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	345448	A. BUILDING ______ B. WING ______	C 06/04/2021

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F 000	INITIAL COMMENTS The survey team entered the facility on 5/25/2021 and 5/27/2021 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 5/26/2021, 5/28/2021-5/29/2021 and 6/1/2021-6/4/2021. Therefore, the exit date was 6/4/2021. 1 of the 5 complaint allegations was substantiated and resulted in deficiency F757. Event ID# OJGP11.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		7/16/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/01/2021

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 655	Continued From page 1 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours for 1 of 1 Resident (Resident #1). The findings included: Resident #1 was admitted to the facility's COVID unit on 1/21/2021 with a diagnosis that included Type 2 Diabetes Mellitus without complications. Review of Resident #1's hospital discharge summary dated 1/19/2021 revealed the resident was discharged with diagnoses of diabetes mellitus type 2 and COVID-19 virus infection. A review of Resident #1's medical record revealed no baseline care plan to monitor the diagnosis of diabetes. A review of the Nurse Practitioner's (NP) progress note dated 1/21/2021 revealed Resident #1 had a diagnosis of type 2 diabetes mellitus.	F 655	Maple Grove acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Maple Grove reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. F 655 483.21 Baseline Care Plans	

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F 655	Continued From page 2 An interview with Minimum Data Set (MDS) Coordinator #1 on 5/27/2021 at 12:32 pm indicated nurses were responsible for baseline care plans. She revealed the care plan would be updated when the admission assessment and Care Assessment Areas (CAAs) were completed. An interview with the Administrator on 5/29/2021 at 12:25 pm revealed Resident #1 did not have a baseline care plan that included interventions for diabetes. The Administrator indicated the facility was unaware that Resident #1 was diabetic until the resident's family member contacted the facility inquiring about Resident #1's blood sugar levels. The Administrator revealed it was the responsibility of the admitting nurse to complete baseline care plans and to assess residents. An interview was conducted with the Director of Nursing (DON) and the facility Administrator on 6/2/2021 at 9:40 am. The DON revealed diabetes was not typically care planned unless there was a physician order for blood sugar checks. An interview with Nurse #2 on 6/2/2021 at 10:06 am revealed she was the unit manager at the time Resident #1 was residing at the facility. She further revealed the admission nurse was responsible for completing the baseline care plan but she believed they were unaware they were responsible. Resident #1 did not have a baseline care plan and was prescribed Metformin (oral antidiabetic). She further indicated that diabetes was not on Resident #1's hospital discharge summary and the facility was unaware Resident #1 was diabetic upon admission. Blood sugar checks were ordered following a discussion with Resident #1's family member who was inquiring	F 655	1. Resident #1 no longer resides at the facility. 2. Any resident presently residing at the facility is at risk. 3. Root Cause Analysis: Facility Nurses and the Agency Nurses were unaware it was their responsibility to initiate and update baseline care plans. On 6/25/2021, Staff Development Coordinator, Director of Nursing, and Unit Managers began baseline care plan education. The education was for the facility nurses and the agency nurses. The education covered updating care plan baseline care plans, including baseline care plans will be completed within 48 hours. The education was completed on 7/16/2021. Any facility nurses and agency nurses presently working at the facility will not be allowed to work until the nurse has received this education. Any newly hired nurse/new agency staff nurse working will also receive this education prior to working independently. On 6/29/2021, the Director of Nursing and Unit Managers completed a 100% audit of baseline care plans. The audit revealed 80% of baseline care plans were not completed/revised timely. 100% of baseline care plans were revised/updated by 6/29/2021. On 7/2/2021, Administrator and Director	

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F 655	Continued From page 3 about blood sugar levels. The family member informed the facility the resident was diabetic. Nurse #2 indicated monitoring diabetic residents typically included reviewing labs, diet orders and possibly blood sugar checks. An interview with the Administrator on 6/2/2021 at 3:21 pm revealed he was not sure how the diagnosis of diabetes was missed for Resident #1. He stated baseline care plans were created within 24 hours to 48 hours of admission and residents admitted with diabetes should have the diagnosis and medications included in a baseline care plan. The Administrator further revealed the DON was made aware of Resident #1's diagnosis of diabetes after a family member called the facility.	F 655	of Nursing began reviewing Care Plan Timing & Revision in the morning interdisciplinary team (IDT) meeting to ensure care plans are initiated and revised timely. Beginning on 7/2/2021, prior to the IDT meeting, the Director of Nursing and Assistant Director of Nursing will meet and discuss the Care Plans. Anyone that does not have a baseline care plan will be discussed in the morning IDT Meeting. 4. The Director of Nursing/Assistant Director of Nursing/Unit Mangers will conduct Quality Assurance Audits on baseline care plans. The audits will be completed: 5 residents weekly for 3 months, 3 residents weekly for 3 months, 2 residents weekly for 3 months. The results of the Quality Improvement monitoring will be reported by Director of Nursing/Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee monthly for nine months for continued substantial compliance and/or revision.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		7/16/21

