

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

PRINTED: 01/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345314</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/31/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FOREST CITY HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>830 BETHANY CHURCH ROAD</b> <b>FOREST CITY, NC 28043</b>		
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F 000	<p>INITIAL COMMENTS</p> <p>483.10 (F157) at J Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the fluctuation of low blood sugar levels without physician notification. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>483.13 (F224) at J Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the nurse failed to initiate the blood sugar monitoring protocol, and treatment, and clocked out and left the facility without informing another nurse, supervisor, Director of Nursing, or the physician of Resident #139's condition. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of G (actual harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. Example two is at a harm level of G.</p> <p>483.25 (F309) at J Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the nurse failed to</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/24/2015

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 000	Continued From page 1 initiate the blood sugar monitoring protocol, and treatment, and clocked out and left the facility without informing another nurse, supervisor, Director of Nursing, or the physician of Resident #139's condition. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.  483.25 (F333) at J Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.	F 000			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157		2/2/15	

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F 157	<p>Continued From page 2</p> <p>status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and physician interviews the facility failed to notify the physician after a long acting insulin had been administered with no physician's order and failed to notify the physician of a resident's low blood sugar levels for 1 of 1 sampled residents (Resident #139).</p> <p>Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the fluctuation of low blood sugar levels without physician notification. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The</p>	F 157	<p>F157</p> <p>1. Residents identified to be affected by the deficient practice - On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The licensed nurses caring for the resident on second and third shifts on the evening of 12/11/14 failed to notify the supervisor and the physician per the facility's Diabetic Protocol on the medication error and low blood sugar level so that interventions could be put in place to provide for the resident's wellbeing. The facility identified the medication error</p>		

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F 157	<p>Continued From page 3</p> <p>facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>The findings included:</p> <p>Resident #139 was admitted to the facility on 12/11/14 with diagnoses which included shoulder joint replacement, high blood pressure, and diabetes mellitus type 2. The 5 day admission Minimum Data Set (MDS) dated 12/16/14 indicated Resident #139 was cognitively intact and was capable of daily decision making.</p> <p>A review of the nurse's notes dated 12/11/14 through 12/12/14 revealed the following entries:</p> <ul style="list-style-type: none"> <li>· 12/11/14 at 11:38 PM--Nurse #3, working the 3PM until 11PM shift, did not document in her notes that the physician had been notified that Resident #139 had been administered a long acting insulin without a physician's order.</li> <li>· 12/12/14 at 12:31 AM-Nurse #2, working the 11PM to 7AM shift, documented that Resident #139's finger stick blood sugars (FSBS) was 48 and that the resident was given 8 ounces (oz.) of orange juice and peanut butter crackers. Nurse #2 documented a re-check FSBS 15 minutes later of 76 at which time she gave Resident #139 an 8 oz. cup of med pass (a fortified nutritional shake) with another re-check FSBS 30 minutes later of 88.</li> <li>· 12/12/14 at 1:45 AM--Nurse #2 documented a re-check FSBS of 51 and Resident #139 was</li> </ul>	F 157	<p>on 12/12/14 and began an investigation into the causes of the deficient practice. The physician was notified on the morning on 12/12/14 and interventions were continued based on his direction. A Medication Variance Report was completed by the Unit Manager on 12/12/14. Resident #139 was monitored by licensed nurses for changes in condition and the physician was notified of any changes during the period of 12/12/14 through discharge on 12/16/14.</p> <p>2. Residents with the potential to be affected by the alleged deficient practice - Residents who have a significant change in condition related to a finger stick indicating a low blood sugar level have the potential to be affected by the alleged deficient practice. On 12/29/14, the Director of Nursing began a detailed review of actions taken for the affected residents and audited the corresponding documentation in the medical records of these residents to ensure that interventions were implemented, and nurses communicated to the physician based on the facility's Diabetic Protocol for the past 30 days.</p> <p>3. Systemic Measures - The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning 12/29/14 regarding notification to the physician or physician extender of changes in condition, such as symptoms of hypoglycemia, which may include diaphoresis, confusion, hunger, shakiness, or blurred vision. Licensed Nurses were also educated on actively</p>		

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F 157	<p>Continued From page 4</p> <p>sleepy but alert and oriented to person, place, and time. Nurse #2 documented that she gave Resident #139 milk and a tangerine, at which time Resident #139 consumed the entire carton of milk and ate half of the tangerine. Nurse #2 documented a re-check FSBS 20 minutes later of 88 and again provided Resident #139 with milk, another pack of crackers, and a container of yogurt. There was no documentation in Nurse #2's notes that the physician had been notified of the fluctuation in Resident #139's low FSBS throughout her shift.</p> <ul style="list-style-type: none"> <li>12/12/14 at 7:30 AM---The Unit Manager (UM) documented that she notified the physician of Resident #139's low blood sugars and that the facility's protocol was being followed. The UM documented that the physician had advised her to continue the protocol and monitor Resident #139's urine output for next 24 hours.</li> <li>12/12/14 at 8:00 AM---Nurse #4, working the 7AM to 3PM shift, documented a FSBS of 47 and that Resident #139 was alert with confusion. Nurse #4 documented an IV (intravenous) was started and dextrose 50 (D50) was pushed via the IV and a bag of fluid which contained dextrose 5% (D5) &amp; ½ normal saline (NS) was hung for infusion and was set to run at 100 milliliters (ml) per hour. Nurse #4 documented a re-check FSBS 15 minutes after giving the D50 of 427.</li> </ul> <p>A review of a Medication Variance Report written by the UM dated 12/12/14 at 7:30 AM indicated Nurse #3 had administered the wrong medication to the wrong resident. The report noted the medication administered was Levemir insulin 45</p>	F 157	<p>listening to residents when they inform them of potential errors in medication administration. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Area Staff Development Manager. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. The Director of Nursing or Unit Manager will review the 24-Hour Report daily, Monday through Friday, to identify changes in condition and that appropriate notification of physician and interested parties has been completed. On weekends, the RN on duty will review the 24-Hour Report to identify changes in condition and notification of physician and interested parties has been completed. Members of the District Team (which may include, but not limited to, the District Director of Operations, Division Director of Clinical Education, District Rehabilitation Manager, and District Care Management Director) will make periodic visits for three months to monitor that physician notification of change in condition has been completed. The Interdisciplinary Team (including the Director of Nursing, Administrator, Unit Manager, Unit Coordinator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, and Resident Care Management Director) will review on a</p>		

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F 157	<p>Continued From page 5</p> <p>Units one time by SQ (subcutaneous) to Resident #139. (Levemir is a long acting insulin which starts to work in 1 to 3 hours, with a peak in 8 to 10 hours, and lasts for 18 to 26 hours). The report indicated "error/harm: an error occurred that may have contributed to or resulted in temporary resident harm and required intervention." The variance report revealed the Physician was contacted on 12/12/14 at 7:30 AM and orders were received and the Director of Nursing (DON), the Pharmacy, the Family, and the Administrator were contacted on 12/12/14 at 8:15 AM. The report further indicated the findings/actions taken: Nurse #3 was suspended, was re-educated, and required medication administration observations. The report was signed by the DON and the Administrator on 12/12/14.</p> <p>During an interview on 12/29/14 at 10:45 AM the UM verified she had completed the medication variance report. She stated on the morning of 12/12/14 at 7:15 AM she overheard the 3rd shift nurse, Nurse #2, and the 1st shift nurse, Nurse #4, discussing the fluctuation of Resident #139's FSBS. She indicated at that time she went to check on the resident and Resident #139 informed her of the injection of insulin the 2nd shift nurse had administered. The UM further indicated that during the course of her investigation she "figured out" that Resident #139 was given Resident #134's insulin; Resident #134 was across the hall from Resident #139. She stated she immediately advised the DON of the error and called the physician.</p> <p>During a telephone interview on 12/29/14 at 11:36 AM Nurse #2 indicated she was responsible for the care of Resident #139 on 12/11/14 at 11PM</p>	F 157	<p>daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to ensure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate by reviewing the 24-Hour Report and telephone orders.</p> <p>In addition to the above measures, Directed In-Service education will be conducted by a practice consultant from the North Carolina Board of Nursing on January 28, 2015 for licensed nurses regarding prevention of medication errors which will include education on notification of the physician and supervisor in the event a medication error is made.</p> <p>4. Quality Assurance and Performance Improvement Measures - The Director of Nursing or Administrator will review the data collected from the audits of 24-Hour Reports and telephone orders, analyze the data, and report patterns or trends to the QAPI Committee every other month for four months. The QAPI Committee will evaluate the effectiveness of the plan and make changes based on outcomes to ensure continued compliance.</p>		

