STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165305	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHARITON SPECIALTY CARE	**1214 NORTH SEVENTH STREET CHARITON, IA 50049**

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** Based on record review and interview, the facility failed to notify the Responsible Party of a medication change for 1 of 4 sampled (Resident #1). The facility reported a census of 41. Findings include: 1. The Minimum Data Set assessment dated [DATE], listed Resident #1 had [DIAGNOSES REDACTED].#1 required setup assistance for eating and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. Resident #1 had a Brief Interview for Mental Status score of 13 indicating intact cognition. A Care Plan entry dated 7/9/20 directed staff to communicate with the resident's family regarding her needs. A physician's orders [REDACTED]. Review of the Clinical Record revealed a lacked of documentation to reflect the facility notified Resident #1's Responsible Party of the order for [MEDICATION NAME]. During an interview on 8/26/20 at 10:15 a.m., the Director of Nurses stated the facility should notify the family of resident changes. During an interview on 8/26/20 at 11:00 a.m., the Director of Nurses stated they did not have a policy regarding family and physician notification and stated they followed the federal standard of practice.
F 0684 **Level of harm -** 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 record review and interview, the facility failed to provide timely assessments and intervention when residents had blood glucose levels outside of normal parameters, failed to administer insulin according to the manufacturers recommendations, and failed to recheck a blood glucose level when requested for 2 of 4 sampled. Resident #1 requested to have her blood glucose rechecked and the Nurse declined. The staff later found Resident #1 unresponsive with a blood glucose level of 30 and administered two doses of [MEDICATION NAME] prior to transferring to the Emergency Department. The facility reported a census of 41. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had [DIAGNOSES REDACTED].#1 required setup assistance for eating and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. Resident #1 had a Brief Interview for Mental Status score as 13 indicating intact cognition. The Care plan entry dated 5/22/20 revealed Resident #1 had diabetes and directed staff to administer insulin medications as ordered, monitor blood glucose as ordered, and monitor for side effects such as low blood sugar, headache, weakness, sweating, and [MEDICAL CONDITION]. According to the American Diabetes Association@ www.diabetes.org a normal blood glucose ranged from 80 to 130 milligrams (mg)/deciliter (dl). Review of the Weights and Vitals Summary from June 23, 2020 to July 20, 2020, Resident #1 had the following blood glucose readings below 60 mg/dl and exceeding 350 mg/dl: a. On 6/25/20, 347 mg/dl. b. On 6/27/20, 12 mg/dl. c. On 6/28/20, 353 mg/dl. d. On 6/30/20 at 4:45 a.m., 51 mg/dl. e. On 6/30/20 at 7:53 a.m., 481 mg/dl. f. On 7/1/20, 384 mg/dl. g. On 7/2/20 at 8:32 a.m., 52 mg/dl. h. On 7/2/20 at 12:41 p.m., 404 mg/dl. i. On 7/4/20, 50 mg/dl. j. On 7/9/20, 54 mg/dl. Review of the Clinincal Record revealed a lack of Physician notification and assessments and intervention for the above abnormal blood glucose levels. A physician's orders [REDACTED]. The Clinical Record lacked documentation of a food diary every shift for 7 days and lacked documentation submitted to the Physician for review on 7/1/20. A Progress Noted dated 7/13/20 1:35 p.m., revealed the resident's blood sugar was 343 mg/dl. The facility obtained an order for [REDACTED]. A Weights and Vitals summary 7/13/20 at 2:43 p.m., documented Resident #1 had a blood glucose level of 109 mg/dl. On 7/13/20 at 4:28 p.m., Resident #1 had a reading of 102 mg/dl. The Medication Administration Audit Report dated 7/13/20 at 4:33 p.m. revealed Resident #1 received [MEDICATION NAME] per sliding scale. The July 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A facility meal intake record indicated on 7/13/20, the resident ate 76-100% of breakfast and refused lunch. The record stated not applicable for the supper entry. The Progress Note dated 7/13/20 6:32 p.m. revealed a Nurse Aide summoned the Nurse to Resident #1's room due to Resident #1 slouched forward in her recliner, unresponsive, and diaphoretic (sweating profusely). The Staff checked Resident #1's blood glucose level and obtained a reading of 30 mg/dl. The Staff administered and injection of [MEDICATION NAME] (medication to raise blood glucose) and informed the physician. The Physician directed staff to administer another dose of [MEDICATION NAME] if the resident did not respond. The Progress Note dated 7/13/20 6:40 