident (R) 29 received treatment and care in accordance with professional standards of practice by the failure of staff to identify, document, and monitor bruises, and the failure to put into place measures to help prevent R29 from bruising, while on an anticoagulant (chemical substance that prevents or reduces coagulation of blood, prolonging the clotting time) medication. Findings included: - Review of the Inpatient Discharge Instructions from the local Medical Center dated 01/22/20 revealed the following Diagnosis: [REDACTED].) Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R29 was independent with all activities of daily living (ADL) and did not receive an anticoagulant. Review of the Medicare five-day MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognition. R29 was independent with all ADL and received an anticoagulant medication daily during the lookback period. The Care Plan lacked instruction to staff for R29's anticoagulant use and possibility of R29 bruising easily, higher risk of bleeding, and no interventions to prevent bruising were in place. Review of the [MED] Medication Guide as found on the Food and Drug Administration (FDA) website (www.fda.gov) revealed, while taking [MED]: 1) you may bruise more easily. 2) it may take longer than usual for any bleeding to stop. Review of the physician orders [REDACTED]. 2) An order dated 01/22/20 for: [MED] (anticoagulant medication) 5 milligrams (mg), give one tablet by mouth two times a day for [MEDICAL CONDITION]. 3) An order dated 01/22/20 for: Weekly skin assessments, every evening shift, every Monday for skin assessment. 4) An order dated 01/23/20 for: Aspirin 81 mg, give one tablet by mouth one time a day for [MEDICAL CONDITION]. 5) An order dated 01/22/20 for: Weekly skin review. Review of the January 2020 Electronic Treatment Administration Record (ETAR) revealed: 1) Monitoring for signs and symptoms of bleeding related to anticoagulant use every evening shift started on 01/24/20. The staff completed the documentation but did not indicate any new bruising. 2) Weekly skin assessment, every evening shift, every Monday for skin assessment started on 01/27/20. The staff completed the documentation but did not indicate any new bruising. Review of the February 2020 ETAR revealed: 1) Monitoring for signs and symptoms of bleeding related to anticoagulant use every evening shift started on 01/24/20. The staff completed the documentation but did not indicate any new bruising. 2) Weekly skin assessment, every evening shift, every Monday for skin assessment started on 01/27/20. The staff completed the documentation but did not indicate any new bruising. An observation on 03/02/20 at 10:20 AM revealed R29 sat in her recliner crocheting. Her skin on both of her lower arms were exposed and several bruises on both hands and lower arms were visible. Her upper left arm had a blood-soaked gauze bandage in place due to a skin tear. R29 did not have anything in place to help protect her arms from getting bruised. During an interview on 03/03/20 at 10:20 AM, R29 stated she never really bruised as much before starting [MED]. She stated staff monitored her arms regularly but had not provided education concerning bruises and had not provided interventions to help her avoid bruising. R29 stated some of her bruises may have resulted from her recent hospital stay in January 2020 but she did not know how she got all of her bruises. R29 stated she tended to miss the center of doorways and bumped into the doorframes. During an interview on 03/03/20 at 10:31 AM, Certified Medication Aide (CMA) M stated R29 was on an aspirin regimen, and she did not receive any other medications that could cause her to bleed or bruise easily. CMA M stated R29 was independent and went out and about regularly. During an interview on 03/04/20 at 09:47 AM, Certified Nurse Aide (CNA) N stated they did not know of anything about the medications R29 received. CNA N stated R29 bruised easily, and bumped her arms frequently. CNA N stated R29 did not use arm protectors, or at least she never had seen her wear any. CNA N stated she did not know if there was anything in the care plan about R29's bruising or interventions in place to help prevent bruising. During an interview on 03/04/20 at 10:53 AM, Licensed Nurse (LN) H stated R29 received a baby aspirin and [MED]. LN H stated R29 had a skin tear which bled after bumping her arm. LN H stated R29 did not have any problems with bruising. LN H stated they had educated R29 to use pillows to provide padding to her arm while seated in her recliner. LN H stated skin checks were performed weekly, and this was where staff noted any new bruising to the resident. LN H stated there was not anything specific in the care plan pertaining to R29 bruising, or the use of an anticoagulant medication. During an interview on 03/04/20 at 11:15 AM, Administrative Nurse D stated she expected nursing staff to assess resident R29 daily for any signs of bruising, or bleeding, and to document this