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F 157	<p>Continued From page 6</p> <p>until 12/12/14 at 7AM. She stated during the change of shift report at 11PM, she was not made aware of any concerns and/or problems with Resident #139. She further stated she always checked on her residents at the beginning of her shift and during her initial check that night of Resident #139, when she opened the resident's door, Resident #139 called out to her for assistance to the bathroom. At which time, Nurse #2 stated Resident #139 indicated to her that she was "feeling funny and weird" and advised her that she had been given a shot of insulin. Nurse #2 stated she checked Resident #139's blood sugar and noted it was in the 40's. She further stated she gave Resident #139 carbohydrates to eat and when she re-checked Resident #139's blood sugar it had come up into the 80's. She indicated she did not call the physician during the night because the resident was alert and talking, but she had continued to check Resident #139's blood sugar and gave her carbohydrates to eat throughout her shift.</p> <p>During a telephone interview on 12/29/14 at 11:51 AM Nurse #4 indicated she was responsible for the care of Resident #139 on 12/12/14 from 7AM until 3PM. She stated during the change of shift report at 7AM she was informed by Nurse #2 of Resident #139's fluctuating blood sugars throughout the night. Nurse #4 indicated after she received report, she and the UM went to assess Resident #139. Nurse #4 stated she checked Resident #139's blood sugar and noted it to be 46. She further indicated the UM called the physician and the physician gave them the orders to start an IV, administer D50, and infuse fluids of D5 ½ NS at 100 ml/hour.</p> <p>During a telephone interview on 12/29/14 at 1:47</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>PM Nurse #3 indicated she was responsible for the care of Resident #139 on 12/11/14 from 3PM until 11PM. She admitted she gave Resident #139 the wrong medication on 12/11/14 around 9PM. She indicated she gave the resident Levemir insulin 45 Units. She further indicated she did not use any of the resident identifiers nor did she ask the resident to state her name and/or her date of birth. She stated she told Resident #139 she was going to give her an insulin shot and the resident stated "I don't take insulin." Nurse #3 further stated she replied to Resident #139 that the insulin was ordered for her and she was supposed to have it. Nurse #3 stated she realized she had given the wrong medication when she went to back to the Medication Administration Record (MAR) to document that she had given the insulin. Nurse #3 indicated that she did not document that she had given Resident #139 the insulin and she only checked Resident #139's blood sugar 2 more times before her shift ended at 11PM. She further indicated she clocked out and left the facility without telling anyone that she had administered the long acting insulin, Levemir, to Resident #139. She stated she was unaware of what to do at the time she made the error. She further stated she did not talk with anyone about the medication error until the next morning when the DON called her at home and asked her about the insulin medication error. She reiterated that she did not call the physician to inform him of the medication error on 12/11/14.</p> <p>During an interview on 12/29/14 at 5:26 PM the physician indicated he was not the practicing physician at the time of the insulin medication error. He further indicated the physician that was contacted was no longer at the facility. He stated</p>	F 157			



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F 157	<p>Continued From page 8</p> <p>he was made aware of the error upon his arrival to the facility on 12/15/14. He indicated he would have expected Nurse #3 to have called the physician as soon as she was aware that she had made a medication error. He stated he would have sent the resident to the hospital to be monitored due to the insulin being that of a long acting type and the large dosage amount which was administered to Resident #139.</p> <p>During an interview on 12/29/14 at 6:14 PM the DON stated he was not aware of the medication error until 12/12/14 at 8:15 AM. He indicated the UM told him of the medication error. He stated he expected the nurses to contact the physician anytime there was a change in a resident's condition. He further stated he would have expected Nurse #3 to have notified the physician when the insulin medication error was detected and he would have also expected Nurse #2 to have notified the physician when Resident #139's FSBS were low and fluctuating.</p> <p>The Administrator was informed of Immediate Jeopardy on 12/29/14 at 6:32 PM for Resident #139.</p> <p>A Credible Allegation of Compliance was accepted on 12/31/14 at 11:54 AM as follows:</p> <p>Credible Allegation of Compliance: Notification of Change</p> <p>1. Residents identified to be affected: by the deficient practice.</p> <p>On 12/11/14, Resident #139 was administered long-acting insulin without a</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>physician's order. The licensed nurses caring for the resident on second and third shifts on the evening of 12/11/14 failed to notify the supervisor and the physician per the facility's Diabetic Protocol of the medication error and low blood sugar level so that interventions could be put in place to provide for the resident's wellbeing. The facility identified the medication error on 12/12/14 and began an investigation into the causes of the deficient practice. The physician was notified on the morning of 12/12/14 and interventions were continued based on his direction. A Medication Variance Report was completed by the Unit Manager on 12/12/14.</p> <p>2. Residents with the potential to be affected by the alleged deficient practice.</p> <p>Residents who have a significant change in condition related to a finger stick indicating a low blood sugar level have the potential to be affected by the alleged deficient practice. On December 29, 2014, the Director of Nursing began a detailed review of actions taken for the affected residents and audited the corresponding documentation in the medical records of these residents to insure that interventions were implemented, and nurses communicated to the physician based on the facility's Diabetic Protocol for the past 30 days.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning December 29, 2014 regarding notification to the physician or physician extender of changes in condition, such as symptoms of hypoglycemia which may include diaphoresis, confusion, hunger, shakiness, or</p>	F 157			

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F 157	Continued From page 10 blurry vision. Licensed Nurses were also educated on actively listening to residents' when they inform them of potential errors in medication administration. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Area Staff Development Manager. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. The Director of Nursing or Unit Manager will review the 24-hr Report, daily Monday through Friday, to identify changes in condition and that appropriate notification of physician and interested parties has been completed. On weekends, the RN on duty will review the 24-hour Report to identify changes in condition and notification of physician and interested parties has been completed.  3. Systemic Measures  The Interdisciplinary Team (including the Director of Nursing, Administrator, Unit Manager, Unit Coordinator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, and Resident Care Management Director) will review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate by reviewing the 24 hour reports and telephone orders.	F 157			

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F 157	Continued From page 11  Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when interviews with nurses revealed awareness of the prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. They verified they had received in-service training and were made aware of the importance of the notification of the physician, family, nursing supervisor, and DON, which included actively listening to the residents when they inform them of a potential error in medication administration, and the reporting process for medication variances to include a mediation variance report. The nurses further indicated the in-service training included observations of administering medications to residents in the facility, and included examples and potential factors for medication errors, such as, distraction, knowledge deficits, and what should be done if a resident questions the medications for which they are to be given.	F 157			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and physician interviews, the facility neglected to document a	F 224	Residents identified to be affected by the deficient practice:	2/2/15	

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F 224	<p>Continued From page 12</p> <p>significant medication error, neglected to initiate the low blood sugar protocol, and neglected to inform another nurse, supervisor, or physician that a resident had received long acting insulin in error for 1 of 2 sampled residents (Resident #139). The facility also failed to remove a bedpan from under a resident for 1 of 2 sampled residents (Resident #133).</p> <p>Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the nurse failed to initiate the blood sugar monitoring protocol, and treatment, and clocked out and left the facility without informing another nurse, supervisor, Director of Nursing, or the physician of Resident #139's condition. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of G (actual harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education, and for example number two.</p> <p>The findings included:</p> <p>Review of the facility's undated document titled "Diabetic Protocol" read in part:</p> <p>C. Insulin is to be given as per (physician) MD's orders.</p> <p>D. FSBS - if lower than 80, notify MD, hold insulin until MD gives specific orders. Inform MD of any nursing interventions, such as giving sugar &amp; orange juice. Note what the resident has eaten and general condition of the resident.</p> <p>E1. If resident is alert and FSBS is low give Oral Glucose Gel 15 Gm (grams), give per</p>	F 224	<p>12/11/14, Resident #139 was administered a long-acting insulin without a physician's order. Resident #139 was monitored by licensed nurses for changes in condition related to the medication error. The physician was notified of any changes during the period of 12/12/14 through discharge on 12/16/14. Resident #133 is provided with care and services for toileting needs in a timely fashion.</p> <p>2. Residents with the potential to be affected by the alleged deficient practice: Residents who require the administration of medications have the potential to be affected by the deficient practice. The Director of Nursing completed an audit of all current residents' Medication Administration Records for the last 30 days to review for significant medication errors to be completed by 12/30/14. No additional significant errors were identified during this review.</p> <p>Residents who require assistance with utilizing a bed pan for toileting have the potential to be affected by the alleged deficient practice. The Director of Nursing or Resident Care Management Director has completed an audit to identify those residents who require such assistance and have updated care grids to aid in the identification of care needs. No other residents were identified as having been effected by the deficient practice.</p> <p>3. Systemic Measures - The Director of Nursing, Administrator, and Unit Managers will review on a daily basis, Monday through Friday, the 24-Hour Report and Medication Variance Reports,</p>		

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F 224	<p>Continued From page 13</p> <p>manufacturer's directions.</p> <p>E2. If consciousness is diminished or impaired in a diabetic whose FSBS is low, an IV (intravenous) of D5-1/2 NS (Dextrose 5% and ½ Normal Saline) at 100 ml (milliliters) per hour is to be started and 1 amp (ampule) of D50 (Dextrose 50) is to be pushed while trying to contact the attending MD. If unable to start an IV with 1st stick, give Glucagon 1 mg (milligrams) IM (intramuscular). Then continue to place IV. Recheck FSBS in 15 minutes after pushing D50. Continue IV until otherwise ordered by MD, but D/C (discontinue) in 24 hours if FSBS is staying greater than 125.</p> <p>Resident #139 was admitted to the facility on 12/11/14 with diagnoses which included shoulder joint replacement, high blood pressure, and diabetes mellitus type 2. The 5 day admission Minimum Data Set (MDS) dated 12/16/14 indicated Resident #139 was cognitively intact and was capable of daily decision making.</p> <p>A review of the physician's orders dated 12/11/14 indicated Metformin 500 milligrams (mg) one tablet by mouth three times a day for prophylaxis related to complications of type 2 diabetes. Further review of the physician's orders indicated finger stick blood sugars (FSBS) twice daily (6:30 AM and 9:00 PM) related to diabetes. Further review revealed there was no physician's order for Levemir indicated for Resident #139. (Levemir is a long acting insulin which starts to work in 1 to 3 hours, with a peak in 8 to 10 hours, and lasts for 18 to 26 hours).</p> <p>A review of the Medication Administration Record (MAR) dated for December 2014 revealed Resident #139 was to be given Metformin 500mg</p>	F 224	<p>and conduct investigations to identify that physician notification has occurred and interventions have been put in place to provide for the resident's well-being and their needs are not neglected. On weekends, the RN on duty will review the 24-Hour Report and any medication variance reports to ensure physician notification has occurred and interventions have been put in place so that residents' needs are identified and provided for. One to One education regarding medication administration practices and prevention of medication errors was completed on 12/15/14 for the licensed nurse by the Area Staff Development Coordinator. The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning 12/29/14 regarding Abuse &amp; Neglect Prohibition and the requirement to report medication errors to the physician and Director of Nursing or Supervisor to ensure that resident's needs are being met and not neglected, and interventions are put in place to address the error. This education included the definition of Neglect and examples were discussed. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Area Staff Development Manager. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education.</p>		