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(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to update a falls care plan interventions, specifically placing the resident in a gerichair at the nursing station and continual monitoring for 1 of 2 Residents (Resident #2) who was assessed as high risk for falls.

The findings included:

Resident #2 was admitted to the facility on 2/8/21 with a diagnosis that included Adult failure to thrive, retention of urine, dementia without behavioral disturbance, fracture shaft of femur and nondisplaced fracture of olecranon (bony prominence of the elbow).

The admission Minimum Data Set (MDS)

F 657

F 657 483.21 Care Plan Timing & Revision POC

1. Resident #2 no longer resides at the facility.

2. Any resident presently residing at the facility is at risk.

3. Root Cause Analysis: Facility Nurses and the Agency Nurses were unaware it was their responsibility to update the care plans with interventions and timely revisions.

On 6/25/2021, Staff Development Coordinator, Director of Nursing, and Unit Managers began care plan intervention

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assessment dated 2/15/21 revealed Resident #2 required extensive assistance with Activities of Daily Living (ADL) and was moderately cognitively impaired. Resident #2 was coded as having a fall prior to admission and no falls while residing in the facility.

Resident #2's care plan dated 2/9/21 revealed she was at risk for falls due to dementia, failure to thrive, retention of urine, fracture of right femur, history of falls, was incontinent of bowel and bladder, had an unsteady gait, and impaired cognition. The goal stated Resident #2 would not sustain serious injury. The interventions included bed in lowest position, encourage resident to take rest periods as needed, have commonly used articles within easy reach. The interventions further stated, keep call light in reach due to Resident #2's impaired cognition, may not use call light always, observe and intervene for factors causing falls, observe for signs and symptoms of shortness of breath and wear nonslip footwear.

An incident report dated 2/25/21 revealed staff responded to Resident #2 yelling heard at the nurse's desk. The report indicated the fall was unwitnessed. Resident #2 was on floor with her head against her bed. Intervention put into place post incident revealed Resident #2 was placed in bed in the lowest position. Resident Quality Assurance report stated Resident found on floor with head on bed bottom. Resident had small knot on the back of her head.

Resident #2's fall care plan revealed it was updated on 2/25/21 included interventions to include pin call bell to Resident #2's gown when in bed, environment free of clutter, assist resident with transfer and mobility due to unsteady gait

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education. The education was for the facility nurses and the agency nurses. The education covered updating care plan interventions and timely revisions. The education was completed on 6/28/2021.

Any facility nurses and agency nurses presently working at the facility will not be allowed until the nurse has received this education. Any newly hired nurse/new agency staff nurse working will also receive this education.

On 6/29/2021, the Director of Nursing and Unit Managers completed a 100% audit of baseline care plans. The audit revealed 80% of baseline care plans were not completed/revised timely. 100% of baseline care plans were revised/updated by 6/29/2021.

On 7/2/2021, Administrator and Director of Nursing began reviewing Care Plan Timing & Revision in the morning interdisciplinary team (IDT) meeting to ensure care plans are initiated and revised timely.

4. The Director of Nursing/Assistant Director of Nursing/Unit Mangers will conduct Quality Assurance Audits on care plans for timing and revisions. The audits will be completed: 5 residents weekly for 3 months, 3 residents weekly for 3 months, 2 residents weekly for 3 months. The results of the Quality Improvement monitoring will be reported by Director of Nursing/Assistant Director of Nursing to the Quality Assurance Performance

