STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455901	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KPC PROMISE SKILLED NURSING FACILITY OF WICHITA FA	**1101 GRACE ST WICHITA FALLS, TX 76301**

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 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 interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 4 residents (Resident #2 and #4) reviewed for medication administration. The facility failed to ensure: - Resident #2's Insulin Administration Record and Medication reflected [MEDICATION NAME] U-100 Insulin 10 units Subcutaneous was documented on 7/19/20 at 4:30 PM and 7/11/20 at 8:00 PM and [MEDICATION NAME] U- 100 Insulin 55 units was documented on 7/11/20 at 8:00 PM. Resident #2's fingerstick blood sugars and site were documented on 7/11/20 at 8 PM and 7/19/20 at 4:30 PM - Resident #4's Insulin Administration Record and Medication reflected [MEDICATION NAME] U-100 Insulin 9 units was accurately documented as given on 7/2/20, 7/20/20 and 7/26/20 at 8:00 PM, and her [MEDICATION NAME] U-100 Insulin 4 units was accurately documented on 7/2/20, 7/6/20, 7/7/20, 7/10/20, 7,11/20, 7/12/20, and 7/26/20 at 7:30 AM. Resident ID # 4's fingerstick bloodsugars were documented on 7/6/20, 7/7/20, 7/10/20, 7/11/20,7/12/20 at 4:30 PM This failure could place residents at risk of not receiving adequate treatment and care, resulting in a decline in health. Findings include: Resident #2 Record review of Resident #2's, Admission face sheet, not dated, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of resident ID # 2's physician's orders [REDACTED]. Orders with a start date of 06/30/18 for [MEDICATION NAME] U-100 insulin 10 units subcutaneous. (Special instructions: with additional units needed per signs and symptoms). Document and rotate sites. Administer before meals and at bedtime at 6:30 AM, 11:30 AM, 4:30 PM, and 8:00 PM. 2. Orders with a start date of 8/31/18 for [MEDICATION NAME] Insulin 100 units/ml: If blood sugar is 0-149 give 0 units, If blood sugar is 150-199 give 2 units, if blood sugar is 200-249 give 4 units, if blood sugar is 250-299 give 6 units, if blood sugar is 300-349 give 8 units, if blood sugar is 400 to 800 give 12 units, If blood sugar is greater than 800 call MD. 3. Orders with a start date of 5/14/20 [MEDICATION NAME] U-100 Insulin administer 55 units subcutaneous twice a day at 8:00 AM and 8:00 PM. Record review of Resident ID #2 Insulin administration record for the month of July 2020 revealed the following: [MEDICATION NAME] U-100 Insulin 10 units Subcutaneous was not documented on 7/19/20 at 4:30 PM and 7/11/20 at 8:00 PM and [MEDICATION NAME] U- 100 Insulin 55 units was not documented on 7/11/20 at 8:00 PM. They were blank with no initials or circle. Resident #2's fingerstick blood sugars and site were not documented on 7/11/20 at 8 PM and 7/19/20 at 4:30 PM. They were blank with no initials or circles. In an interview with Resident ID #2 at 3:30 PM on 7/28/20 she gets her insulin and the nurses take good care of her. She states they do her fingersticks. Resident ID # 4 Record review of Resident #4's, admission face sheet, not dated, and Physician's progress note dated 3/24/20 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE], and a re-admission date of [DATE]. Her [DIAGNOSES REDACTED]. [MEDICAL CONDITION] disorder, dementia, cerebral infarct and dysphagia. Record review of resident ID # 4's physician's orders [REDACTED]. Orders with a start date of 3/1/19 for [MEDICATION NAME] Insulin 100 units/ml: Amount to administer per sliding scale. If blood sugar is 0-149 give 0 units, if blood sugar is 150-199 give 2 units, if blood sugar is 200-249 give 4 units, if blood sugar is 250-299 give 6 units, if blood sugar is 300-349 give 8 units, if blood sugar is 400 to 800 give 12 units, if blood sugar is greater than 800 call MD. Administer before meals and at bedtime. Blood sugar at 6:30 AM, 11:30 AM, 4:30 PM and 8:00 PM Notify MD if Blood sugar is greater than 375 Document and rotate sites do not cover resident at 6:30 AM Finger stick blood sugar. 2. Orders with a start date of 4/1/19 for [MEDICATION NAME] U-100 Insulin 100 units/ml administer 4 units at 7:30 AM and 9 units at 8:00 PM. Record review of Resident ID #4's Insulin administration record for the month of July revealed the following: [MEDICATION NAME] U-100 Insulin 9 units was not documented as given on 7/2/20, 7/20/20 and 7/26/20 at 8:00 PM, and her [MEDICATION NAME] U-100 Insulin 4 units was not documented on 7/2/20, 7/6/20, 7/7/20, 7/10/20, 7,11/20, 7/12/20, and 7/26/20 at 7:30 AM. Resident ID # 4's fingerstick bloodsugars were not documented on 7/6/20, 7/7/20, 7/10/20, 7/11/20, 7/12/20 at 4:30 PM. During an interview with LVN A (day shift charge nurse) on 7/28/20 at 2:00 PM, she stated it is the nurse's responsibility to document the administration of medication or document the refusal or reason for holding a medication at the time of administration. She stated if a medicine is not documented it could cause a medication error. She stated she was scheduled off on the days the documentation was missing, she stated the resident ID # 4 refused care at times and it was often necessary to go back later to try and perform care for the resident. During interview on 07/28/20 at 2:45 p.m., the DON stated it was her expectation that al medications should be signed for and documented at the time of administration, if it was not administered it should be documented as refused and the reason for holding the medication and the time documented in the nurses' notes. She stated the family and the physician should be notified. The DON stated she and the ADON were responsible for monitoring the nurse's documentation. She stated she would call the Nurse responsible for the missing documentation and counsel and in-service them on the proper procedures and investigate the reason for the blanks in documentation. She stated due to the resident's behaviors, she often refused care and the staff would go back later to provide care. She stated that she felt it was a documentation error. The DON confirmed that there was no documentation in the medical record of resident ID #'S 2 and 4 of their refusal, family or physician notification of a missed dose of insulin. In an interview and an observation on 7/28/2020 at 3:00 PM the ADON was observed checking the Insulin administration sheets. She stated she monitors for omissions in documentation and investigates reason for missing documentation. Record review of the Administering Medications Policy, revised December 2012 revealed the following (in part): 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record [REDACTED]. 19. The individual administering the medication must initial the resident's Medication Administration Record [REDACTED].

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.