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F 224	<p>Continued From page 14</p> <p>one tablet by mouth at 9:00 AM, 1:00 PM, and at 5:00 PM. Additional review of the MAR revealed Resident #139's last dose of Metformin was administered on 12/11/14 at 5:00 PM. The Metformin was held on 12/12/14 due to Resident #139's low FSBS and was re-started on 12/13/14 at 9:00 AM. Further review of the MAR revealed there was no indication for Levemir to be administered.</p> <p>A review of the nurse's notes dated 12/11/14 through 12/12/14 revealed the following entries:</p> <ul style="list-style-type: none"> <li>· 12/11/14 at 11:38 PM--Nurse #3, working the 3PM until 11PM shift, documented Resident #139 was resting comfortably and medications were tolerated with no adverse effect noted. There was no documentation in Nurse #3's notes or on the Medication Administration Record (MAR) to indicate any FSBS had been checked or that Resident #139 had been given insulin. Further review of the MAR revealed Resident #139 was administered her Metformin 500mg tablet by mouth on 12/11/14 at 5PM.</li> <li>· 12/12/14 at 12:31 AM-Nurse #2, working the 11PM to 7AM shift, documented that Resident #139's FSBS was 48 and that the resident was given 8 ounces (oz.) of orange juice and peanut butter crackers. Nurse #2 documented a re-check FSBS 15 minutes later of 76 at which time she gave Resident #139 an 8 oz. cup of med pass (a fortified nutritional shake) with another re-check FSBS 30 minutes later of 88.</li> <li>· 12/12/14 at 1:45 AM---Nurse #2 documented a re-check FSBS of 51 and Resident #139 was sleepy but alert and oriented to person, place, and time. Nurse #2 documented that she had</li> </ul>	F 224	<p>Beginning 12/30/14, the Director of Nursing will conduct interviews with interviewable residents at least three (3) times per week for four weeks, then three times per month thereafter to identify allegations of neglect related to medication administration. Investigations will be conducted, if necessary, based on interview information.</p> <p>Directed In-Service education will be conducted by our regional Ombudsman on January 27 &amp; January 28 for licensed nurses, Resident Care Specialists (C.N.As), and facility staff members regarding Neglect of Resident Care that will include education on notification of the physician and supervisor in the event a medication error is made so that the resident's needs are provided for in a timely manner, as well as, examples of what constitutes Neglect and the requirements for reporting of allegations of abuse or neglect.</p> <p>The Director of Nursing, Unit Managers, or Interdisciplinary Team Members will conduct rounds at least three (3) times per week for four (4) weeks, then at least weekly for three (3) months, on random shifts, to monitor that care is being delivered according to the needs of the residents.</p> <p>The Administrator or Social Services Director will review Resident Council Meeting minutes on a monthly basis to monitor for concerns related to provision of care and services. If a concern is identified, the information will be reviewed to determine reporting requirements. Residents will be provided with</p>		

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F 224	<p>Continued From page 15</p> <p>administered 15 grams of glucose gel by mouth to Resident #139 and gave her milk and a tangerine, at which time Resident #139 consumed the entire carton of milk and ate half of the tangerine. Nurse #2 documented a re-check FSBS 20 minutes later of 88 and again provided Resident #139 with milk, another pack of crackers, and a container of yogurt. There was no documentation in Nurse #2's notes that the physician had been notified of the fluctuation in Resident #139's low FSBS throughout her shift.</p> <ul style="list-style-type: none"> <li>12/12/14 at 7:30 AM---The Unit Manager (UM) documented that she notified the physician of Resident #139's low blood sugars and that the low blood sugar protocol was being followed. The UM documented that the physician had advised her to continue the protocol and monitor Resident #139's urine output for next 24 hours.</li> <li>12/12/14 at 8:00 AM---Nurse #4, working the 7AM to 3PM shift, documented a FSBS of 47 and that Resident #139 was alert with confusion. Nurse #4 documented an IV (intravenous) was started and dextrose 50 (D50) was pushed via the IV and a bag of fluid which contained dextrose 5% (D5) &amp; ½ normal saline (NS) was hung for infusion and was set to run at 100 milliliters (ml) per hour. Nurse #4 documented a re-check FSBS 15 minutes after giving the D50 of 427.</li> </ul> <p>A review of a Medication Variance Report written by the UM dated 12/12/14 at 7:30 AM indicated Nurse #3 had administered the wrong medication to the wrong resident. The report noted the medication administered was Levemir insulin of 45 Units one time by SQ (subcutaneous) to</p>	F 224	<p>information regarding their right to be free from abuse or neglect during Council meetings, as well as other Resident Rights, monthly during meetings. Resident concerns will be reviewed by the Interdisciplinary Team daily, Monday through Friday, and investigations will be conducted, as necessary, based on the information provided. In the event of an allegation of abuse or neglect during off-hours, the staff will notify the Director of Nursing or Administrator immediately, and an investigation will be initiated to provide for the resident's safety and to determine reporting requirements.</p> <p>4. Quality Assurance and Performance Improvement Measures - The Director of Nursing or Administrator will review the data collected from the rounds, Resident Council meeting minutes, Concerns, and investigations of allegations of abuse or neglect; analyze the data, and report patterns or trends to the QAPI Committee every other month for four months. The QAPI Committee will evaluate the effectiveness of the plan and make changes based on outcomes to ensure continued compliance.</p>		



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F 224	<p>Continued From page 16</p> <p>Resident #139. The report indicated "error/harm: an error occurred that may have contributed to or resulted in temporary resident harm and required intervention." The variance report revealed the Physician was contacted on 12/12/14 at 7:30 AM and orders were received and the Director of Nursing (DON), the Pharmacy, the Family, and the Administrator were contacted on 12/12/14 at 8:15 AM. The report further indicated the findings/actions taken: Nurse #3 was suspended, was re-educated, and required medication administration observations. The report was signed by the DON and the Administrator on 12/12/14.</p> <p>During an interview on 12/29/14 at 10:45 AM the UM verified she had completed the medication variance report. She stated on the morning of 12/12/14 at 7:15 AM she overheard the 3rd shift nurse, Nurse #2, and the 1st shift nurse, Nurse #4, discussing the fluctuation of Resident #139's FSBS. She indicated at that time she went to check on the resident and Resident #139 informed her of the injection of insulin the 2nd shift nurse had administered. The UM further indicated that during the course of her investigation she "figured out" that Resident #139 was given Resident #134's insulin; Resident #134 was across the hall from Resident #139. She stated she immediately advised the DON of the error and called the physician.</p> <p>During a telephone interview on 12/29/14 at 11:36 AM Nurse #2 indicated she was responsible for the care of Resident #139 on 12/11/14 at 11PM until 12/12/14 at 7AM. She stated during the change of shift report at 11PM, she was not made aware of any concerns and/or problems with Resident #139. She further stated she always</p>	F 224			

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F 224	<p>Continued From page 17</p> <p>checked on her residents at the beginning of her shift and during her initial check that night of Resident #139, when she opened the resident's door, Resident #139 called out to her for assistance to the bathroom. At which time, Nurse #2 stated Resident #139 indicated to her that she was "feeling funny and weird" and advised her that she had been given a shot of insulin. Nurse #2 stated she checked Resident #139's blood sugar and noted it was in the 40's. She further stated she gave Resident #139 carbohydrates to eat and when she re-checked Resident #139's blood sugar it had come up into the 80's. She indicated she did not call the physician during the night because the resident was alert and talking, but she had continued to check Resident #139's blood sugar and gave her carbohydrates to eat throughout her shift.</p> <p>During a telephone interview on 12/29/14 at 11:51 AM Nurse #4 indicated she was responsible for the care of Resident #139 on 12/12/14 from 7AM until 3PM. She stated during the change of shift report at 7AM she was informed by Nurse #2 of Resident #139's fluctuating blood sugars throughout the night. Nurse #4 indicated after she received report, she and the UM went to assess Resident #139. Nurse #4 stated she checked Resident #139's blood sugar and noted it to be 46. She further indicated the UM called the physician and the physician gave them the orders to start an IV, administer D50, and infuse fluids of D5 ½ NS at 100 ml/hour.</p> <p>During a telephone interview on 12/29/14 at 1:47 PM Nurse #3 indicated she was responsible for the care of Resident #139 on 12/11/14 from 3PM until 11PM. She admitted she gave Resident #139 the wrong medication on 12/11/14 around</p>	F 224			

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F 224	Continued From page 18 9PM. She indicated she gave the resident Levemir insulin 45 Units. She further indicated she did not use any of the resident identifiers nor did she ask the resident to state her name and/or her date of birth. She stated she told Resident #139 she was going to give her an insulin shot and the resident stated "I don't take insulin." Nurse #3 further stated she replied to Resident #139 that the insulin was ordered for her and she was supposed to have it. Nurse #3 stated she realized she had given the wrong medication when she went to back to the Medication Administration Record (MAR) to document that she had given the insulin. Nurse #3 indicated that she did not document that she had given Resident #139 the insulin and she only checked Resident #139's blood sugar 2 more times before her shift ended at 11PM. She further indicated she clocked out and left the facility without telling anyone that she had administered the long acting insulin, Levemir to Resident #139. She stated she was unaware of what to do at the time she made the error. She further stated she did not talk with anyone about the medication error until the next morning when the DON called her at home and asked her about the insulin medication error. She reiterated that she did not call the physician to inform him of the medication error or of Resident #139's condition prior to her clocking out and leaving the facility. She indicated on 12/15/14 she had to take a class titled "Medication Management" and was observed on 12/15/14 by the Area Staff Development Coordinator administer medications to the residents during her shift. She further indicated she was observed 2 other times to administer medications, on 12/16/14 and on 12/18/14.  During an interview on 12/29/14 at 6:14 PM the	F 224			