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F 657	Continued From page 6 and impaired balance. Update further revealed staff were to provide Resident #2 incontinent care routinely and Peri care as needed to maintain comfort. An incident report dated 3/2/21 revealed Resident #2 had an unwitnessed fall and was found lying on the floor by bedside with no skin impairments. The intervention put into place was frequent checks. Resident #2's fall care plan revealed it was updated on 3/2/21 to included provide frequent reminders for resident to call for assistance before getting up. An incident dated 3/4/21 revealed Resident #2 was found on floor in her room. The section titled "Action Taken" stated Resident #2 was assessed, vital signs were taken and was assisted off floor to bed. The witness statement indicated Resident #2 was found on floor in front of her Geri-Chair. Resident #2's fall care plan revealed no updated interventions regarding residents fall from Geri Chair. Nursing note dated 3/5/21 stated Nurse #6 heard noises from Resident #2's room during walking rounds. The note continued that Nurse #6 knocked on Resident #2's door, entered the room and observed the resident between wall and bed with knees bent and her feet underneath her. The note stated Resident #2 sild gently to the floor from a low bed. Resident #2 had urinary catheter, was incontinent of BM and had removed her brief. Incontinent care was provided and Resident #2's bed pushed up against wall as intervention on resident's left side.	F 657	Improvement Committee monthly for nine months for continued substantial compliance and/or revision	

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An incident upright position with knees bent underneath herself and slid to floor. The section titled "immediate action taken" stated Resident's bed was to be placed against the wall on one side when care was not being performed. The investigation summary indicated the care plan was updated to reduce the risk of falls.

Resident #2's fall care plan revealed it was updated with an intervention on 3/5/21 to provide supervision as needed and answer call light timely.

Nursing note dated 3/9/21 revealed Resident #2 was found by a housekeeper lying on the floor on her left side at her bed. The note continued with Resident #2 was at great risk for falls and always needed redirecting to sit back in bed/chair.
An incident report dated 3/9/21 revealed Resident #2 was found by a housekeeper lying on the floor in her room lying on her left side. The section titled "immediate action taken" stated Resident #2 was assessed, vital signs were taken, and she was gotten off the floor.

Resident #2's fall care plan revealed no updated intervention regarding residents fall from her bed.

Incident dated 3/10/21 revealed staff walked by Resident #2 room and noticed the resident sitting on the floor on her bottom with her legs facing the bed. Head to toe assessment was performed with no injuries noticed. The immediate action taken stated Nurse and Nursing Assistant (NA) assisted resident into geriatric chair and placed at nurse station to continue monitoring. Resident #2's bed was in lowest position and call bell was within reach.

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Resident #2 fall care plan revealed no updated intervention regarding Resident #2's repeat falls.

Incident report dated 3/13/21 stated Resident #2 was noted on the floor beside her bed with no injured noted. Interventions put into place post incident stated Resident #2 was up in Geri-chair at nurses' station to be continually monitored.

Resident #2 fall care plan revealed interventions were updated to include when Resident #2 was awake get her up, in wheelchair and place resident in common area for supervision. The intervention did not identify Geri-chair as an intervention as documented in incident report dated 3/13/21.

Nursing note written by Nurse #6 dated 3/15/21 stated Resident #1 frequently required 1:1 staff attention due to fall risk.
Incident report dated 3/18/21 stated Resident #2 slid off her wheelchair. The note stated Resident #2 stated she was attempting to get up and walk. Interventions put into place post incident stated frequent observations.

Resident #2 fall care plan revealed an update to interventions that stated provide frequent staff observations.

Nursing note written by Nurse #3 dated 4/3/21 stated Resident #2 was lying in bed awake and an aide at bedside. While up to Geri-Chair Resident #2 continued to throw her legs over the arms (right/left) of the chair. Staff continuously had to redirect Resident #2. The note continued that staff would continue to monitor Resident #2.

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F 657	Continued From page 9 Interview with Activity Director on 5/27/21 at 10:33 am revealed Resident #2 was cognitively impaired and would refuse care occasionally. Resident #2 was capable of standing. She indicated she was unaware of any fall interventions. She stated on 4/8/21 she was on the hall and noticed Resident #2 in a Geri-chair at the nursing station. She indicated the Geri chair was in the reclined position. She revealed Resident #2 was the only resident at the nursing station at the time of the incident. Resident #2 did not have a one-on-one at the time of her observation. Interview with Nurse #4 on 5/27/21 at 10:48 am revealed one-on-one was an intervention put into place for residents that have frequent falls and are put in common areas for supervision. With one-on-one a Nursing assistant (NA) would wheel the resident round and have things for them to do as far as activities. 30-minute checks or hourly checks are also implemented. The facility had staff that assisted with providing one-on-one. One-on-one interventions were to be documented by the staff providing the one-on-one paper. She was unsure where the file that identified one-on-one was provided. She recalled Resident #2 being placed at the nursing station for observation because she was a frequent faller. She did not recall if she had a one-on-one supervision. She stated it was the responsibility of the floor nurse to update care plan interventions. Interventions that are put into place should be identified in the resident's plan of care. Interview with the MDS coordinator #1 on 5/27/21 at 12:31 pm revealed nursing was responsible for updating resident care plans. She revealed she updated resident care plan when she completed	F 657		

