STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676178	A. Building B. Wing	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duncanville Healthcare and Rehabilitation Center	419 S Cockrell Hill Rd Duncanville, TX 75116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15315 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 4 residents reviewed for quality of care. The facility failed to ensure Resident #1's admission orders including medications were verified with the physician and transcribed correctly into the electronic medical records. On 06/20/22, Resident #1 admitted to the ICU after he was noted with a change in condition. The resident admitted with a blood glucose greater than 1200 milligrams per deciliter and was treated for hyperglycemic hyperosmolar nonketotic coma (HHNC-Severely elevated glucose levels typically greater than 600 to 800 mg/dL accompanied by dehydration and altered mental status). It was determined a past non-compliance Immediate Jeopardy existed from 06/04/22 to 06/20/22. The Immediate Jeopardy was determined to have been removed on 06/20/21 due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation on 06/24/22. These failures placed residents at risk of not receiving medications and care to address their medical conditions, which could cause exacerbations and manifest into other health complications resulting in serious injury, harm and/or death. Findings included: Review of Resident #1's undated electronic Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Physician's undated electronic order summary reflected diagnoses included Hypertension, Type II Diabetes Mellitus, Acute Kidney Failure, and End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Review of Resident #1's admission MDS assessment dated [DATE] reflected the resident required total physical assistance of two or more persons for bed mobility and hygiene and extensive assistance of two or more persons for dressing. The resident's BIMS score was 8 indicating moderately impaired cognition. The MDS assessment further reflected the resident received nutrition via a gastric feeding tube (feeding tube placed through the abdominal wall and into the stomach) and active diagnoses included Diabetes Mellitus (no type indicated). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's comprehensive care plan dated 06/20/22 revealed the diagnoses of diabetes mellitus and goals included the resident being free from complications including hyperglycemia. Interventions included administering medications according to physician's orders and monitoring fasting serum blood glucose as ordered by the physician. Review of Resident#1's progress notes documented by the DON dated 06/20/22 reflected the resident was not responding at normal baseline. A telemedicine visit was performed, and the assessment reflected rapid respirations of 38 per minute with 12 seconds of apnea (temporary cessation of breathing). Orders were received to transfer the resident to the hospital for further evaluation. There was no documented evidence in the clinical records of Resident #1's medications were verified by the physician or NP on admission. Review of MARs and Physician orders dated 06/2022 revealed there no insulin was ordered or administered. There were no orders for blood glucose monitoring and no evidence Resident #1's blood glucose was monitored in the facility. Review of Resident #1's hospital records (admitted [DATE]) prior to admission to the facility, revealed there were no discharge orders or instructions in the records provided to the facility from the transferring hospital. The records contained a recap of the resident stay in the hospital including five-day medication administration records dated 05/27/22 through 05/31/22. The medication administration records reflected the resident was receiving 20 units of Lantus insulin two times a day and Regular insulin as needed according to a sliding scale (varied doses of insulin based on blood glucose level). The hospital records reflected the resident's blood glucose was routinely being monitored. Interview on 06/24/21 at 2:00 p.m. the DON stated prior to Resident #1's admission on 06/04/22 there had been no procedures in place to review and/or check to ensure orders were verified with the physician, transcrived and/or reconciled accurately. Interview with the Corporate Nurse and Administrator on 06/24/22 at 3:33 p.m. revealed no discharge orders were received from the hospital when Resident #1 admitted to the facility on [DATE]. They stated the admitting nurse (LVN A) used the hospital records that listed medications the resident had been receiving in the hospital and transcribed some but not all of the medications the resident was receiving onto the facility's medication administration records. They stated LVN A told them she became distracted and did not transcribe all of the medications from the hospital records. They further stated they had not been able to fully interview LVN A and had been attempting to reach the nurse without success. Interview with Resident #1's family D on 06/24/22 at 4:45 p.m. revealed they were present in the facility on 06/20/22 and noted the resident was not responding as usual. Facility nursing staff were notified and asked the family if the resident was a diabetic. After a telemedicine assessment the resident was transferred to the hospital. The family stated they were not sure if Resident #1 had been receiving Insulin in the facility but had been receiving Insulin prior to admitting to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of Resident #1 in the hospital on 06/27/22 at 10:15 a.m. revealed he was awake in bed. He was utilizing an external urinary catheter and a gastric feeding tube was in place. Attempts to interview the resident were unsuccessful. He stated he could not recall if he received insulin in the facility. The resident's family E was present at the bedside and stated the resident had been receiving Insulin for a long time and they had observed the resident self-administer insulin injections prior to admission to the facility. The hospital RN stated Resident #1 was receiving dialysis and was somewhat confused and forgetful. The RN further stated the resident was stable and blood glucose levels were currently within normal limits. Review of a hospital records dated 06/20/22 reflected Resident #1's chief complaints were hyperglycemia (high blood glucose) and altered mental status (a disruption in how your brain works that causes a change in behavior). Past medical history included diabetes mellitus. The records reflected on arrival