



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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February 14, 2019

Rachel Zimmerman, Administrator
Aspen Park Of Cascadia
420 Rowe Street
Moscow, ID 83843-9319

Provider #: 135093

Dear Ms. Zimmerman:

On **January 31, 2019**, a survey was conducted at Aspen Park Of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Rachel Zimmerman, Administrator
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 25, 2019**. Failure to submit an acceptable PoC by **February 25, 2019**, may result in the imposition of penalties by **March 19, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 7, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 1, 2019**. A change in the seriousness of the deficiencies on **March 17, 2019**, may result in a change

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2019** includes the following:

Denial of payment for new admissions effective **May 1, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 30, 2019**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 1, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Rachel Zimmerman, Administrator
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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

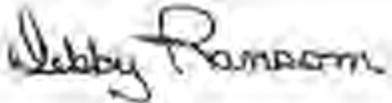
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 25, 2019**. If your request for informal dispute resolution is received after **February 25, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2019
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NAME OF PROVIDER OR SUPPLIER ASPEN PARK OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from January 27, 2019 through January 31, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN Team Coordinator Deborah Abasciano, RN</p> <p>Abbreviations:</p> <p>BG = Blood Glucose (blood sugar) DNS = Director of Nursing Services MAR = Medication Administration Record MDS = Minimum Data Set mg/dl = milligram per deciliter</p>	F 000		
F 622 SS=D	<p>Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)</p> <p>§483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;</p>	F 622		3/7/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/22/2019
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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 622	<p>Continued From page 1</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this</p>	F 622			

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F 622	<p>Continued From page 2</p> <p>section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for emergent situations for 1 of 2 residents (Resident #17) reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to lack of information. Findings include:</p>	F 622	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility</p>		

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F 622	<p>Continued From page 3</p> <p>Resident #17 was readmitted to the facility on 1/7/19, with multiple diagnoses including pneumonia.</p> <p>A discharge MDS assessment, dated 1/3/19, documented Resident #17 was discharged to an acute care hospital.</p> <p>A Nursing Progress Note, dated 1/3/19 at 1:10 PM, documented Resident #17 had a change of condition, Emergency Medical Services was notified, and Resident #17 was transported to the hospital via emergency transport.</p> <p>Resident #17's record did not include documentation his physician was notified and ordered the transfer to the hospital and information regarding Resident #17's status was conveyed to the hospital.</p> <p>On 1/31/19 at 11:06 AM, the DNS stated the facility did not fill out the Transfer Form when Resident #17 had a medical emergency and needed to be sent to the emergency room quickly. The DNS stated Resident #17's record did not include documentation the Transfer/Discharge Form and paperwork were provided to the paramedics, a physician's order to transport him, and the reason for admission to the hospital.</p>	F 622	<p>reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The clinical management team reviewed resident #17. Resident was transported via emergent ambulance for respiratory distress on 1/3/19. MD was notified of discharge to ER on 1/3/19 after resident was discharged but communication was not placed in medical record. A copy of notification was provided by the physician's office, it is placed in the medical record as evidence of notification.</p> <p>Other Residents The clinical management team reviewed other residents discharged in the last 30 days for physician notification. No adjustments were indicated.</p> <p>Facility Systems Licensed nurses are educated to regarding transfer and discharge documentation requirements. Re-education was provided by Staff Development Coordinator and/or designee to include but not limited to, emergent transfers documentation of information sent to the acute setting with the resident, residents that become direct admission from a physician office, and</p>		

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F 622	Continued From page 4	F 622	validation of a physician's order. The system is amended to include review in clinical meeting of discharges to validate documentation of information packet sent is reflected in the medical record. Monitor The Executive Director and/or designee will audit discharged resident records for Physician Notification and order for transfer, as well as proper information packet documentation to receiving entity with each discharge for 8 weeks. Starting the week of 3/7/19 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance 3/7/2019		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		3/7/19	

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F 625	<p>Continued From page 5</p> <p>return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a second bed-hold notice was provided to a resident or their representative upon transfer to the hospital. This was true for 1 of 2 residents (Resident #17) who were reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed-Hold Readmission Policy, dated 11/28/17, documented the facility issued two notices related to bed-holds, as follows:</p>	F 625	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The ID team reviewed resident #17s</p>		

