STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A188	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOLIVAR MEDICAL CENTER LTC	901 E SUNFLOWER RD CLEVELAND, MS 38732

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification from 9/17/19 through 9/19/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid and cited regulatory deficiencies at F641 and F842. The census was 32 and the facility was licensed for 35 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately complete the Minimum Data Set (MDS) for a resident who required a lap buddy for safety, Resident #16 and failed to code the MDS accurately for pressure ulcers for Resident #19; for two (2) of 18 assessments reviewed. Findings include: Review of the facility policy titled, "Nursing Assessment and Interdisciplinary Care Plan", 2019, revealed, "...Procedure:...2. Long Term Care Facility will conduct a comprehensive, accurate, standardized reproducible assessment upon admission and at regular intervals to ensure that each resident meet his/her highest practicable level of physical, mental, and psychosocial functioning".	F 641	1. Director of Nursing (DON)discussed the deficiency with the MDS/Registered Nurse (RN)Coordinator and the other nurses on duty on September 18, 2019. For Resident #16,in which a restraint was inaccurately coded for her, the DON provided education on restraint definitions and the proper coding for restraints on the MDS. Resident #16 should not have been coded for a restraint because she is able to easily remove the lap buddy. The MDS/RN Coordinator completed and submitted an MDS Modification on September 18, 2019 and correctly coded the lap buddy as 0 (no restraints). For Resident #19, in which the MDS/RN Coordinator failed to code the MDS accurately for pressure ulcers by coding two pressure sores as Stage 3 for both, but there was no documentation to	10/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2019

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F 641	Continued From page 1 Resident #16 Record review of the MDS, with an Assessment Reference Date (ARD) of 7/24/19, revealed a Trunk restraint was marked as used daily. Record review of the Medication Review Report dated September 3, 2019, revealed "Lap Buddy and or lap tray to wheelchair for safety every shift", with a start date of 12/1/16. On 09/18/19, at 12:28 PM, during an interview with Registered Nurse #1/ MDS nurse, she stated that the lap buddy is an enabler because Resident #16 has problems with poor balance. She leans forward in her chair and she takes it off frequently. She also likes to lean forward and rest on it. She stated "It kind of helps her and enables her. It was my misunderstanding that it was coded on the MDS as a restraint. It should not have been coded on the MDS as a restraint. That's an error". During an interview on 09/18/19, at 12:57 PM, the Director of Nursing (DON) revealed that the definition of a restraint is something that the resident cannot remove easily. She stated that some days she removes it, and when asked to remove the lap buddy for lunch and toileting, she does. She stated that it is not a restraint for Resident #16, but an enabler. On 09/18/19 at 02:50 PM, in an interview with Resident #16's Responsible Party, her daughter, she stated, "That lap buddy is for her safety. It doesn't stop her from getting up. She takes it off all the time when she wants to". On 09/18/19 at 03:15 PM, interview with the DON confirmed, "It is the policy of the facility to	F 641	support this from 8/2/19 - 8/8/19, the DON provided education on staging pressure sores based on MDS definitions and that there must be documentation in the weekly assessments that includes the correct stage and a description to support that. The MDS/RN Coordinator completed and submitted an MDS Modification on October 7,2019 and correctly coded the 2 pressure sores as Stage 2, as based on the actual description in the weekly pressure sore assessment. 2. All other residents with pressure sores have the potential to be affected by inaccurate coding and documentation on the MDS for presure sores and restraints. There was only one other resident who had a pressure sore, and on September 19, 2019 the DON and MDS/RN Coordinator reviewed the MDS coding and weekly documentation to validate the correct coding and found the pressure sore was coded correctly, based on the documentation required to support the stage. There were no other residents who were coded with a restraint. The DON began educating all nurses on September 18, 2019 on the MDS requirements for properly documenting and coding pressure sores and restraints. 3. STAFF TRAINING: The DON began education with the nurses on September 18, 2019 and also held a mandatory in-service for all nurses on October 9, 2019. The MDS/RN Coordinator, the Registered Nurse (RN) Supervisor, and all other nurses were educated on the proper	

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F 641	Continued From page 2 complete the MDS accurately to reflect the condition of the resident during the look back period. It was completed inaccurately by the MDS nurse, due to lack of knowledge". Resident #19 Record review of the Quarterly MDS with an ARD of 8/8/19, revealed the number of pressure ulcers was documented as two (2). Review of physician's orders and nurse's notes for the look back period of 8/2/19 - 8/8/19 revealed no documentation of a Stage 3 pressure ulcer in the medical record. In an interview on 09/18/19 at 4:44 PM, Registered Nurse #1(RN)/MDS nurse, she stated that the Resident #19 doesn't have a pressure ulcer on the side of the right foot plantar area at this time, it was healed in May. She stated the resident has a place on the left foot now. During an interview on 09/18/19 at 5:00 PM, the Director of Nursing (DON) confirmed that there was no documentation in the resident's medical record of a Stage 3 or Stage 4 pressure ulcer during the look back period for the Quarterly MDS with an ARD of 8/8/19. She stated "RN #1 couldn't find any either".	F 641	MDS coding for pressure sores and restraints. Nurses will have full understanding of requirements as follows: a. Staging of pressure sores - nurses will understand the 4 stages of pressure sores based on MDS requirements and definitions and how to accurately code the correct stage on the MDS, based on the documentation required to support the stage. b. The MDS/RN Coordinator or one of the other registered nurses who complete pressure sore assessments will now be required to include the staging of pressure sores in each weekly assessment. c. The MDS/RN Coordinator will now be required to notify the DON and/or RN Supervisor of any new MDS that is coded with a pressure sore, and the MDS will be reviewed before submission to CMS for accuracy. d. Restraints - nurses will understand the definition of a restraint and how to accurately code a restraint on the MDS. Nurses will understand when a lap buddy is considered a restraint. e. The MDS/RN Coordinator will now be required to do a restraint assessment during care plan for any resident with a lap buddy or restraint to help determine how to accurately code the MDS. Additionally, the MDS/RN Coordinator will be required to notify the DON or RN Supervisor of any new MDS that is coded with a restraint for review for accuracy before the MDS is submitted to CMS. 4. The DON began conducting weekly audits on September 24, 2019 and she or	