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) in the ETAR. Administrative Nurse D stated the weekly skin assessments should include something about bruising. Administrative Nurse D stated the skin and wound evaluation form allowed staff to document for bruising but the weekly skin assessment did not have a place for documenting bruises unless the staff marked it for a new wound then it would take the nurse to the skin and wound evaluation form. Administrative Nurse D stated if a new bruise were identified, she expected the nurse to be told and assess the bruise and document it. Administrative Nurse D stated for a bruise of unknown origin she expected an incident report to be completed and verified there were none completed for R29. Administrative Nurse D verified there were no interventions in place to help prevent bruising for R29. Administrative Nurse D stated she expected staff to monitor a resident on an anticoagulant daily for signs and symptoms of bleeding which also included bruising. The facility did not provide a policy specific to bruising as requested on 03/04/20. The facility failed to have a system in place to assess, document and follow-up on bruises, and failed to implement interventions to help prevent bruises for R29, who received anticoagulant medication.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 49 residents with 13 residents in the sample one resident reviewed for [MEDICAL TREATMENT]. Based on observation, interview, and record review the facility failed to ensure the staff obtained vital signs before and after Resident (R) 14 received [MEDICAL TREATMENT] (procedure where impurities or wastes were removed from the blood). Findings included: - Review of R14's physician progress notes [REDACTED]. The 04/04/18 Admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R14 required no assistance with Activities of Daily Living (ADL) and received Special Treatments which included [MEDICAL TREATMENT]. The 12/24/19 Quarterly Minimum Data Set (MDS) assessment revealed a BIMS score of 15 indicating intact cognition. R14 required no assistance with ADLs and received Special Treatments of [MEDICAL TREATMENT]. The nursing Care Plan dated 02/27/20 revealed R14 needed [MEDICAL TREATMENT] related to [MEDICAL CONDITION]. The care plan noted R14 received [MEDICAL TREATMENT] three times a week on Tuesday, Thursday, and Saturday's. The staff were to assess R14's vital signs (blood pressure, pulse, temperature and respiration) before leaving for [MEDICAL TREATMENT] and upon return to the facility. Review of the Vitals in R14's Electronic Medical Record revealed the following [MEDICAL TREATMENT] dates lacked documentation of vital signs for R14: 1. October 2019: 10/08, 10/10, 10/15, 10/17, 10/19, 10/22, 10/24, and 10/29 and lacked vital signs upon return from [MEDICAL TREATMENT] on 10/12, 10/26, and 10/31. 2. November 2019: 11/02, 11/07, 11/16, 11/21, 11/26, and 11/30 and lacked vital signs upon return from [MEDICAL TREATMENT] on 11/05, 11/09, 11/12, 11/14, and 11/19. 3. December 2019: 12/02, 12/05, 12/12, 12/14, 12/17, 12/21, 12/24, 12/28 and lacked vital signs upon return from [MEDICAL TREATMENT] on 12/07, 12/10, and 12/26. 4. January 2020: 01/02, 01/04, 01/07, 01/09, 01/14, 01/16, 01/23, 01/28, 01/30 and lacked vital signs upon return from [MEDICAL TREATMENT] on 01/11, 01/21, and 01/23. 5. February 2020: 02/04, 02/06, 02/08, 02/13, 02/20, and 02/27. Observation on 03/03/20 at 12:15 PM revealed Licensed Nurse (LN) G obtained a set of vital signs upon R14's return to the facility from [MEDICAL TREATMENT]. Interview with LN G on 03/04/20 at 09:43 AM revealed the staff obtained R14's set of vital signs, weight, and blood sugar when R4 returned from [MEDICAL TREATMENT]. Interview with Administrative Nurse D on 03/04/20 at 10:57 AM revealed the facility noted a discrepancy regarding vital signs the staff assessed before and after [MEDICAL TREATMENT] and a new form was implemented, which included vital signs to be obtained before and after [MEDICAL TREATMENT]. Administrative Nurse D said the Electronic Medicare Record updated to trigger the nurse to obtain vital signs. The facility failed to provide a policy regarding protocol on [MEDICAL TREATMENT]'s vital signs as requested on 03/04/20. The facility failed to ensure the staff obtained vital signs before and after R14 received [MEDICAL TREATMENT].