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the care area assessment and admission assessment. The facility was kept abreast of resident falls during interdisciplinary team (IDT) meetings. The MDS coordinator stated she recalled discussions about frequent falls possible interventions. She was unsure of interventions put into place for Resident#2 with falls surrounding falls from resident's chair, bed or if Resident #2 was receiving one-on-one. One-on-one would normally include one staff member with the resident at all times. The intervention of one-on-one should have been updated to Resident #2's fall care plan.

Interview with Nurse #3 on 5/27/21 at 3:55 pm revealed she recalled being assigned to Resident #2. She recalled Resident #2 being with her at the nursing station in her chair. She further recalled NAs also being with the resident at the nursing station. Resident #2 would doze off and then wake up while seated at the nursing station, had a cloth in her hand. In a continued interview at 4:32 pm Nurse #3 revealed she recalled Resident #2 would throw her legs to one side and then the other while seated in her Geri-chair and described Resident #2 as pleasantly confused. She revealed 1:1 was a service provided to residents that required a staff member to be with the resident at all times. She recalled nursing note written 3/15/21 in which Nurse #3 documented 1:1 was frequently required for Resident #2. She stated that if she wrote a note that stated 1:1 then an individual staff person was put with Resident #2 due to her fall risk.

Interview with the Director of Nursing (DON) was conducted on 6/2/21 at 3:00 pm. He had reviewed the care plan should be updated with interventions put into place following incidents of

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falls. He stated it was the responsibly of the floor nurse to update resident care plans to reflect efforts put into place to prevent further falls. Resident #2's care plan was not updated to reflect interventions put into place following the falls identified by incident reports. One-on-one should have been reflected on the care plan and the bed against the wall was not reflected on the care plan. One-on-one should have parameters placed around it as to when it should occur.

Interview with the Administrator on 6/2/21 at 3:31 pm revealed Resident #2's care plan should have been updated per incident reporting and per each individual fall. He further stated other interventions should have been put into place for each fall and facility staff should do whatever to prevent further falls. One on one depends on verbiage. Some one-on-one means bedside care around the clock and some indicated supervision in an area when up so someone could see them. He stated there were no parameters around the resident receiving one-on-one supervision. The care plan should identity what type of supervision was being provided.

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F 711 SS=B	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F 711		7/16/21

§483.30(b) Physician Visits
The physician must-

§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

§483.30(b)(2) Write, sign, and date progress notes at each visit; and

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§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to obtain physician signatures on resident's orders for 4 of 4 residents (Residents #1, #2, #3 and #4).

The Findings included:

1 a. Resident #1 was admitted to the facility's COVID unit on 1/21/2021.
Physician Order sheets revealed orders without physician signatures for the month of January 2021.

b. Resident #2 was admitted to the facility on 2/8/2021.
Physician Order sheets revealed orders without physician signatures for the month of February 2021.

c. Resident #3 was admitted to the facility 1/22/2021.
Physician Order sheets revealed orders without physician signatures for the months of January 2021 and February 2021.

d. Resident # 4 was admitted to the facility on 1/21/2021.
Physician Order sheets revealed orders without physician signatures for the months of January 2021 and February 2021.

F 711

F711 483.30 Physician Visits - Review Care/Notes/Order
1. Resident #1 no longer resides at the facility.
Resident #2 no longer resides at the facility.
Resident #3 no longer resides at the facility.
Resident #4 no longer resides at the facility.