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F 224	<p>Continued From page 19</p> <p>DON stated he was not aware of the medication error until 12/12/14 at 8:15 AM. He indicated the UM told him of the medication error. He stated he expected the nursing staff to use at least two resident identifiers before administering any medications and he expected the nurses to contact the physician anytime there was a change in a resident's condition. He indicated he would have expected Nurse #3 and/or any of his nursing staff to have contacted him, their supervisor or the nurse on call with any questions, concerns, doubt, or any medication errors. He further indicated he expected all of the nursing staff to give a report of their resident's to another nurse before they leave the hall and especially before clocking out and leaving the facility.</p> <p>The Administrator was informed of Immediate Jeopardy on 12/29/14 at 6:32 PM for Resident #139.</p> <p>A Credible Allegation of Compliance was accepted on 12/31/14 at 11:54 AM as follows:</p> <p>Credible Allegation of Compliance: Staff Treatment of Residents</p> <p>1. Residents identified to be affected by the deficient practice.</p> <p>On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The licensed nurse failed to follow the resident identification procedures of validating the resident's identity via name or confirming the resident's identity with another nurse prior to the administration of medication. The licensed nurse</p>	F 224			

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F 224	<p>Continued From page 20</p> <p>also failed to acknowledge the resident's advising that she (the resident) was not on insulin. In addition, the nurse left the facility at the end of the shift without reporting the error to the Nursing Supervisor or oncoming nurse. The facility identified the medication error on 12/12/14 and began an investigation into the causes of the deficient practice. The licensed nurse was suspended on 12/12/14 pending the outcome of the investigation. One to one education regarding medication administration practices and prevention of medication errors was completed on 12/15/14 for the licensed nurse by the Area Staff Development Manager.</p> <p>2. Residents with the potential to be affected by the deficient practice. Residents who require the administration of medications have the potential to be affected by the deficient practice. The Director of Nursing will complete an audit of all current residents' Medication Administration Records for the last 30 days to review for significant medication errors to be completed by 12/30/14.</p> <p>3. Systemic Measures</p> <p>The Director of Nursing, Administrator, and Unit Managers will review on a daily basis, Monday through Friday, the 24-hour Report and Medication Variance Reports, and conduct investigations to identify that physician notification has occurred and interventions have been put in place to provide for the resident's well-being and their needs are not neglected. On weekends, the RN on duty will review the 24-hour Report and any medication variance reports to ensure physician notification has occurred and</p>	F 224			

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

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F 224	<p>Continued From page 21</p> <p>interventions have been put in place so that residents' needs are identified and provided for.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning December 29, 2014 regarding Abuse &amp; Neglect Prohibition and the requirement to report medication errors to the physician and Director of Nursing or Supervisor to ensure that residents' needs are being met and not neglected, and interventions are put in place to address the error. This education included the definition of Neglect and examples were discussed. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Area Staff Development Manager. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. Beginning 12/30/14, the Director of Nursing or Social Services Director will conduct interviews with interview able residents at least three(3) times per week for four weeks, then three times per month thereafter to identify allegations of neglect related to medication administration. Investigations will be conducted, if necessary, based on interview information.</p> <p>Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when interviews with nurses revealed awareness of the prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. They verified they had received in-service training and were made</p>	F 224			

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F 224	<p>Continued From page 22</p> <p>aware of the reporting process for medication variances to include a mediation variance report, notification of the physician, family, nursing supervisor, and DON. The nurses further indicated the in-service training included the definition of neglect and to ensure that residents' needs have been met and not neglected before leaving the facility, as well as observations of administering medications to residents in the facility, and included examples and potential factors for medication errors, such as, distraction, knowledge deficits, and what should be done if a resident questions the medications for which they are to be given.</p> <p>2. Resident #133 was admitted to the facility 11/06/14 with diagnoses which included ovarian cancer and diabetes mellitus. An admission Minimum Data Set (MDS) dated 11/14/14 described Resident #133's speech was clear, made herself understood, and was able to understand others. The MDS specified cognition was intact and the resident required extensive assistance of 2 staff for bed mobility, personal hygiene, and toileting. The MDS indicated the resident had an indwelling urinary catheter and was occasionally incontinent of bowel. A Care Area Assessment (CAA) specified the resident required extensive assistance with all activities of daily living and was able to make her needs known.</p> <p>A care plan dated 11/18/14 described Resident #133 with a self-care performance deficit for activities of daily living related to terminal illness. The care plan goal specified the resident would maintain the current level of function through the</p>	F 224			

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F 224	<p>Continued From page 23</p> <p>next 90 day review. Interventions included the resident required extensive assistance of 2 staff members to turn and reposition in bed on care rounds and as necessary and the resident was totally dependent on 2 staff members for toilet use.</p> <p>On 12/29/14 at 1:51 PM, Resident #133 was observed during a dressing change to a pressure ulcer on her sacral area. The resident was observed lying on an air mattress. When the resident was rolled to her left side, a bruise was noted from the top of the right thigh and ascending over the right buttock. Just above the sacral area, the bruise curved and extended across the resident's lower back. The bruise curved again and descended down the left buttock to the top of the left thigh. The bruise was in the shape of a thin line in width and dark red to light red in color. The bruise had the appearance and shape of the edge of a bedpan. The bruise was observed with no skin breakdown.</p> <p>An interview was conducted with the resident's Responsible Party (RP) on 12/29/14 at 2:49 PM. The RP stated she left the resident on 12/26/14 around 4:30 PM and the resident's buttocks showed no signs of bruising. She stated she returned to the facility on 12/27/14 around 11:30 AM and the resident was complaining that it hurt her to use the bedpan. The RP stated she noted bruising on the resident's buttocks when she was informed by a nurse aide the resident had been left on the bedpan through the night. The RP stated the resident had used her call light when she needed something. The RP explained the resident was declining due to her terminal illness. At times the resident used her call light if she</p>	F 224			



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F 224	<p>Continued From page 24 needed care. At other times she yelled out.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/30/14 at 3:30 PM. The DON stated she had received a report on the morning of 12/27/14 between 5:30 AM and 6:00 AM that the night nurse found a bedpan under Resident #133. The DON added the facility was investigating this incident as neglect. She explained Resident #133 was assessed on the morning of 12/27/14 for other bruises or injuries and none were found.</p> <p>An interview was conducted via phone with Nurse #1 on 12/31/14 at 9:41 AM. Nurse #1 stated she worked the 11PM to 7AM shift on the evening of 12/26/14. She stated as she started her medication pass about 5:30 AM to 5:45 AM, she heard Resident #133 calling out for help. When asked, Resident #133 stated her backside was burning. Nurse #1 explained she solicited Nurse Aide (NA) #3 to assist with repositioning the resident. As they rolled the resident to her side, a bedpan was found under her. Nurse #1 stated Resident #133 had an indention where the bedpan had touched her skin. Nurse #1 explained she and NA #3 cleaned the resident and applied a moisture barrier cream to her backside. Nurse #1 stated she reported the incident to her relief nurse.</p> <p>An interview was conducted with NA #1 via phone on 12/31/14 at 10:09 AM. NA #1 stated she and NA #2 had worked the 3PM to 11PM shift on 12/26/14. She stated they were assigned to the end of the hall where Resident #133 resided. NA #1 stated she and NA #2 were extremely busy answering call lights and attending to residents' needs. NA #1 explained about 10:15 PM to 10:20</p>	F 224			

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F 224	<p>Continued From page 25</p> <p>PM, Resident #133 turned on her call light. NA #1 responded to the light and the resident asked to be put on the bedpan. NA #1 described Resident #133 used her call light several times during the evening and NA #1 was waiting for the resident to let her know when she was ready to get off the bedpan. NA #1 stated she got very busy and did not go back to see about Resident #133. She stated since she had not heard Resident #133's call light, she assumed NA #2 had taken her off the bedpan. NA #1 stated she should have gone back to check on the resident, but she did not. NA #1 further explained before she left the facility that evening, she did not give a report to the relieving nurse aide.</p> <p>An interview was conducted with NA #3 via phone on 12/31/14 at 10:43 AM. NA #3 stated she had worked the 11PM to 7AM shift on the evening of 12/26/14. She stated she did not get a report from any of the nurse aides she was relieving. NA #3 stated she walked down the hall and looked into each resident's room. When she got to Resident #133's room, she saw the resident moving in bed so she walked in and asked the resident if she needed anything. NA #3 stated the resident asked for some water which she provided and then left the room. NA #3 stated she went into Resident #133's room around 2:00 AM and emptied the resident's urinary catheter bag. She asked Resident #133 if she was alright and the resident replied she was. NA #3 stated about 5:00 AM to 5:15 AM she went into Resident #133's room. The resident complained of her backside hurting. NA #3 explained Nurse #1 was nearby administering medications and came to help her. When they turned Resident #133 over, they found a bedpan under the resident. NA #3 stated Resident #133 had been using the call light</p>	F 224			

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F 224	Continued From page 26 until a couple of weeks ago. NA #3 stated the resident started yelling out when she needed something. NA #3 acknowledged she was unaware Resident #133 was on the bedpan.  An additional interview was conducted with the DON on 12/31/14 at 12:03 PM. The DON explained she expected residents in this facility to receive the care they need and as they need it.  An interview was conducted with NA #2 via phone on 12/31/14 at 12:21 PM. NA #2 stated she worked the 3PM to 11PM shift on 12/26/14 and was assigned to Resident #133's end of the hall. She stated she assisted Resident #133 with the bedpan right after supper. NA #2 stated she did not assist Resident #133 with the bedpan anymore that evening.	F 224			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to provide the correct size of incontinence briefs for 1 of 3 residents reviewed for accommodation of residents' needs. (Resident #130).	F 246	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 130 by providing the correct size incontinence briefs. 2. Facility residents who require the use	2/2/15	