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F 625	<p>Continued From page 6</p> <ul style="list-style-type: none"> * The first notice was provided in the admission packet. * The second notice was provided to the resident at the time of transfer, or in cases of emergency transfer, within 24 hours of the transfer. * The notice provided information to the resident that explained the duration of the bed-hold. <p>Resident #17 was readmitted to the facility on 1/7/19, with multiple diagnoses including pneumonia.</p> <p>Resident #17 was transferred to the hospital on 1/3/19, and readmitted to the facility on 1/7/19. Resident #17's record did not include documentation he received a second bed-hold notification when he was transferred to the hospital.</p> <p>On 1/31/19 at 11:59 AM, the LSW stated Resident #17 did not receive a second bed-hold notification.</p>	F 625	<p>record. Resident no longer requires written notification of Bed Hold Policy, as they have returned to their bed at the facility. If resident requires a subsequent transfer, resident will receive notification of Bed Hold Policy.</p> <p>Other Residents The ID team reviewed other residents who are currently in an acute care setting. Bed Hold Policy has been issued as indicated.</p> <p>Facility Systems Admissions Coordinator, Social Services, and nursing staff were educated to the Bed Hold Policy. The Executive Director and/or designee re-educated to include but not limited to, providing the bed hold policy at time of discharges and/or transfers to acute care setting or within 24 hours of the resident leaving the facility. The system is amended to include notification of manager on call for weekend acute care discharges and review in clinical meeting for residents who transfer to the acute care setting to validate communication of the Bed Hold Policy .</p> <p>Monitor The Executive Director and/or designee will audit Bed Hold Policy provided to the resident and/or representative at time of discharge of within 24 hours and present</p>		

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F 625	Continued From page 7	F 625	in medical record. Monitoring will occur with each discharge for 8 weeks. Starting the week of 3/7/19 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance 3/7/2019		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 3 of 15 residents (#27, #32, and #46) reviewed for standards of practice. Resident #27 BG levels were high and the physician was not notified timely and her insulin orders were not correctly transcribed to the MAR. Resident #32's hyperglycemia (high BG level) care plan was not followed and action taken in response to Resident #46's hyperglycemia were not	F 684	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements,	3/7/19	

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F 684	<p>Continued From page 8</p> <p>documented. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practice. Findings include:</p> <p>The facility's Hyperglycemia and Diabetic Coma policy and procedure, dated 10/31/17, documented, "It is important to treat hyperglycemia as soon as it is detected. If not treated, a condition called ketoacidosis (diabetic coma) could occur... If the resident's blood glucose is over 240 mg/dl and is not on sliding scale insulin, call the physician for directives."</p> <p>1. Resident #27 was admitted to the facility on 5/8/17, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #27's January 2019 physician's orders, dated 1/8/19, documented Resident #27 was to receive an injection of 14 units of Novolog insulin before meals and the injection was to be held if her BG levels were less than 70 mg/dl. Resident #27 was also to receive an injection of 58 units of Letemir insulin at bedtime and the injection was to be held if her BG levels were less than 70 mg/dl.</p> <p>Resident #27's January 2019 physician's orders did not include hyperglycemia parameters regarding when to notify the physician. Resident #27 was not on sliding scale insulin.</p> <p>Resident #27's diabetes mellitus care plan, dated 11/14/18, documented, "if hyperglycemic (greater than 300 mg/dl) follow sliding scale (if applicable) or contact the physician and follow orders.</p>	F 684	<p>findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific The clinical management team reviewed resident #27 and #32, received physician orders that included hyperglycemia/hypoglycemia parameters regarding when to notify the physician. Care plan has been updated to match the physician's parameters. Physician order dated 1/18/19 to increase Levemir insulin injection for resident #27 was d/c. Resident#3 Resident no longer resides at the facility.</p> <p>Other Residents The clinical management team reviewed other residents for Hyperglycemia/ Hypoglycemia parameters and notified physicians to get resident specific parameters. Resident specific parameters have been entered on the medication administration review and care plans have been update to reflect physician orders. Adjustments have been made as indicated.</p> <p>See F622 for compliance on discharge/transfer plan.</p> <p>Facility Systems LN's are educated on management of diabetes. The Staff Development</p>		