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F 641	Continued From page 3	F 641	the RN Supervisor will continue weekly audits for four weeks to capture all future MDS coding of pressure sores and restraints and if compliance is achieved, audits will then go to monthly for at least one year. Any noted problems will be addressed immediately. Audit findings will be reported by the DON to the Quality Assurance Performance Improvement Committee and by the Administrator to the Bolivar Medical Center Quality Council quarterly and recommendations will be made as needed to ensure full compliance with the requirements.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		10/18/19

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F 842	Continued From page 4 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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F 842	Continued From page 5 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately document a physician's order related to insulin dose for one (1) of 18 resident records reviewed, Resident #1. Findings include: Facility policy review revealed: It is the policy the facility to ensure safe ordering and transcribing of medication orders to enhance medication safety. All orders entered electronically by a physician or nurse must be verified by a pharmacist, prior to administration. If a pharmacist is not available to verify medication, then a second nurse must verify the order prior to administering the dose. Record review of physician's orders revealed the following phone order with an order date of 8/23/2019 - Novolog Solution 100 unit/ML (milliliter)- Inject 24 ML subcutaneously before meals related to Type 1 Diabetes Mellitus without Complications. The order was taken and entered by Licensed Practical Nurse #2, and reviewed by Licensed Practical Nurse #1. The physician signed off on the order on 8/29/2019. Review of the Medication Administration Record (MAR) for August and September 2019, revealed documentation that the dose of 24 milliliters of insulin was given to Resident #1.	F 842	1. Director of Nursing (DON) discussed the deficiency on September 18, 2019 with all nurses on duty, including Licensed Practical Nurse (LPN)#1 and LPN #2 and also notified the attending physician of the error in which a phone order was inaccurately entered in the electronic medical record for Novalog Solution 100 unit/ML(milliliter)- inject 24 ML subcutaneously before meals related to Type 1 Diabetes Mellitus without complications. The order should have been for Novolog 24 units. An incident report was done and the Risk Manager was notified. Our electronic medical records "Help Desk" was notified of the error and this will be reviewed with one of their committees to determine possible solutions in terms of the computer possibly tagging future errors of this kind. That will be done off site as a possible solution, in addition to what our Long Term Care Facility (LTCF) is implementing. The provider of pharmaceutical services for LTCF, including medications and pharmacy consultants, was notified of the error to alert their staff to make sure no insulin is ordered with milliliters. For Resident #1, the attending physician was notified on September 18, 2019 of the error and a new order was given for Novalog Solution 100 units/ml. The DON did verify that the nurses did give units	

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F 842	Continued From page 6 Interview with Licensed Practical Nurse #1 on 9/18/2019 at 3:30 PM, revealed that it should have been entered as 24 units not 24 milliliters. She stated that 24 units is what has been given. She stated that it would have been deadly if she would have been given 24 milliliters of Novolog insulin. Interview with Director of Nursing on 9/18/2019 at 3:40 PM, revealed that the orders are entered by the nurse that receives it, then checked and signed off by a second nurse. Phone interview with physician on 9/19/2019 at 10:45 AM, revealed the order should have been for Novolog 24 units.	F 842	instead of milliliters, despite the written error. For LPN #1 and LPN #2, the DON stressed the importance of making sure all insulin orders are with units and not milliliters. 2. All residents with insulin orders have the potential to be affected by a medication error indicating milliliters instead of units for insulin orders. On September 18, 2019 the DON checked all other residents with insulin orders and found that they were correctly ordered with units and not milliliters. 3. STAFF TRAINING: The DON began educating the nurses on September 18, 2019 and a mandatory in-service for all nurses was held on October 9, 2019. All the nurses were educated on proper insulin orders. The DON emphasized that insulin orders should always have units and not milliliters for dosing. Nurses will have full understanding of insulin orders as follows: a. Nurses will acknowledge that they know that all insulin orders will be ordered with units and not milliliters for dosing. b. Nurses will be expected to focus closely during medication passes that all insulin orders are correctly ordered with units and not milliliters for dosing. c. Nurses will immediately contact the attending physician if any insulin orders are not in units, for clarification. d. DON will involve the Pharmacy Consultants who review the medications monthly to focus on insulin orders to ensure that they are ordered with units	

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F 842	Continued From page 7	F 842	and not milliliters. 4. The DON checked all insulin orders on September 18, 2019 to ensure all were correct. The DON or RN Supervisor will continue to conduct weekly audits for one month and then monthly thereafter to ensure that all insulin orders are ordered with units and not milliliters. Any noted problems will be addressed immediately. Audit findings will be reported by the DON to the Quality Assurance Performance Improvement Committee and by the Administrator to the Bolivar Medical Center Quality Council quarterly and recommendations will be made as needed to ensure full compliance with the requirements.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 09/20/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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