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F 246	<p>Continued From page 27</p> <p>The findings included:</p> <p>Resident #130 was admitted to the facility 11/17/14 for short term rehabilitation following an acute hospital stay. An admission Minimum Data Set (MDS) dated 11/24/14 identified Resident #130 with moderately impaired cognition and able to make needs known. The MDS specified the resident was frequently incontinent of bowel and bladder and required extensive assistance of 2 staff for toileting needs.</p> <p>An interview was conducted with Resident #130 on 12/29/14 at 3:23 PM. The resident stated she was admitted to the facility back in November. She explained the facility had run out of bariatric incontinence briefs twice since her admission. Resident #130 added last Friday, 12/26/14 was the last time she had been without the correct size incontinence brief. The resident stated she was in the smaller briefs for 1 to 2 days each time. Resident #130 described the smaller briefs were uncomfortable and rubbed her skin in the groin area.</p> <p>An observation of incontinence care was conducted on 12/29/14 at 4:09 PM. Nurse Aide (NA) #4 was observed providing the care. NA #4 removed a white colored incontinence brief. Following peri care, another white incontinence brief was applied. The brief was observed to fit across the resident's abdomen without being stretched or cutting into the resident's groin areas. At that time, NA #4 explained the white briefs were the correct size for Resident #130. The green briefs were a size smaller and fit tighter around the resident's legs and could not be fastened as securely and comfortably as the green brief.</p>	F 246	<p>of incontinence briefs have the potential to be affected by the same alleged deficient practice. The Central Supply Clerk has completed an audit of current residents' incontinence brief needs and residents are provided with incontinence supplies based on their assessed needs.</p> <p>3. Measures put in place to ensure the alleged deficient practice does not recur include: in-service re-education by the Director of Nursing or Area Staff Development Manager for Resident Care Specialists (C.N.A.s) regarding the provision of services while in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered, specifically, residents are to be provided with the appropriate incontinence briefs based on their size assessment unless the resident voices a need for different supplies. If this occurs, the Unit Manager or Director of Nursing will review the request with the resident to determine the most appropriate changes to be made. The Central Supply Clerk will establish a par level system to ensure that residents are provided with the appropriate size incontinence briefs. Newly admitted residents who require incontinence briefs will be assessed by the Central Supply Clerk using the vendor's measurement scale, and adequate supplies of briefs will be made available to the resident. The Administrator or Social Services Director will review concerns daily, Monday through Friday, during the Interdisciplinary Team Meeting to identify potential issues</p>		

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F 246	Continued From page 28  In a continued interview on 12/29/14 at 4:23 PM, NA #4 stated this past Friday, 12/26/14, the white briefs were not available. She stated the facility had run out of the larger size incontinence briefs several times over the past few weeks. NA #4 knew where the back up supply of briefs was kept and did have access to that supply.  An interview was conducted with the Central Supply Clerk (CSC) on 12/30/14 at 2:25 PM. The CSC explained the facility had an Incontinence Consultant visit the facility to assess each resident for the size of incontinence brief they required. The CSC stated she used the sizes provided by this consultant and estimated out how many briefs each resident utilized daily. As she placed her orders on Monday, Wednesday, and Friday, she multiplied the number of briefs she estimated were used by each resident by the number of days until the next order. The CSC stated she did not go into the supply closet and count how many briefs of each size had actually been used since the last order. The CSC stated she knew some of the residents that had been assessed for the green briefs preferred the white ones. She added she also knew some residents asked to wear 2 white briefs when they attended activities outside of their rooms.  An interview was conducted with the Administrator on 12/30/14 at 3:21 PM. The Administrator stated the facility did not have a good tracking system in place for ensuring the larger white briefs were kept available.  In a continued interview on 12/31/14 at 11:57 AM the Administrator stated she expected the CSC to have knowledge of how many briefs of each size	F 246	with provision of briefs. The facility's Ambassadors (facility management staff) will conduct rounds at least two (2) times per week for four (4) weeks to monitor for concerns related to availability of incontinence briefs according to size requirements and accommodation of resident needs.  4. The Administrator or Social Services Director will review the results of rounds, concerns, and par level monitoring; analyze the data; and report patterns/trends to the QAPI Committee every other month for four (4) months. The QAPI Committee will evaluate the effectiveness of the plan and make changes, as needed, to ensure continued compliance.		

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F 246	Continued From page 29 were actually used and place her order according to that usage. The Administrator stated she expected the facility to keep adequate supplies of all supply items required by residents.	F 246			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and physician interviews the facility failed to assess, monitor closely, and consult with the physician for the continuum of care for a resident after the administration of a long acting insulin with no physician's order for 1 of 4 sampled residents (Resident #139).  Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the nurse failed to initiate the blood sugar monitoring protocol, and treatment, and clocked out and left the facility without informing another nurse, supervisor, Director of Nursing, or the physician of Resident #139's condition. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D	F 309	1. On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The physician was notified on the morning of 12/12/14 and interventions were continued based on his direction. Resident #139 continued to be monitored and orders were implemented to address any future low blood sugar levels through the remainder of her stay. The resident was discharged on 12/16/14 in stable condition. 2. Residents with the potential to be affected by the deficient practice-Resident who exhibit acute changes in condition related to finger sticks indicating low blood sugar levels requiring intervention have the potential to be affected by the alleged deficient practice. The Director of Nursing has identified current residents who have had an acute	2/2/15	

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F 309	<p>Continued From page 30</p> <p>(no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>The findings included:</p> <p>Review of the facility's undated document titled "Diabetic Protocol" read in part:</p> <p>C. Insulin is to be given as per (physician) MD's orders.</p> <p>D. FSBS - if lower than 80, notify MD, hold insulin until MD gives specific orders. Inform MD of any nursing interventions, such as giving sugar &amp; orange juice. Note what the resident has eaten and general condition of the resident.</p> <p>E1. If resident is alert and FSBS is low give Oral Glucose Gel 15 Gm (grams), give per manufacturer's directions.</p> <p>E2. If consciousness is diminished or impaired in a diabetic whose FSBS is low, an IV (intravenous) of D5-1/2 NS (Dextrose 5% and ½ Normal Saline) at 100 ml (milliliters) per hour is to be started and 1 amp (ampule) of D50 (Dextrose 50) is to be pushed while trying to contact the attending MD. If unable to start an IV with 1st stick, give Glucagon 1 mg (milligrams) IM (intramuscular). Then continue to place IV. Recheck FSBS in 15 minutes after pushing D50. Continue IV until otherwise ordered by MD, but D/C (discontinue) in 24 hours if FSBS is staying greater than 125.</p> <p>Resident #139 was admitted to the facility on 12/11/14 with diagnoses which included shoulder joint replacement, high blood pressure, and diabetes mellitus type 2. The 5 day admission Minimum Data Set (MDS) dated 12/16/14 indicated Resident #139 was cognitively intact</p>	F 309	<p>change in condition related to low blood sugar levels in the past 30 days and reviewed their corresponding documentation to determine that a nursing assessment has been documented and interventions were implemented in a timely fashion.</p> <p>A Medication Variance report was completed by the Unit Manager on 12/12/14. One to One counseling with the nurses regarding the requirement for notification of the physician and supervisor in the event of a medication error, as well as implementing interventions to maintain the resident's wellbeing was conducted by the Director of Nursing on 12/12/14.</p> <p>3. Systemic Measures-The Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator or Unit Manager, and Resident Care Management Director) will review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to ensure that assessment or observations of symptoms have been documented, interventions were initiated timely, and the attending physician was contacted as appropriate. On weekends, the RN on Duty will perform the review of the 24-Hour Report to identify residents who have experienced acute changes in condition and ensure assessment or observations have been documented, interventions initiated timely, and the attending</p>		

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F 309	<p>Continued From page 31 and was capable of daily decision making.</p> <p>A review of the physician's orders dated 12/11/14 indicated Metformin 500 milligrams (mg) one tablet by mouth three times a day for prophylaxis related to complications of type 2 diabetes. Further review of the physician's orders indicated finger stick blood sugars (FSBS) twice daily (6:30 AM and 9:00 PM) related to diabetes. Further review revealed there was no physician's order for Levemir indicated for Resident #139. (Levemir is a long acting insulin which starts to work in 1 to 3 hours, with a peak in 8 to 10 hours, and lasts for 18 to 26 hours).</p> <p>A review of the nurse's notes dated 12/11/14 through 12/12/14 revealed the following entries:</p> <ul style="list-style-type: none"> <li>· 12/11/14 at 11:38 PM--Nurse #3, working the 3PM until 11PM shift, did not document in her notes or on the Medication Administration Record (MAR) any FSBS had been checked or that the physician had been notified that Resident #139 had been administered a long acting insulin without a physician's order.</li> <li>· 12/12/14 at 12:31 AM-Nurse #2, working the 11PM to 7AM shift, documented that Resident #139's FSBS was 48 and that the resident was given 8 ounces (oz.) of orange juice and peanut butter crackers. Nurse #2 documented a re-check FSBS 15 minutes later of 76 at which time she gave Resident #139 an 8 oz. cup of med pass (a fortified nutritional shake) with another re-check FSBS 30 minutes later of 88.</li> <li>· 12/12/14 at 1:45 AM--Nurse #2 documented a re-check FSBS of 51 and that she gave Resident #139 milk and a tangerine, at which</li> </ul>	F 309	<p>physician has been contacted as appropriate. Adjustments to the plan of care and Care Grids will be made based on these reviews and the input of medical professionals.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning 12/29/14 regarding the identification of changes in condition, use of Change of Condition tools as guidelines for assessment/evaluation components, and the expectation of timely intervention and physician involvement for identified acute changes in resident condition. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. Directed in-service training will be conducted for licensed nursing staff by a practice consultant with the NC Board of Nursing on January 28, 2015 in regards to prevention of medication errors. This education will include discussion of notification of the physician and supervisor in the event of medication error so that interventions can be put in place to provide for the resident's well-being. The Director of Nursing, Unit Coordinator, Unit Manager, or Resident Care Management Director will conduct care</p>		