to the ER the resident was not speaking in clear words and was moaning and groaning in response to questions. The resident was treated with an IV antibiotic, IV fluids, IV Insulin drip and Insulin via slow IV push. The records reflected the resident was admitted to the ICU and his blood glucose was greater than 1200 milligrams per deciliter. Hospital lab reports dated 06/20/22 reflected Resident #1's blood glucose was 1,224 milligrams per deciliter (normal range (70-110). Resident #1 transferred to an intermediate care floor on 06/25/22. Interview with the DON on 06/27/22 at 12:09 p.m. revealed on 06/20/22 Resident #1's family D voiced concerns to the charge nurse LVN C, that the resident was not looking or responding as usual. The assigned charge nurse had been busy assisting another resident and she (the DON) assisted with Resident #1's assessment and telemedicine visit. She stated the resident was experiencing respiratory distress with rapid respirations and 12 seconds of apnea. The primary physician was notified, orders were received to transfer the resident to the hospital and 911 was summoned. The DON stated the medications transcribed by LVN A on Resident #1's admission (06/04/22) were from a physician's progress note listed in the clinical records sent from the hospital. She stated she did not know if LVN A verified the resident's admission medications with the physician. The DON stated the admitting nurse was responsible for verifying admission orders/medications. She stated LVN A should have checked the paperwork sent by the hospital for a plan of care and discharge orders and called the hospital for discharge orders and/or contacted the facility's physician to obtain admission orders for medications if no orders were sent at all. The DON further stated if the nurse had continued to have problems or issues with obtaining orders, she (the DON) should have been notified. Additionally, the DON stated she did not know if LVN A had contacted the facility's physician to verify Resident #1's admission medications. The DON stated if nursing staff did not verify admission orders/medications with the facility' physician and transcribe medications correctly it could cause a delay in care, treatment and place the resident in a detrimental situation. She stated the medication list provided in the hospital records could have been used if the medications had been verified by the physician. Attempts to interview LVN C on 06/27/22 at 2:00 p.m. and 4:00 p.m. were unsuccessful as the voicemail box was full. Interview on 06/27/22 at 1:30 p.m. revealed Physician B was Resident #1's primary care physician at the facility. Physician B stated she nor her NP were notified of Resident #1's arrival to the facility on [DATE] or verified the resident's admission orders/medications. Physician B stated it was very unusual for discharge orders not to be sent with the resident on admission. She stated her expectations were that facility nursing staff would notify her or the NP for a review of the new admits history, medications, vitals, and skin assessment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LVN A via phone on 06/27/22 at 5:33 p.m. revealed she was the admitting nurse for Resident #1 on 06/04/22. She stated she did not receive report or discharge orders from the transferring hospital and when she attempted to contact someone at the hospital about the missing orders, she was unable to reach anyone. LVN A stated she only received medical records from the hospital and transcribed medications from a list of medications the resident received in the hospital. She initially stated she did not recall notifying the physician or NP then stated she did recall notifying the NP of Resident #1's arrival to the facility but she was not sure if she verified the medications or discussed the lack of admission orders for Resident #1. LVN A further stated she had worked at the facility for many years and was aware of the admission process, but she felt she must have been distracted during the transcription of the resident's medications and omitted transcribing some of the medications. According to www.cdc.gov/diabetes viewed on 02/28/22, The patient with HHNC has severe hyperglycemia and shows signs/symptoms of hypovolemia (decreased volume of circulating blood in the body) and severe dehydration. Central nervous system deficits may occur to include hallucinations, aphasia (loss of ability to understand or express speech), and focal or grand mal seizures. Coma may ensue. According to www.diabeteseducator.org viewed on 02/28/22, HHNC is a deadly and avoidable complication that is due to not having enough insulin for the present condition, is diagnosed when blood glucose is over 600 mg/dl (milligrams/deciliter) and usually takes days rather than hours to occur. Review of the facility's policy/procedure (P/P), revised July 2019, and titled Reconciliation of Medications on Admission reflected in part: The purpose of the procedure was to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation included gathering information needed to reconcile the medication list to include the discharge summary from the referring facility and finding a quiet place that is free from distractions. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medication by creating an accurate list of both prescription and over the counter medications. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medication the resident needs and has been taking continue to be administered without interruption. Medication reconciliation helps to ensure that medications, routes, and dosages have been accurately communicated to the Attending Physician and care team. If a discrepancy or conflict in medications, dose, route, or frequency is noted determine the most appropriate action to resolve the discrepancy including, contacting the nurse or physician from the referring facility, contacting admitting and/or the primary physician of the receiving facility. Review of the facility's P/P, revised10/01/19, titled Prescriber Medication Orders reflected in part: C. Written Transfer Orders, (sent with a resident by a hospital or other health care facility) a. Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless unclear or incomplete or the date signed is different from the date of admission. b. If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending physician before medications are administered. The nurse documents verification on the admission order record by entering the time, date, and signature. (continued on next page)

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