2. Any resident presently residing at the facility have the potential to be affected.

3. Root Cause Analysis: Nursing Leadership/Staff Nurses and Agency Nurses were not aware and or following through with obtaining Physician Designated Provider signatures and dates on all orders.
On 6/25/2021, Medical Records Director, Staff Development Coordinator and the Director of Nursing were educated by the facility Licensed Nursing Home Administrator (LNHA) regarding ensuring weekly physician/ designated provider signatures and dates are on all orders.
The education by LNHA also included for any physician orders not signed and dated by a physician/designated provider, the Director of Nursing/Assistant Director of

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F 711	Continued From page 13 An interview was conducted with the Director of Nursing (DON) and the Administrator on 6/2/2021 at 9:40 am. The DON revealed orders were signed by the physician once a week. He was unaware Resident #1's physician orders were unsigned. An interview was conducted with the Administrator and the DON on 6/4/2021 at 2:49 pm. The DON stated orders should be signed by a physician when they come to the facility. He was unsure of why physician orders were unsigned. The Administrator indicated all physician orders should be signed by a physician.	F 711	Nursing will notify the facility physician/designated provider to sign and date the unsigned orders. On 6/25/2021, nurse management were educated by Staff Development Coordinator and Director of Nursing regarding Physician/designated provider orders should be checked after each physician/designated provider visit to the facility. The orders should be checked prior to the following morning Cardinal IDT meeting. Any orders that have not been signed by a physician/designated provider will be given to the Director of Nursing/Assistant Director of Nursing who will notify the physician/designated provider for the required signature timely (weekly). On 6/25/2021, facility nurses/agency nurses were educated by Staff Development Coordinator and Director of Nursing regarding placing any orders requiring a physician/designated provider signature in the Medical Doctor/designated provider book located at the nurse station. This education will be completed by 7/16/2021. Any nurses/agency nurses working at the facility will not be able to work until the nurse has received this education. Any newly hired nurse/new agency staff nurse employed will be educated on the process of placing any orders requiring a physician/designated provider signature in the Medical Doctor/designated provider book located at the nurse station.	

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F 711	Continued From page 14	F 711	On 6/24/2021, a 100% audit of Physician orders was completed by Director Of Nursing and Unit Managers. The Medical Records Director sent any unsigned orders to the Physician/designated provider to be signed. On 7/1/2021 a 100% audit was completed by the Director of Nursing (DON) and Unit Managers who checked the April, May, June pharmacy recommendations for unsigned physician orders. The audit revealed that the pharmacy recommendations did not identify unsigned physician orders. Starting 7/1/2021, the Director of Nursing and Unit Managers will check the pharmacy recommendations reports for unsigned physician orders. The Director of Nursing and Unit Managers will notify the physician within 24 hours of any unsigned physician orders identified by pharmacy. 4. The Director of Nursing/Assistant Director of Nursing/Unit Mangers will conduct Quality Assurance audits to ensure orders have been signed by a physician/designated provider. Audits will be completed as follows: 5 random residents' physician orders weekly for 9 months. The results of the Quality Improvement monitoring will be reported by Director of Nursing/Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee monthly for nine months for continued substantial compliance and/or revision.	

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F 757 SS=H	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, hospital record review, family interview, staff interviews, consultant pharmacist, nurse practitioner, and physician interviews, the facility administered multiple unnecessary doses of a steroid medication to Resident #1 over the course of six days which had an outcome of elevated blood sugars requiring insulin administration to correct. The facility also failed to monitor blood sugars after the physician ordered monitoring. Resident #1 was admitted to the hospital and diagnosed with urinary tract infection with sepsis. This problem	F 757	F 757 483.21 Drug Regimen is Free from Unnecessary Drugs 1. Resident #1 no longer resides at the facility. 2. Any resident presently residing at the facility is at risk for unnecessary drugs. 3. Root Cause Analysis: Nurse failed to properly transcribe physician order. On 5/30/2021, the Director of Nursing began educating the facility nurses,	7/16/21

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affected 1 of 3 Residents (Resident #1) reviewed for medication errors.

The findings included:

Resident #1's hospital discharge summary dated 1/19/2021 revealed that the resident was discharged with diagnoses of diabetes mellitus type 2 and COVID-19 virus infection. Resident #1 received Decadron (steroid) for COVID-19 treatment while in the hospital and the medication was completed on 1/16/2021. Resident #1 was not discharged on Decadron or insulin. The resident was discharged on Metformin (oral antidiabetic medication). The summary indicated hospice would be revoked while the resident was at the Skilled Nursing Facility (SNF) and hospice should resume after discharged from the SNF.

Resident #1 was admitted to the facility's COVID unit on 1/21/2021 with diagnoses that included COVID 19 positive and type 2 diabetes mellitus without complications.