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F 684	<p>Continued From page 9</p> <p>Document treatment/interventions and symptoms/assessment in progress notes." The care plan parameters for notification of the physician was not consistent with the facility's policy.</p> <p>Resident #27's MAR, from 1/8/19 to 1/15/19, documented Resident #27's BG levels were greater than 300 mg/dl, as follows:</p> <ul style="list-style-type: none"> - On 1/8/19 at 5:30 PM = 321 mg/dl - On 1/8/19 at bedtime = 332 mg/dl - On 1/9/19 at 11:30 AM = 352 mg/dl - On 1/9/19 at 5:30 PM = 316 mg/dl - On 1/9/19 at bedtime = 437 mg/dl - On 1/10/19 at 11:30 AM = 322 mg/dl - On 1/11/19 at 7:30 AM = 339 mg/dl - On 1/11/19 at 11:30 AM = 303 mg/dl - On 1/11/19 at 5:30 PM = 362 mg/dl - On 1/11/19 at bedtime = 465 mg/dl - On 1/12/19 at 11: 30 AM =337 mg/dl - On 1/12/19 at 5:30 PM = 361 mg/dl - On 1/12/19 at bedtime = 382 mg/dl - On 1/13/19 at 7:30 AM = 316 mg/dl - On 1/13/19 at 11:30 AM = 335 mg/dl - On 1/13/19 at 5:30 PM = 428 mg/dl - On 1/13/19 at bedtime = 449 mg/dl - On 1/14/19 at 7:30 AM = 329 mg/dl - On 1/14/19 at 11:30 AM = 399 mg/dl - On 1/14/19 at 5:30 PM = 354 mg/dl - On 1/14/19 at bedtime = 360 mg/dl - On 1/15/19 at 11:30 AM = 339 mg/dl - On 1/15/19 at 5:30 PM =356 mg/dl <p>A Nurse's Progress Note, dated 1/13/19 at 10:18 PM, documented the physician was notified by fax of Resident #27's BG level before dinner (5:30 PM) was 428 mg/dl and her bedtime BG</p>	F 684	<p>Coordinator and/or designees re-educated to the updated policy for Hyperglycemia and Diabetic Coma policy, to include but not limited to, validation of parameters on hyperglycemia for non-sliding scale residents, monitoring for accurate transcription of physician orders, and notification and documentation on BS that are out of stated parameters. The system is amended to include notification of MD upon admission for residents with a diabetic diagnosis, insulin dependent, to determine physician preference on parameters and notification for hypoglycemia and hyperglycemia. Medical records will be reviewed in clinical meeting to validate. See F622 for compliance on discharge/transfer plan.</p> <p>Monitor The Director of Nursing and/or designee will audit insulin dependent residents Blood Glucose results and physician notification of results outside of parameters 2 times weekly for 4 weeks, then 1 time weekly for 8 weeks starting the week of 3/7/19. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>See F622 for compliance on discharge/transfer plan.</p>		

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F 684	<p>Continued From page 10 level was 449 mg/dl.</p> <p>A Nurse's Progress Note, dated 1/14/19 at 11:05 AM, documented the physician replied to the fax on 1/13/19, requesting information on how much insulin Resident #27 was currently receiving. The note stated the licensed nurse sent Resident #27's current insulin orders to the physician by fax.</p> <p>A physician's order for Resident #27, dated 1/15/19 at 7:00 PM, 2 days following the 1/13/19 notification of high BG levels, documented to increase the amount of the Letemir insulin injection from 58 units to 70 units daily. Resident #27's January 2019 MAR, dated 1/15/19 at 7:00 PM, documented Resident #27's Letemir insulin was increased to 70 units at bedtime and the injection was to be held if her BG level was less than 70 mg/dl.</p> <p>The physician was not notified of Resident #27's BG levels that were greater than 300 mg/dl on 1/8/19, 1/9/19, 1/10/19 - 1/12/19, twice on 1/13/19, 1/14/19, and 1/15/19, per her care plan. Resident #27's record documented the physician was notified via fax on 1/13/19 of her BG levels that were greater than 400 mg/dl and the physician responded with new insulin orders on 1/15/19. The physician orders did not include parameters of when to notify the physician of Resident #27 hyperglycemia.</p> <p>The January 2019 MAR documented Resident #27's BG levels greater than 300 mg/dl from 1/16/19 to 1/18/19 as follows:</p> <p>- On 1/16/19 at 5:30 PM = 472 mg/dl</p>	F 684	<p>Date of Compliance</p> <p>3/7/19</p>		