p.m., documented the Nurse administered a second dose of [MEDICATION NAME] due a blood glucose reading of 48 mg/dl. The Progress Notes dated 7/13/20 7:42 p.m., revealed Resident #1 transferred to the Emergency Department. The Emergency Department report dated 7/13/20 revealed Resident #1 had a blood glucose reading in the 400 mg/dl range at lunchtime and the physician ordered of 10 units of regular insulin and to recheck the reading. The facility called the Physician at 6:32 p.m. and stated the resident was unresponsive and had a blood glucose reading of 30 mg/dl. The Physician ordered [MEDICATION NAME] and Resident #1 did not respond well. The resident transferred to the Emergency Department unresponsive but aroused when her blood glucose level raised. In the emergency room , the resident's blood sugar was 101 mg/dl. The report stated that the resident did not eat any food for lunch or dinner and stated a facility CNA asked the resident's nurse to check the resident's blood sugar but she did not and went on break instead. Resident #1 transferred from the Emergency Department to another hospital for further cardiac workup. A handwritten statement dated 7/13/20 composed by Staff C (Registered Nurse) documented Staff B (Nurse Aide) informed Staff C that she asked Staff A (Registered Nurse) to check Resident #1's blood glucose level twice prior to finding Resident #1unresponsive. Staff A sat at the Nurses Station eating and stated she was too busy. The facility lacked documentation of an investigation carried out related to the concern submitted by Staff C. The [MEDICATION NAME] Patient Information sheet provided by the facility on 8/26/20, stated [MEDICATION NAME] acted fast and a meal should eaten within 5-10 minutes after injection. The Blood Glucose Monitoring policy dated January 2015 directed staff to notify the physician for blood glucose levels below 60 mg/dl or above 200 mg/dl. The Diabetic Management of Hypo/[MEDICAL CONDITION] policy dated January 2015 instructed the facility to establish blood glucose parameters with the physician including at what level to treat and when to notify in order to identify serious complications. The Grievance/Concern Investigations policy dated June 2019 stated investigation forms were intended to assist in making concerns known in order to take action and follow up. During an interview on 8/25/20 at 9:12 a.m., the Dietary Manager stated the evening meal was at 5:00 p.m. and this would be the earliest they would serve. During an interview on 8/25/20 at 7:54 a.m., Staff E (Licensed Practical Nurse) stated she worked the day shift on 7/13/20 and the resident's blood sugar was high. She stated the physician gave an order to give her a dose of insulin. She didn't remember the specifics but she was to give a lower dose of insulin if the resident did not eat lunch. The resident did not end up eating so Staff E gave her the lower dose. Staff E stated when she administered insulin, she tried to make sure the resident ate within 15-20 minutes. She stated she informed the evening nurse coming on shift that the resident's blood

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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) sugar was high and she did not eat. She stated the evening meal began at 5:00 p.m. and would not be earlier than this. During an interview on 8/24/20 at 3:51 p.m., Staff B (Nurse Aide) stated on 7/13/20 4:20 p.m. or 4:30 p.m. Resident #1 put her call light on and told Staff B she wasn't feeling very well. Staff B thought the resident's blood glucose level was low and reported this to Staff A (Registered Nurse). Staff B then assisted other residents. At 5:00 p.m., she took Resident #1's dinner tray into her and sat it in her lap as the resident preferred. The resident requested to have her blood glucose level checked. Staff B encouraged the resident to eat something and informed Staff A. Staff B stated Staff A was sitting at the nursing station eating. She stated Staff A said the resident's blood glucose level was fine when she administered her insulin and stated she didn't have time to take it again. According to Staff B, Staff A stated she would go into the resident's room when she had time. Staff B then assisted other residents and when she entered Resident #1's room at 6:15 p.m., the resident was slumped over in her chair and her food was on the floor. Staff B stated it appeared as though she dropped her tray. She tried to rouse the resident and called for a nurse. Staff B stated Staff A was still on break but Staff C (Registered Nurse) had just arrived for her shift and she came to the resident's room to assist her. Staff B stated she remained in the room until the paramedics came to transport her to the hospital. Staff B stated she reported to Staff C that she had informed Staff A of