The admission Minimum Data Set (MDS) dated 1/28/2021 revealed Resident #1 was cognitively intact and had an active diagnosis of diabetes mellitus.

Resident #1's medical record revealed no baseline care plan for the diagnosis of diabetes or the use of a steroid.

A standing order titled "All Residents Admit Orders" for the COVID unit included an order for Decadron 6mg by mouth daily for 10 days to start after 7 days of admission.

Resident #1's admission medication orders titled

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agency nurses, and medication aides on medication order transcription and drug regimen administration to ensure drug regimen is free from unnecessary drugs. The education was completed on 6/6/2021.

On 6/6/2021 the Staff Development Coordinator (SDC) began educating the facility nurses, agency nurses, and medication aides on medication order transcription and drug regimen administration. The education will be completed by 7/16/2021.

Any facility nurses, agency nurses, or medication aides will not be allowed to work until the nurse/medication aide has received this education. Any newly hired facility nurse, new agency nurse, or medication aide will receive this education prior to working independently.

On 7/1/2021 a 100% audit was completed by the Director of Nursing (DON) and Unit Managers who checked all MARs for unnecessary medications. The audit revealed that no residents were receiving unnecessary medications.

On 7/1/2021 a 100% audit was completed by the Director of Nursing (DON) and Unit Managers who checked the April, May, June pharmacy recommendations for unnecessary medications. The audit revealed that no residents were receiving unnecessary medications. Starting 7/1/2021, the Director of Nursing and Unit Manages will check the pharmacy

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F 757	Continued From page 17 "Physician's Orders" dated 1/21/2021 included Decadron 6 milligrams (mg) by mouth four times a day for 10 days. The medication orders were transcribed by Nurse #1 and did not have a physician's signature on the order page. The orders further revealed that they were not signed off or reviewed by a second nurse. Resident #1's progress note dated 1/21/2021 revealed Decadron was not listed. The note was signed by the Nurse Practitioner (NP) and revealed the resident had a diagnosis of type 2 diabetes mellitus. A pharmacy notification dated 1/21/2021 at 2:58 pm questioned whether the Decadron was really four times daily (qid). A clarification was requested before the pharmacy sent the medication. An additional notification was sent by the pharmacy on 1/21/2021 at 7:58 pm that stated clarify Decadron qid. The notifications were faxed to the facility. The notifications were not signed by the physician. Resident #1's medication administration record (MAR) for the month of January 2021 revealed the resident received Decadron 6mg by mouth qid beginning on 1/22/2021 and it was discontinued on 1/28/2021. The resident was administered 25 doses of Decadron 6mg. An interview with Resident #1's family member on 6/1/2021 at 11:32 am revealed they were contacted by the facility when a medication error occurred for a steroid. They stated that the man that called them informed them there were no orders for blood sugar checks or insulin. They further revealed that they had contacted the facility before the medication error occurred to	F 757	recommendations reports for unnecessary medications. The Director of Nursing and Unit Manager will notify the physician of any identified unnecessary medications within 24 hours. 4. The DON/Assistant Director of Nursing (ADON) will conduct quality assurance (QA) audits on all residents to ensure the drug regimen is free from unnecessary drugs. The audits will be completed as follows: 5 residents weekly for 3 months; 3 residents weekly for 3 months, and 2 residents weekly for 3 months. The results of the QA audit will be reported by the DON/ADON to the Quality Assurance Performance Improvement Committee (QAPI) monthly for nine months for continuous substantial compliance and/or revision.	

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inquire about Resident #1's blood sugar levels. The family member indicated they informed the facility that Resident #1 had diabetes. The family member stated blood sugar checks began after they spoke with the Director of Nursing (DON). The family member contacted the area ombudsmen who notified the family member to contact emergency services (911) if the facility was not meeting the resident's needs.

Resident #1's physician order dated 1/26/2021 revealed blood sugars should be checked every morning at 6:00 am.

The MAR for January 2021 revealed Resident #1's blood sugar level was not recorded in the morning on 1/27/2021 or 1/28/2021.

Medication Regimen Review dated 1/28/2021 by the consultant pharmacist (Pharmacist #2) revealed Resident #1 was admitted with an order for Decadron 6mg four times daily for 10 days. Pharmacist #2 indicated that the typical protocol had been for QD (daily) and requested verification of the Decadron (steroid) order. Pharmacist #2 noted the Director of Nursing (DON) was emailed 1/28/2021 at 12:00 (am or pm not provided) the information regarding the high frequency of ordered Decadron.