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F 684	<p>Continued From page 11</p> <ul style="list-style-type: none"> - On 1/16/19 at bedtime = 473 mg/dl - On 1/17/19 at 7:30 AM = 325 mg/dl - On 1/17/19 at 11:30 AM = 405 mg/dl - On 1/17/19 at 5:30 PM = 386 mg/dl - On 1/17/19 at bedtime = 382 mg/dl <p>A Nurse's Progress Note, dated 1/16/19 at 7:06 PM, documented Resident #27's BG level before (5:30 PM) dinner was 472 mg/dl and the physician was notified via fax.</p> <p>A Nurse's Progress Note, dated 1/17/19 at 12:29 PM, documented Resident #27's BG level before lunch was 405 mg/dl. The physician was notified Resident #27's BG level before lunch was 405 mg/dl by fax.</p> <p>A Physician's Order for Resident #27, dated 1/18/19 at 11:21 AM, documented to increase Levemir insulin injection by 2 units every 2 days until her fasting BG level was between 150 to 200 mg/dl and to increase her Novolog insulin to 20 units before meals.</p> <p>The physician was not notified of Resident #27's BG levels that were greater than 300 mg/dl per Resident #27's care plan. Resident #27's record documented the physician was notified via fax on 1/16/19 of her BG levels that were greater than 400 mg/dl and the physician responded with new insulin orders on 1/18/19, 2 days later. The new orders did not include hyperglycemia parameters for Resident #27.</p> <p>Resident #27's January 2019 MAR, dated 1/18/19 at 5:30 PM, documented to inject 20 units of Novolog insulin before meals and to hold the injection if her BG level was less than 70</p>	F 684			

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F 684	<p>Continued From page 12 mg/dl.</p> <p>Resident #27's January 2019 MAR, dated 1/18/19 at 7:00 PM, documented to inject 72 units of Letemir insulin one time a day at bedtime and to hold the injection if her BG level was less than 70 mg/dl.</p> <p>The Letemir insulin was order was transcribed to Resident #27's MAR to be administered at bedtime and was increased by 2 units to equal 72 units at bedtime. The physician did not write hyperglycemia parameters on when to be notified.</p> <p>On 1/31/19 at 2:09 PM, the DNS stated Resident #27's BG levels were running high in the month of January and the physician was adjusting the routine insulin to get her BG levels down. The DNS was unable to provide a physician's order for Resident #27's hyperglycemia parameters of when to notify the physician. The DNS stated the physician should have been called on 1/13/19 at 5:30 PM when Resident #27's BG level was 428 mg/dl and again should have been called on 1/13/19 at bedtime when her BG level was 449 mg/dl. The DNS stated her expectation for the licensed nurses was to notify the physician by phone not fax when residents' BG levels were out of hyperglycemia parameters. The DNS stated Resident #27 did not receive sliding scale insulin and did not have hyperglycemia parameters. The DNS stated there should have been a physician's order written, the order transcribed to the MAR, and hyperglycemia parameters included on Resident #27 care plan. The DNS stated the nurse did not transcribe the full physician's order on 1/18/19.</p>	F 684			