the resident's condition earlier but Staff A did not take action. During an interview on 8/24/20 at 12:08 p.m., Staff C (Registered Nurse) stated she arrived for her shift around 6:30 p.m. on 7/13/20. She stated a Nurse Aide asked for a nurse and she and Staff D (Licensed Practical Nurse) went to the resident's room and she was unresponsive in her recliner. She took her blood sugar and it was very low. They gave her a shot of [MEDICATION NAME] and called the doctor. Staff A returned from break and they updated her. During an follow-up interview on 8/25/20 at 9:00 a.m., Staff C stated Staff B reported to her she reported the resident's condition to Staff A and she did not check on the resident. Staff C stated she documented this concern and submitted it to the Administrator. During an interview on 8/24/20 at 3:18 p.m., Staff D (Licensed Practical Nurse) stated on 7/13/20 she heard a nurse was needed in Resident #1's room. She stated she and Staff C went to the resident's room and she was slumped over in her recliner and was unresponsive. She stated they checked her blood sugar and it was around 32 or 34. They gave her a shot of [MEDICATION NAME]. She stated Staff A (Resident's #1's nurse) was on break and when she returned they updated her and she took over. She stated Resident #1 was a brittle diabetic and she would not give the resident her insulin until she had the tray in front of her. She stated supper trays did not come out before 5:00 p.m. During a follow-up interview on 8/25/20 at 10:20 a.m., Staff D stated Staff B had informed her she reported the resident's condition to Staff A but Staff A stated she was too busy. During an interview on 8/24/20 at 1:12 p.m., Staff A stated on 7/13/20 when she gave the resident her insulin, it was dinner time and she had her tray in front of her. She stated she was not sure if she ate anything or not. She stated she was not the nurse who found the resident unresponsive as she was on break at the time. She stated Resident #1 had a high blood glucose level earlier in the day and the doctor ordered a one-time dose of insulin. During an interview on 8/25/20 at 10:48 a.m., the Director of Nurses (DON) stated she received a call on 7/13/20 of the resident's low blood glucose level and the resident was sent to the Emergency Department. She stated earlier her blood glucose level was high. She stated she would want the nurse to make sure she was eating or hold the insulin. She stated she did not remember any staff members reporting any concerns with other staff. During an interview on 8/26/20 at 10:15 a.m., the DON stated she would expect the nurses to double check when inputting blood sugars. She stated there should have been parameters on the Medication Administration Record [REDACTED]. She stated moving forward, the facility would do this. She stated the facility should have followed through with getting the resident a mechanical soft diet and acknowledged the food diary was not done. She stated the evening meal was at 5:00 p.m. and not before then. She stated Staff A should not deny care to a resident. During an interview on 8/25/20 at 8:41 a.m., Resident #1's Physician stated Resident #1 had a high blood glucose level around 500 mg/dl and he ordered a dose of insulin. He stated on the evening shift, the resident would not eat and the aide told the nurse to check on her but the nurse did not. He stated by the time the nurse checked on her, her blood sugar was 30 mg/dl. The staff subsequently gave an injection of [MEDICATION NAME] but the resident did not respond. He stated if a resident did not eat, nurses should recheck blood sugars. During an interview on 8/25/20 at 10:58 a.m., the Administrator stated as far as she knew no one had spoken to Staff A regarding the concern Staff C submitted regarding her not responding to a resident after a Nurse Aide told her the resident was not doing well. She stated normally they would investigate. During an interview on 8/26/20 at 11:00 p.m., the DON stated they did not have a policy regarding family and physician notification or assessment and intervention and stated they followed the federal standard of practice. 2. The Face Sheet revealed Resident #3 admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Progress Notes dated 8/19/20 revealed Resident #3 had a fall at home with a blood glucose reading of 29 milligrams (mg)/deciliter (dl). The Weights and Vitals Summary dated 8/22/20 at 8:00 p.m., listed a blood glucose reading of 433 mg/dl. Review of the Clinical Record revealed a lack of documentation to reflect the staff notified the Physician, completed further assessments and carried out interventions for the high glucose reading. The Care Plan entry dated 8/20/20 revealed Resident #3 had diabetes and directed staff to monitor blood glucose levels and side effects.