A nurse progress note dated 1/28/2021 revealed Resident #1's blood sugar level was 445 mg/dl (milligrams per deciliter). According to the Mayo Clinic, 140 mg/dl or less was considered a normal blood sugar level.

Resident #1's physician order dated 1/28/2021 discontinued Decadron 6mg, added 14 units of Humalog (insulin) 100 units/milliliter

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F 757	Continued From page 19 subcutaneous once now then check blood sugar, checked blood sugar ACHS (before meals and at bedtime) and gave Humalog (insulin) according to sliding scale. The order continued with Resident #1's blood sugar should be checked every 4 hours for 24 hours. The "IDT Review of Incident" report 1/28/2021 indicated that a medication error occurred on 1/28/2021 and described the incident as an incorrect Decadron order. The "actions taken during investigation" revealed the medical doctor and family were notified of the medication error. New orders were updated on the MAR and in Resident #1's chart. The area identifying follow up, systemic changes, in-servicing and monitoring were left blank. No outcome was identified. Post facility hospital records indicated Resident #1 was admitted to the hospital 2/1/2021. She remained in the hospital until 2/11/2021 when she was discharged home with hospice. Resident #1 was treated for urinary tract infection as a source of sepsis during her hospital stay. An interview on 5/28/2021 at 9:33 am with Nurse #1 revealed he was working at the facility as a contract (agency) nurse at the time the medication transcription error occurred. Nurse #1 stated that a standing order was taped at the nurse's station on the COVID unit that included an order for Decadron. The standing order was used to transcribe Resident #1's medication orders. Nurse #1 revealed that the transcription error was identified after Resident #1's family member called and asked Nurse #1 about the resident's medications. The family member informed Nurse #1 that the resident should not be	F 757		

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on Decadron. Nurse #1 then reviewed the resident's orders and determined that Resident #1 was receiving an incorrect dose of Decadron. He did not recall the frequency for the use of Decadron.

An interview with the consultant pharmacist (Pharmacist #1) on 5/28/2021 at 2:15pm revealed she had not seen an order like Decadron 6mg qid before this order. Pharmacist #1 revealed that the indicated dose and frequency of 6mg qid were high for Decadron. The pharmacy and dispensing team made 2 attempts to clarify the Decadron medication order by faxing the facility's nursing station on 1/21/2021. Pharmacist #1 revealed that the pharmacy did not dispense the medication until 1/23/2021 or 1/24/2021. The medication was dispensed after the pharmacy received a refill request. Pharmacist #1 further indicated that a result of taking Decadron (steroid) 6mg qid was increased blood sugar levels.

An interview with the Nurse Practitioner (NP) on 5/28/2021 at 3:45 pm revealed that there were standing orders at the nurse's station for COVID patients. She further revealed that Resident #1 should not have received Decadron at admission due to the order stating the resident should receive it 7 days after admission. The NP was not aware that Resident #1 was receiving Decadron until she was notified of the medication transcription error. The NP stated that Resident #1's blood glucose level was elevated at the time that the medication error was identified on 1/28/21. She did not recall the exact blood sugar level. The NP revealed that she was typically notified of medication issues when nurses received faxes at the facility. In an interview on

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6/1/2021 at 4:22 pm, the NP indicated that she signed all orders to include every order sheet. The NP revealed that all orders must have a doctor or nurse practitioner's signature. A follow up interview was conducted with the NP on 6/2/2021 at 2:03 pm. The NP was shown the standing order document that was provided to the survey team by the Director of Nursing (DON). The NP did not recognize the standing orders and relayed that it was not her handwriting. She did not know who wrote the order for Decadron on the standing order sheet. She further relayed that she "clearly wouldn't have ordered [Decadron] QID."

An interview with the DON on 5/28/2021 at 4:21 pm revealed that it was the responsibility of the nurse on the unit to review received faxes and to call the doctor as indicated. The DON also stated that a physician's signature at the top of the standing order page was good for all the orders on the page. The DON further revealed that the process for transcribing orders should include a second nurse review. He did not know why the transcribed order for Decadron was not reviewed by a second nurse. The DON was unaware of how Resident #1 received doses of Decadron prior to the medication being dispensed by the pharmacy. The DON relayed that nurses should follow doctor's orders and that he didn't know why Resident #1's blood sugar levels were not checked prior to 1/28/2021.