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F 309	<p>Continued From page 32</p> <p>time Resident #139 consumed the entire carton of milk and ate half of the tangerine. Nurse #2 documented a re-check FSBS 20 minutes later of 88 and again provided Resident #139 with milk, another pack of crackers, and a container of yogurt. There was no documentation in Nurse #2's notes that the physician had been notified of the fluctuation in Resident #139's low FSBS throughout her shift.</p> <ul style="list-style-type: none"> <li>12/12/14 at 7:30 AM---The Unit Manager (UM) documented that she notified the physician of Resident #139's low blood sugars and that the facility's protocol was being followed. The UM documented that the physician had advised her to continue the protocol and monitor Resident #139's urine output for next 24 hours.</li> <li>12/12/14 at 8:00 AM---Nurse #4, working the 7AM to 3PM shift, documented a FSBS of 47 and that Resident #139 was alert and confused. Nurse #4 documented an IV (intravenous) was started and dextrose 50 (D50) was pushed via the IV and a bag of fluid which contained dextrose 5% (D5) &amp; ½ normal saline (NS) was hung for infusion and was set to run at 100 milliliters (ml) per hour. Nurse #4 documented a re-check FSBS 15 minutes after giving the D50 of 427.</li> </ul> <p>A review of a Medication Variance Report written by the UM dated 12/12/14 at 7:30 AM indicated Nurse #3 had administered the wrong medication to the wrong resident. The report noted the medication administered was Levemir insulin 45 Units one time by SQ (subcutaneous) to Resident #139. The report indicated "error/harm: an error occurred that may have contributed to or resulted in temporary resident harm and required</p>	F 309	<p>rounds at least three (3) times per week for four (4) weeks then at least weekly for three (3) months to include discussion with randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident's need.</p> <p>4. Quality Assurance and Performance Improvement Measures - The Director of Nursing or Administrator will review the data collected from the audits of 24-Hour Reports and care rounds, analyze the data, and report patterns or trends to the QAPI Committee every other month for three months. The QAPI Committee will evaluate the effectiveness of the plan and make changes based on outcomes to ensure continued compliance.</p>		

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F 309	<p>Continued From page 33</p> <p>intervention." The variance report revealed the Physician was contacted on 12/12/14 at 7:30 AM and orders were received and the Director of Nursing (DON), the Pharmacy, the Family, and the Administrator were contacted on 12/12/14 at 8:15 AM. The report further indicated the findings/actions taken: Nurse #3 was suspended, was re-educated, and required medication administration observations. The report was signed by the DON and the Administrator on 12/12/14.</p> <p>During an interview on 12/29/14 at 10:45 AM the UM verified she had completed the medication variance report. She stated on the morning of 12/12/14 at 7:15 AM she overheard the 3rd shift nurse, Nurse #2, and the 1st shift nurse, Nurse #4, discussing the fluctuation of Resident #139's FSBS. She indicated at that time she went to check on the resident and Resident #139 informed her of the injection of insulin the 2nd shift nurse had administered. The UM further indicated that during the course of her investigation she "figured out" that Resident #139 was given Resident #134's insulin; Resident #134 was across the hall from Resident #139. She stated she immediately advised the DON of the error and called the physician.</p> <p>During a telephone interview on 12/29/14 at 11:36 AM Nurse #2 indicated she was responsible for the care of Resident #139 on 12/11/14 at 11PM until 12/12/14 at 7AM. She stated during the change of shift report at 11:00 PM, she was not made aware of any concerns and/or problems with Resident #139. She further stated she always checked on her residents at the beginning of her shift and during her initial check that night of Resident #139, when she opened the</p>	F 309			

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F 309	<p>Continued From page 34</p> <p>resident's door, Resident #139 called out to her for assistance to the bathroom. At which time, Nurse #2 stated Resident #139 indicated to her that she was "feeling funny and weird" and advised her that she had been given a shot of insulin. Nurse #2 stated she checked Resident #139's blood sugar and noted it was in the 40's. She further stated she gave Resident #139 carbohydrates to eat and when she re-checked Resident #139's blood sugar it had come up into the 80's. She indicated she did not call the physician during the night because the resident was alert and talking but that she had continued to check Resident #139's blood sugar and gave her carbohydrates to eat throughout her shift.</p> <p>During a telephone interview on 12/29/14 at 11:51 AM Nurse #4 indicated she was responsible for the care of Resident #139 on 12/12/14 from 7AM until 3PM. She stated during the change of shift report at 7AM she was informed by Nurse #2 of Resident #139's fluctuating blood sugars throughout the night. Nurse #4 indicated after she received report, she and the UM went to assess Resident #139. Nurse #4 stated she checked Resident #139's blood sugar and noted it to be 46. She further indicated the UM called the physician and the physician gave them the orders to start an IV, administer D50, and infuse fluids of D5 ½ NS at 100 ml/hour.</p> <p>During a telephone interview on 12/29/14 at 1:47 PM Nurse #3 indicated she was responsible for the care of Resident #139 on 12/11/14 from 3PM until 11PM. She admitted she gave Resident #139 the wrong medication on 12/11/14 around 9PM. She indicated she gave the resident Levemir insulin 45 Units. She further indicated she did not use any of the resident identifiers nor</p>	F 309			

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F 309	<p>Continued From page 35</p> <p>did she ask the resident to state her name and/or her date of birth. She stated she told Resident #139 she was going to give her an insulin shot and the resident stated "I don't take insulin." Nurse #3 further stated she replied to Resident #139 that the insulin was ordered for her and she was supposed to have it. Nurse #3 stated she realized she had given the wrong medication when she went to back to the Medication Administration Record (MAR) to document that she had given the insulin. Nurse #3 indicated that she did not document that she had given Resident #139 the insulin and she only checked Resident #139's blood sugar 2 more times before her shift ended at 11PM. She further indicated she clocked out and left the facility without telling anyone that she had administered the long acting insulin, Levemir, to Resident #139. She stated she was unaware of what to do at the time she made the error. She further stated she did not talk with anyone about the medication error until the next morning when the DON called her at home and asked her about the insulin medication error.</p> <p>During an interview on 12/29/14 at 5:26 PM the physician indicated he was not the practicing physician at the time of the insulin medication error. He further indicated the physician that was contacted was no longer at the facility. He stated he was made aware of the error upon his arrival to the facility on 12/15/14. He indicated he would have expected Nurse #3 to have called the physician as soon as she was aware that she had made a medication error. He stated he would have sent the resident to the hospital to be monitored due to the insulin being that of a long acting type and the large dosage amount the was administered to Resident #139.</p>	F 309			

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F 309	Continued From page 36  During an interview on 12/29/14 at 6:14 PM the DON stated he was not aware of the medication error until 12/12/14 at 8:15 AM. He indicated the UM told him of the medication error. He stated he expected the nursing staff to use at least two resident identifiers before administering any medications. He further stated he would have expected Nurse #3 to have notified the physician when the insulin medication error was detected and to have not left the facility without informing her supervisor and/or another nurse. He indicated he would have expected Nurse #2 to have also contacted the physician of Resident #139's low and fluctuating FSBS. He stated he would have always expected all of his nursing staff to have contacted him, their supervisor or the nurse on call, and/or the physician with any medication errors and/or concerns that would involve the well-being of a resident.  The Administrator was informed of Immediate Jeopardy on 12/29/14 at 6:32 PM for Resident #139.  A Credible Allegation of Compliance was accepted on 12/31/14 at 11:54 AM as follows:  Credible Allegation of Compliance: Quality of Care  1. Residents identified to be affected by the deficient practice.  On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order.	F 309			

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F 309	<p>Continued From page 37</p> <p>The licensed nurses caring for the resident on second and third shifts on the evening of 12/11/14 failed to notify the supervisor and the physician per the facility's Diabetic Protocol of the medication error and low blood sugar level so that interventions could be put in place to provide for the resident's wellbeing. The facility identified the medication error on 12/12/14 and began an investigation into the causes of the deficient practice. The physician was notified on the morning of 12/12/14 and interventions were continued based on his direction. A Medication Variance Report was completed by the Unit Manager on 12/12/14. One to one counseling with the nurses regarding the requirement for notification of the physician and supervisor in the event of a medication error, as well as implementing interventions to maintain the resident's wellbeing was conducted by the Director of Nursing on 12/12/14.</p> <p>2. Residents with the potential to be affected by the deficient practice.</p> <p>Residents who exhibit acute changes in condition related to finger sticks indicating low blood sugar levels requiring intervention have the potential to be affected by the alleged deficient practice. The Director of Nursing has identified current residents who have had an acute change in condition related to low blood sugar levels in the last 30 days and reviewed their corresponding documentation to a determine that a nursing assessment has been documented and interventions were implemented in a timely fashion. Plans of care will continue to be reviewed by the Interdisciplinary Team quarterly, annually and with significant change of condition.</p>	F 309			

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F 309	Continued From page 38 3. Systemic Measures  The Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator or Unit Manager, and Resident Care Management Director) will review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms have been documented, interventions were initiated timely, and the attending physician was contacted as appropriate. On weekends, the RN on Duty will perform the review of the 24-hour Report to identify residents who have experienced acute changes in condition and ensure assessment or observations have been documented, interventions initiated timely, and the attending physician has been contacted as appropriate. Adjustments to the plan of care and Care Grids will be made based on these reviews and the input of medical professionals.  The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning December 29, 2014 regarding the identification of changes in condition, use of Change of Condition tools as guidelines for assessment/evaluation components, and the expectation of timely intervention and physician involvement for identified acute changes in resident condition. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education will be included in the facility's new hire orientation	F 309			