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** The facility reported a census of 49 residents. Based on record review and interview the facility failed to complete the required nurse aide performance reviews (at least once every 12 months) for three of the five Certified Nurse Aides (CNA) reviewed in order to provide in-service education based on the outcome of the reviews. Findings Include: - Review of five Certified Nurse Aides (CNA) records (with employment for the facility documented as more than one year) revealed lack of documentation of performance reviews for three of the five CNAs reviewed. (CNA P, CNA Q, CNA R) On 03/03/20 at 01:29 PM Administrative Nurse D stated she knew the facility did not have evaluations completed, knew they needed them, and they were working on them. On 03/03/20 at 03:23 PM Administrative Staff A stated he knew that the employee yearly evaluations were behind and stated they were starting with a new form and said they would be all caught up in March. The facility failed to provide a policy for performance reviews as requested on 03/04/20. The facility failed to complete performance reviews on three of the five CNAs reviewed, to ensure adequate cares provided to the residents of the facility.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 49 residents with 13 residents in the sample and five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure the pharmacist identified the lack of parameters and monitoring for blood pressure for Resident (R)38. Findings included: - Review of the R38's signed Physician order [REDACTED]. Review of the Significant Change Minimum (MDS) data set [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of the Quarterly Minimum (MDS) data set [DATE] revealed a BIMS score of 13 indicating intact cognition. Review of the nurse's Care Plan dated 08/09/19 instructed staff to monitor the residents blood pressure and notify the physician of any abnormal readings. The staff were instructed to monitor for side effects such as orthostatic [MEDICAL CONDITION] (- low blood pressure) and effectiveness. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. Interview with Certified Medication Aide (CMA) R on 03/04/20 at 09:19 AM revealed the MAR indicated [REDACTED]. Interview with Licensed Nurse (LN) D on 03/04/20 at 09:30 AM revealed (LN) D would expect parameters the for blood pressure and monitoring of the blood pressure to be on the MAR. Interview with Administrative Nurse D on 03/04/20 at 11:00 AM revealed the plan of care states to monitor blood pressure and notify physician of abnormal findings expect the nurses to follow the plan of care. Interview on 03/04/20 at 11:55 AM with Consultant Pharmacist GG revealed the vitals signs were reviewed in the Electronic Medical Record. Consultant Pharmacist GG said he/she would looked for abnormal level and expected staff to follow the facility policy. The facility failed to provide a policy regarding parameters and monitoring of blood pressures as requested on 03/05/20. The facility failed to ensure the pharmacist identified the lack of parameter for blood pressure and the lack of monitoring blood pressures medications received by R38.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 49, with13 in the sample, and five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure Resident (R)14 did not receive unnecessary medication due to the failure of staff to notify the physician when R14's blood glucose levels were less than 70 milligrams per deciliter (mg/dL), and greater than 300 mg/dL as ordered. The facility also failed to obtain blood pressure parameters related to the use of [MEDICATION NAME] (blood pressure medication) and failed to monitor blood pressures weekly as ordered by the physician for R38. Findings included: - Review of the Physician order [REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. R14 received [MED] daily during the seven-day observation period. Review of the Quarterly MDS dated [DATE] revealed a brief interview for BIMS score of 15, indicating intact cognition. R14 received [MED] daily during the seven-day observation period. Review of the Care Plan revised 02/10/20 revealed R14 with a [DIAGNOSES REDACTED]. Review of the facilities standing orders for blood sugars indicated the staff were to notify the physician for blood sugars below 70 mg/dL or greater than 300 mg/dL. Review of October 2019 Electronic Medication Administration Record [REDACTED] 304 110/8/19 at 03:50 PM for a blood sugar of 332 11/09/19 at 03:50 PM for a blood sugar of 332 11/10/19 at 10:09 AM for a blood sugar of 353 11/11/19 at 03:29 PM for a blood sugar of 402 11/12/19 at 03:28 PM for a blood sugar of 322 11/12/19 at 08:55 PM for a blood sugar of 400 11/13/19 at 10:28 AM for a blood sugar of 352 11/13/19 at 01:23 PM for a blood sugar of 385 11/13/19 at 08:13 PM for a blood sugar of 317 Review of the January 2020 EMAR revealed the facility staff did not

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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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) notify the physician on the following dates when the resident's blood sugars were out of parameters (mg/dL): 01/28/20 at 07:00 PM for a blood sugar of 385 01/29/20 at 10:26 AM for a blood sugar of 305 An observation on 03/03/20 at 12:15 PM revealed Licensed Nursing (LN) G obtained a blood sugar reading for R14. During an interview on 03/04/20 at 08:42 AM, Certified Nurse Aide (CNA) O stated R14 was a diabetic. During an interview on 03/04/20 at 01:17 PM, Administrative Nurse D stated she expected the nursing staff to notify the physician if blood sugars were out of range. Administrative Nurse D stated the staff follow the standing orders for blood sugar parameters below 70 and over 300 and the computer system prompted staff to document if blood sugars were outside the parameters. Facility did not provide a policy specific to blood sugar parameters as requested on 03/04/20. The facility failed to ensure staff notified the physician as ordered concerning blood sugar levels outside of parameters (less than 70 mg/dL and greater than 300 mg/dL) for R14. - Review of the R38's signed Physician order [REDACTED]. Review of the Significant Change Minimum (MDS) data set [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of the Quarterly Minimum (MDS) data set [DATE] revealed a BIMS score of 13 indicating intact cognition. Review of the nurse's Care Plan dated 08/09/19 instructed staff to monitor the residents blood pressure and notify the physician of any abnormal readings. The staff were instructed to monitor for side effects such as orthostatic [MEDICAL CONDITION] (- low blood pressure) and effectiveness. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. Interview with Certified Medication Aide (CMA) R on 03/04/20 at 09:19 AM revealed the MAR indicated [REDACTED]. Interview with Licensed Nurse (LN) D on 03/04/20 at 09:30 AM revealed (LN) D would expect parameters the for blood pressure and monitoring of the blood pressure to be on the MAR. Interview with Administrative Nurse D on 03/04/20 at 11:00 AM revealed the plan of care states to monitor blood pressure and notify physician of abnormal findings expect the nurses to follow the plan of care. The facility failed to provide a policy regarding parameters and monitoring of blood pressures as requested on 03/05/20. The facility failed to identify the lack of parameter for blood pressure and the lack of monitoring blood pressures for R38.