MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06BC	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from 9/17/19 through 9/19/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M735. The census was 32 and the facility was licensed for 35 beds.	M 000		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary,	M 735		10/18/19

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M 735	Continued From page 1 including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II 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	M 735	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	

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M 735	Continued From page 2 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. Record 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. 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 Nurses 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.	M 735	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 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	

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M 735	Continued From page 3	M 735	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 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.	