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F 309	Continued From page 39 and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education.  Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when interviews with nurses revealed awareness of the prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. They verified they had received in-service training and were made aware of the importance of the notification of the physician, family, nursing supervisor, and DON, which included actively listening to the residents when they inform them of a potential error in medication administration, and the reporting process for medication variances to include a mediation variance report. The nurses further indicated the in-service training included the definition of neglect and to ensure the residents' needs and well-being have been met and not neglected before leaving the facility, as well as observations of administering medications to residents in the facility, and included examples and potential factors for medication errors, such as, distraction, knowledge deficits, and what should be done if a resident questions the medications for which they are to be given.	F 309			
F 312 SS=G	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		2/2/15	



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F 312	Continued From page 40  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews, the facility failed to remove a bedpan from under a resident on the 3:00 PM to 11:00 PM shift for 1 of 4 residents reviewed for activities of daily living. (Resident #133).  The findings included:  Resident #133 was admitted to the facility 11/06/14 with diagnoses which included ovarian cancer and diabetes mellitus. An admission Minimum Data Set (MDS) dated 11/14/14 described Resident #133's speech was clear, made herself understood, and was able to understand others. The MDS specified cognition was intact and the resident required extensive assistance of 2 staff for bed mobility, personal hygiene, and toileting. The MDS indicated the resident had an indwelling urinary catheter and was occasionally incontinent of bowel. A Care Area Assessment (CAA) specified the resident required extensive assistance with all activities of daily living and was able to make her needs known.  A care plan dated 11/18/14 described Resident #133 with a self-care performance deficit for activities of daily living related to terminal illness. The care plan goal specified the resident would maintain the current level of function through the next 90 day review. Interventions included the resident required extensive assistance of 2 staff members to turn and reposition in bed on care rounds and as necessary and the resident was totally dependent on 2 staff members for toilet use.	F 312	1. Corrective action has been accomplished for Resident #133 in regards to the alleged deficient practice by providing for toileting needs in a timely fashion. The resident is provided with a bed pan at her request and staff is timely in removing the bed pan when toileting is complete. 2. Residents who are dependent for toileting assistance have the potential to be affected by the alleged deficient practice. The Resident Care Management Director has completed an audit of the current resident population to identify those residents who require staff assistance with toileting. Care Grids have been reviewed and updated, as needed, to provide information to nursing staff regarding residents' toileting needs. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: in-service education conducted by DON, for nursing staff regarding the provision of services to carry of activities of daily living for those residents who are unable to carry out these activities independently; specifically, staff are to provide toileting assistance in a timely fashion and be aware that those residents who may use a bed pan require frequent checks to remove the bed pan when toileting is complete. The Director of Nursing, Unit Manager, or Unit Coordinator will conduct care rounds at least three (3) times per week for four (4) weeks then at least weekly for three (3)		

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F 312	<p>Continued From page 41</p> <p>On 12/29/14 at 1:51 PM, Resident #133 was observed during a dressing change to a pressure ulcer on her sacral area. The resident was observed lying on an air mattress. When the resident was rolled to her left side, a bruise was noted from the top of the right thigh and ascending over the right buttock. Just above the sacral area, the bruise curved and extended across the resident's lower back. The bruise curved again and descended down the left buttock to the top of the left thigh. The bruise was in the shape of a thin line in width and dark red to light red in color. The bruise had the appearance and shape of the edge of a bedpan. The bruise was observed with no skin breakdown.</p> <p>An interview was conducted with the resident's Responsible Party (RP) on 12/29/14 at 2:49 PM. The RP stated she left the resident on 12/26/14 around 4:30 PM and the resident's buttocks showed no signs of bruising. She stated she returned to the facility on 12/27/14 around 11:30 AM and the resident was complaining that it hurt her to use the bedpan. The RP stated she noted bruising on the resident's buttocks when she was informed by a nurse aide the resident had been left on the bedpan through the night. The RP stated the resident had used her call light when she needed something. The RP explained the resident was declining due to her terminal illness. At times the resident used her call light if she needed care. At other times she yelled out.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/30/14 at 3:30 PM. The DON stated she had received a report on the morning of 12/27/14 between 5:30 AM and 6:00</p>	F 312	<p>months to monitor that toileting assistance is timely and residents are receiving assistance with activities of daily living.</p> <p>4. The Director of Nursing or Administrator will review the results of care rounds; analyze the data and report trends or patterns to the QAPI Committee every other month for four (4) months. The QAPI Committee will evaluate the effectiveness of the plan based on outcomes and may make amendments to the plan to ensure continued compliance.</p>		

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F 312	<p>Continued From page 42</p> <p>AM that the night nurse found a bedpan under Resident #133. She explained Resident #133 was assessed on the morning of 12/27/14 for other bruises or injuries and none were found.</p> <p>An interview was conducted via phone with Nurse #1 on 12/31/14 at 9:41 AM. Nurse #1 stated she worked the 11PM to 7AM shift on the evening of 12/26/14. She stated as she started her medication pass about 5:30 AM to 5:45 AM, she heard Resident #133 calling out for help. When asked, Resident #133 stated her backside was burning. Nurse #1 explained she solicited Nurse Aide (NA) #3 to assist with repositioning the resident. As they rolled the resident to her side, a bedpan was found under her. Nurse #1 stated Resident #133 had an indentation where the bedpan had touched her skin. Nurse #1 explained she and NA #3 cleaned the resident and applied a moisture barrier cream to her backside.</p> <p>An interview was conducted with NA #1 via phone on 12/31/14 at 10:09 AM. NA #1 stated she and NA #2 had worked the 3PM to 11PM shift on 12/26/14. She stated they were assigned to the end of the hall where Resident #133 resided. NA #1 stated she and NA #2 were extremely busy answering call lights and attending to residents' needs. NA #1 explained about 10:15 PM to 10:20 PM, Resident #133 turned on her call light. NA #1 responded to the light and the resident asked to be put on the bedpan. NA #1 described Resident #133 used her call light several times during the evening and NA #1 was waiting for the resident to let her know when she was ready to get off the bedpan. NA #1 stated she got very busy and did not go back to see about Resident #133. She stated since she had not heard</p>	F 312			

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F 312	<p>Continued From page 43</p> <p>Resident #133's call light, she assumed NA #2 had taken her off the bedpan. NA #1 stated she should have gone back to check on the resident, but she did not. NA #1 further explained before she left the facility that evening, she did not give a report to the relieving nurse aide.</p> <p>An interview was conducted with NA #3 via phone on 12/31/14 at 10:43 AM. NA #3 stated she had worked 11PM to 7AM shift on the evening of 12/26/14. She stated she did not get a report from any of the nurse aides she was relieving. NA #3 stated about 5:00 AM to 5:15 AM she went into Resident #133's room. The resident complained of her backside hurting. NA #3 explained Nurse #1 was nearby administering medications and came to help her. When they turned Resident #133 over, they found a bedpan under the resident. NA #3 stated Resident #133 had been using the call light until a couple of weeks ago. NA #3 stated the resident started yelling out when she needed something. NA #3 acknowledged she was unaware Resident #133 was on the bedpan. NA #3 stated she was unaware the resident had been on the bedpan throughout her shift.</p> <p>An additional interview was conducted with the DON on 12/31/14 at 12:03 PM. The DON explained she expected residents in this facility to receive the care they need and as they need it.</p> <p>An interview was conducted with NA #2 via phone on 12/31/14 at 12:21 PM. NA #2 stated she worked the 3PM to 11PM shift on 12/26/14 and was assigned to Resident #133's end of the hall. She stated she assisted Resident #133 with the bedpan right after supper. She acknowledged she shared the hall with NA #1 and did not</p>	F 312			

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F 312	Continued From page 44	F 312			
F 333 SS=J	<p>answer Resident #133's call light later in the shift.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to prevent a significant medication error by administering a long acting insulin with no physician's order for 1 of 2 residents reviewed for medication errors (Resident #139).</p> <p>Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>The findings included:</p> <p>Resident #139 was admitted to the facility on 12/11/14 with diagnoses which included shoulder joint replacement, high blood pressure, and diabetes mellitus type 2. The 5 day admission Minimum Data Set (MDS) dated 12/16/14 indicated Resident #139 was cognitively intact and was capable of daily decision making.</p>	F 333	<p>1. Residents identified to be affected by the deficient practice - On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The facility identified the medication error on 12/12/14. Resident #139 received medications per physician's order for the remainder of his/her stay. The resident was discharged from the facility on 12/16/14.</p> <p>2. Residents with the potential to be affected by the deficient practice - Residents who require the administration of medications have the potential to be affected by the deficient practice. The Director of Nursing completed an audit of all current residents' Medication Administration Records for the last 30 days to review for significant medication. The Director of Nursing has identified current residents who have had an acute change in condition related to low blood sugar levels in the past 30 days and reviewed their corresponding documentation to determine that a nursing assessment has been documented and interventions were implemented in a timely fashion.</p>	2/2/15	