An interview with the Administrator on 5/29/2021 at 12:25 pm revealed that the facility was unaware that Resident #1 had diabetes until the resident's family member began contacting the facility regarding the resident's blood sugar levels.

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F 757	Continued From page 22 An interview was conducted with the physician on 6/1/2021 at 5:56 pm. The physician revealed that he provided the facility with standing orders and a Decadron protocol that included Decadron 6mg to be given daily for 10 days for residents on the COVID unit. The physician stated that he provided a typed and signed standing order to the facility for the nurses to use. The physician was shown the standing order that was provided to surveyors by the Director of Nursing and used to transcribe the Decadron. He revealed that he did not know who wrote the order for Decadron on the handwritten standing order sheet. He stated that it was not his handwriting and that the order was not signed by him. He further revealed that he would never prescribe Decadron 6mg four times a day and that an effect of receiving Decadron was a high blood sugar level. The physician stated that nurses would call or fax the physician or nurse practitioner regarding medications that needed to be reviewed. The physician was unaware of any pharmacy notifications dated 1/21/2021. An interview was conducted with the Director of Nursing (DON) and the Administrator on 6/2/2021 at 9:40 am. The DON revealed that on 1/28/2021 he received the pharmacy recommendation via email to clarify the Decadron medication order. The DON relayed that the recommendation was forwarded to the COVID unit manager (Nurse #2) who was to contact the doctor for medication clarification. The DON was unaware of the communications sent by pharmacy on 1/21/2021 asking for Decadron medication clarification. In reviewing the standing orders sheet, the DON revealed that he was unaware that the Decadron order was not signed by a physician. He further revealed that unsigned physician's orders were	F 757		

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MAPLE GROVE HEALTH AND REHABILITATION CENTER	**308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406**

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F 757	Continued From page 23 not orders. The DON reviewed the standing order and stated that he did not know who wrote the order for Decadron. The DON indicated that blood sugar levels may not be monitored for residents with diabetes unless there was an order for blood sugar checks. An interview with Nurse #2 on 6/2/2021 at 10:06 am revealed she was the unit manager for the COVID unit at the time that Resident #1 was residing at the facility. Nurse #2 was familiar with the medication transcription error that occurred for Resident #1. Nurse #2 stated that she did not recall receiving pharmacy notifications on 1/21/2021 regarding a Decadron order clarification. She revealed that Decadron should never have been given without a second nurse completing a review of the orders. She further revealed that the error could have been prevented with a second nurse verification of the orders. Nurse # 2 indicated the Nurse Practitioner or Physician should sign all orders. A follow up interview was conducted 6/2/2021 at 1:29 pm. Nurse #2 recalled the COVID unit's standing orders were taped at the nurse's station and that it had the physician's signature on it. When shown the standing orders that were provided by the facility, Nurse #2 stated that she did not recognize them. Nurse #2 did not know who wrote the order for Decadron. She was unable to locate the original standing orders because she no longer had access to COVID unit documents. Nurse #2 revealed that Resident #1's blood sugar checks were ordered after the family member inquired about them and informed the facility that Resident #1 had diabetes. She was unaware that Resident #1 had a diagnosis of diabetes upon admission.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING ______ B. WING ______	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 24 An interview was conducted with the Administrator on 6/2/2021 at 3:21 pm. The Administrator revealed orders should come from the doctor and that sometimes the doctor only signed the order on the front. The Administrator stated that the physician was notified when orders needed signatures. The Administrator revealed that the Physician and the Nurse Practitioner were the only providers that could write orders at the facility. He indicated that there was not a physician's signature on the standing order sheet for Decadron. The Administrator stated pharmacy recommendations should be followed as written. He further revealed that it was the responsibility of the DON to ensure that recommendations are carried out by nurses. He did not recall discussing the pharmacy recommendations that were dated 1/21/2021 during the facility's team meetings. The Administrator became aware of the medication transcription error on 1/28/2021 during a facility team meeting. The Administrator stated that he was part of the investigation for the medication transcription error and that it was inconclusive as to who wrote the Decadron order. The Administrator revealed that he recently spoke with the physician regarding the standing order and that the physician denied writing the order for Decadron. The Administrator further indicated that he was not sure how a diabetes diagnosis was missed.	F 757		