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F 684	<p>Continued From page 13</p> <p>On 1/31/19 at 2:11 PM, the Director of Clinical Operations stated Resident #27's diabetes mellitus care plan should have been person centered to notify the physician if BG levels were greater than 400 mg/dl, not the facility's standard of 300 mg/dl or the facility's policy of 240 mg/dl. The Director of Clinical Operations stated Resident #27's hyperglycemia parameters on when to notify the physician should have been documented in a physician's order, then transcribed onto the MAR, and the care plan updated. The Director of Clinical Operations agreed the facility did not follow the facility's hyperglycemia policy.</p> <p>On 1/31/19 at 2:15 PM, the Director of Clinical Operations and the DNS stated Resident #27's physician's order on 1/18/19 for the Levemir insulin was not transcribed accurately on the MAR. The DNS stated "fasting" meant Resident #27's BG level should have been checked in the morning before breakfast and the Levemir should have been administered in the morning before breakfast not at bedtime.</p> <p>2. Resident #32 was admitted to the facility, on 1/17/18, with diagnoses including diabetes mellitus.</p> <p>Resident #32's diabetes mellitus care plan, dated 1/17/18, directed staff to notify the physician if her blood glucose level was greater than 300 mg/dl and to document the assessments, her symptoms, and the treatments and interventions in the progress notes.</p> <p>Resident #32's January 2019 Physician's Orders</p>	F 684			

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F 684	<p>Continued From page 14</p> <p>documented BG level checks to be completed at bedtime.</p> <p>Resident #32's January 2019 physician's orders did not include hyperglycemia parameters on when to notify the physician.</p> <p>The January 2019 MAR documented Resident #32's BG levels greater than 300 mg/dl from 1/2/19 to 1/28/19 as follows:</p> <ul style="list-style-type: none"> - On 1/02/19 at 9:00 PM = 304 mg/dl - On 1/09/19 at 9:00 PM = 352 mg/dl - On 1/19/19 at 9:00 PM = 336 mg/dl - On 1/22/19 at 9:00 PM = 324 mg/dl - On 1/28/19 at 9:00 PM = 361 mg/dl <p>On 1/31/19 at 12:30 PM, the Director of Clinical Operations stated although there was no physician's order for Resident #32's BG level threshold for notification of the physician, Resident #32's BG level threshold was 350 mg/dl per the alert in the electronic MAR and 300 mg/dl per her care plan.</p> <p>On 1/31/19 at 2:00 PM, LPN #1 stated the facility's hyperglycemia policy included notification of the physician when a resident's blood glucose was greater than 400 mg/dl unless the resident had physician's orders for other parameters. LPN #1 stated Resident #32 did not have an order for notifying the physician for hyperglycemia parameters. LPN #1 stated</p>	F 684			

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F 684	<p>Continued From page 15</p> <p>Resident #32 did not have BG levels higher than 400 mg/dl. LPN #1 stated he was not aware the facility's Hyperglycemic and Diabetic Coma policy documented licensed staff were to notify the physician if residents' BG levels were greater than 240 mg/dl.</p> <p>On 1/31/19 at 2:09 PM, the Director of Clinical Operations and the DNS stated Resident #32 did not have a physician's order for hyperglycemia parameters and the facility was not following her care plan of notifying the physician when her BG levels were greater than 300 mg/dl.</p> <p>The facility policy/procedures, electronic record alerts, and staff understanding of what BG constituted hyperglycemia, were inconsistent. The policy identified 240 mg/dl, staff interview identified 300 mg/dl, the alert in the e-MAR system was 350 mg/dl and the leadership staff indented 400 mg/dl.</p> <p>3. Resident #46 was admitted to the facility on 11/15/18, with multiple diagnoses including an infection to the right hip following surgery.</p> <p>A discharge MDS assessment, dated 1/2/19, documented Resident #46 was discharged to an acute care hospital and not anticipated to return to the facility.</p> <p>A Nurse's Progress Note, dated 1/2/19 at 6:31 PM, documented Resident #46 was admitted to a hospital and would not come back to the facility due to the physician's preference to monitor him more closely.</p> <p>Resident #46's record did not include a</p>	F 684			

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F 684	Continued From page 16 physician's order to discharge him to the hospital. On 1/31/19 at 3:54 PM, the DNS stated Resident #46 was at the physician's office for an appointment on 1/2/19 and the physician called the facility and stated Resident #46 was going to be admitted to the hospital from the physician's office. The DNS was unable to provide documentation Resident #46 was a direct admit from the physician's appointment on 1/2/19, reason for admission to the hospital, and a physician's order to discharge him to the hospital.	F 684			