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F 333	<p>Continued From page 45</p> <p>A review of the physician's orders dated 12/11/14 indicated Metformin 500 milligrams (mg) one tablet by mouth three times a day for prophylaxis related to complications of type 2 diabetes. Further review of the physician's orders indicated finger stick blood sugars (FSBS) twice daily (6:30 AM and 9:00 PM) related to diabetes. Further review revealed there was no physician's order for Levemir indicated for Resident #139. (Levemir is a long acting insulin which starts to work in 1 to 3 hours, with a peak in 8 to 10 hours, and lasts for 18 to 26 hours).</p> <p>A review of the Medication Administration Record (MAR) dated for December 2014 revealed Resident #139 was to be given Metformin 500mg one tablet by mouth at 9:00 AM, 1:00 PM, and at 5:00 PM. Additional review of the MAR revealed Resident #139's last dose of Metformin was administered on 12/11/14 at 5:00 PM. The Metformin was held on 12/12/14 due to Resident #139's low FSBS and was re-started on 12/13/14 at 9:00 AM. Further review of the MAR revealed there was no indication for Levemir to be administered.</p> <p>A review of the nurse's notes dated 12/11/14 through 12/12/14 revealed the following entries:</p> <ul style="list-style-type: none"> <li>12/11/14 at 11:38 PM--Nurse #3, working the 3PM until 11PM shift, documented that Resident #139 was resting comfortably and medications were tolerated with no adverse effect noted. There was no documentation in Nurse #3's notes or on the Medication Administration Record (MAR) to indicate any FSBS had been checked or that Resident #139 had been given insulin. Further review of the MAR revealed Resident #139 was administered her Metformin 500mg</li> </ul>	F 333	<p>3. Systemic Measures - The Director of Nursing, Administrator, and Unit Managers will review on a daily basis, Monday through Friday, Medication Variance Reports and conduct investigations to identify corrective actions necessary. The Director of Nursing and Unit Managers will review the 24-Hour Report to identify that nurses have monitored the resident. If Medication Variances occur on weekends, the nurse will report the variance to the Supervisor or Director of Nursing.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training will all scheduled licensed nurses beginning 12/29/14 regarding prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. This education also included examples of errors and factors affecting the potential for medication errors, such as, systemic issues, distraction, poor habits, lack of medication knowledge, knowledge deficits, and what to do if a resident questions the medications being given. This education included the reporting process for medication variances that includes completion of a Medication Variance Report, notification of the physician, Nursing Supervisor, if applicable, responsible party, and the Director of Nursing. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing</p>		

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F 333	Continued From page 46 tablet by mouth on 12/11/14 at 5:00 PM.  · 12/12/14 at 12:31 AM--Nurse #2, working the 11PM to 7AM shift, documented that Resident #139's FSBS was 48 and that the resident was given 8 ounces (oz.) of orange juice and peanut butter crackers. Nurse #2 documented a re-check FSBS 15 minutes later of 76 at which time she gave Resident #139 an 8 oz. cup of med pass (a fortified nutritional shake) with another re-check FSBS 30 minutes later of 88.  · 12/12/14 at 1:45 AM---Nurse #2 documented a re-check FSBS of 51 and Resident #139 was sleepy but alert and oriented to person, place, and time. Nurse #2 documented that she had administered 15 grams of glucose gel by mouth to Resident #139 and gave her milk and a tangerine, at which time Resident #139 consumed the entire carton of milk and ate half of the tangerine. Nurse #2 documented a re-check FSBS 20 minutes later of 88 and again provided Resident #139 with milk, another pack of crackers, and a container of yogurt.  · 12/12/14 at 7:30 AM---The Unit Manager (UM) documented that she notified the physician of Resident #139's low blood sugars and that the low blood sugar protocol was being followed. The UM documented that the physician had advised her to continue the protocol and monitor Resident #139's urine output for next 24 hours.  · 12/12/14 at 8:00 AM---Nurse #4, working the 7AM to 3PM shift, documented a FSBS of 47 and that Resident #139 was alert with confusion. Nurse #4 documented an IV (intravenous) was started and dextrose 50 (D50) was pushed via the IV and a bag of fluid which contained	F 333	or Area Staff Development Manager. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. Medication Pass Observations by the Director of Nursing, Unit Manager, Unit Coordinator, or Area Staff Development Manager will begin on 12/30/14 for at least three (3) licensed nurses per week until all nurses have been observed and then will be conducted randomly at least twice per month ongoing. In addition to the above measures, Directed in-service education will be conducted by a practice consultant for the NC Board of Nursing on January 28, 2015 for licensed nurses regarding the prevention of medication errors and the responsibility of licensed nurses to report errors to the physician and supervisor in order to implement interventions to address the care needs of the resident. The Director of Nursing or Unit Manager will conduct care rounds at least three (3) times per week for four (4) weeks then at least weekly for three (3) months to monitor that residents are receiving medications as ordered and concerns regarding accurate medication administration are identified and addressed. The facility's identification system for residents has been reviewed by the Interdisciplinary Team and includes door identifiers, resident names included on the electronic medical record, as well as a photo identifier in place on each		

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F 333	<p>Continued From page 47</p> <p>dextrose 5% (D5) &amp; ½ normal saline (NS) was hung for infusion and was set to run at 100 milliliters (ml) per hour. Nurse #4 documented a re-check FSBS 15 minutes after giving the D50 of 427.</p> <p>A review of a Medication Variance Report written by the UM dated 12/12/14 at 7:30 AM indicated Nurse #3 had administered the wrong medication to the wrong resident. The report noted the medication administered was Levemir insulin of 45 Units one time by SQ (subcutaneous) to Resident #139. The report indicated "error/harm: an error occurred that may have contributed to or resulted in temporary resident harm and required intervention." The variance report revealed the Physician was contacted on 12/12/14 at 7:30 AM and orders were received and the Director of Nursing (DON), the Pharmacy, the Family, and the Administrator were contacted on 12/12/14 at 8:15 AM. The report further indicated the findings/actions taken: Nurse #3 was suspended, was re-educated, and required medication administration observations. The report was signed by the DON and the Administrator on 12/12/14.</p> <p>During an interview on 12/29/14 at 10:45 AM the UM verified she had completed the medication variance report. She stated on the morning of 12/12/14 at 7:15 AM she overheard the 3rd shift nurse, Nurse #2, and the 1st shift nurse, Nurse #4, discussing the fluctuation of Resident #139's FSBS. She indicated at that time she went to check on the resident and Resident #139 informed her of the injection of insulin the 2nd shift nurse had administered. The UM further indicated that during the course of her</p>	F 333	<p>Medication Administration Record and Treatment Administration Record. The Health Information Manager or the Supervisor will monitor that resident identifiers are present upon admission and will audit for the presence of identifier components at least weekly for three (3) months.</p> <p>4. Quality Assurance and Performance Improvement Measures - The Administrator or Director of Nursing will review the results of variances, reports, care rounds, and audits monthly; analyze the data for trends/patterns and report to the QAPI Committee every other month for four (4) months. The QAPI Committee will evaluate the effectiveness of the plan and may make amendments to the plan based on outcomes to ensure continued compliance.</p>		



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F 333	<p>Continued From page 48</p> <p>investigation she "figured out" that Resident #139 was given Resident #134's insulin; Resident #134 was across the hall from Resident #139. She stated she immediately advised the DON of the error and called the physician.</p> <p>During a telephone interview on 12/29/14 at 11:36 AM Nurse #2 indicated she was responsible for the care of Resident #139 on 12/11/14 at 11PM until 12/12/14 at 7AM. She stated during the change of shift report at 11PM, she was not made aware of any concerns and/or problems with Resident #139. She further stated she always checked on her residents at the beginning of her shift and during her initial check that night of Resident #139, when she opened the resident's door, Resident #139 called out to her for assistance to the bathroom. At which time, Nurse #2 stated Resident #139 indicated to her that she was "feeling funny and weird" and advised her that she had been given a shot of insulin. Nurse #2 stated she checked Resident #139's blood sugar and noted it was in the 40's. She further stated she gave Resident #139 carbohydrates to eat and when she re-checked Resident #139's blood sugar it had come up into the 80's. She indicated she did not call the physician during the night but continued to check Resident #139's blood sugar and gave her carbohydrates to eat throughout her shift.</p> <p>During a telephone interview on 12/29/14 at 11:51 AM Nurse #4 indicated she was responsible for the care of Resident #139 on 12/12/14 from 7AM until 3PM. She stated during the change of shift report at 7AM she was informed by Nurse #2 of Resident #139's fluctuating blood sugars throughout the night. Nurse #4 indicated after she received report, she and the UM went to assess</p>	F 333			

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F 333	<p>Continued From page 49</p> <p>Resident #139. Nurse #4 stated she checked Resident #139's blood sugar and noted it to be 46. She further indicated the UM called the physician and the physician gave them the orders to start an IV, administer D50, and infuse fluids of D5 ½ NS at 100 ml/hour.</p> <p>During a telephone interview on 12/29/14 at 1:47 PM Nurse #3 indicated she was responsible for the care of Resident #139 on 12/11/14 from 3PM until 11PM. She admitted she gave Resident #139 the wrong medication on 12/11/14 around 9PM. She indicated she gave the resident Levemir insulin 45 Units. She further indicated she did not use any of the resident identifiers nor did she ask the resident to state her name and/or her date of birth. She stated she told Resident #139 she was going to give her an insulin shot and the resident stated "I don ' t take insulin." Nurse #3 further stated she replied to Resident #139 that the insulin was ordered for her and she was supposed to have it. Nurse #3 stated she realized she had given the wrong medication when she went to back to the Medication Administration Record (MAR) to document that she had given the insulin. Nurse #3 indicated that she did not document that she had given Resident #139 the insulin and she only checked Resident #139's blood sugar 2 more times before her shift ended at 11PM. She further indicated she clocked out and left the facility without telling anyone that she had administered the long acting insulin, Levemir, to Resident #139. She stated she was unaware of what to do at the time she made the error. She further stated she did not talk with anyone about the medication error until the next morning when the DON called her at home and asked her about the insulin medication error. She indicated on 12/15/14 she had to take</p>	F 333			

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F 333	<p>Continued From page 50</p> <p>a class titled "Medication Management" and was observed on 12/15/14 by the Area Staff Development Coordinator administer medications to the residents during her shift. She further indicated she was observed 2 other times to administer medications; on 12/16/14 and on 12/18/14.</p> <p>During an interview on 12/29/14 at 6:14 PM the DON stated he was not aware of the medication error until 12/12/14 at 8:15 AM. He indicated the UM told him of the medication error. He stated he expected the nursing staff to use at least two resident identifiers before administering any medications. He further stated he would have expected Nurse #3 and/or any of his nursing staff to have contacted him, their supervisor or the nurse on call with any questions, concerns, doubt, or any medication errors.</p> <p>The Administrator was informed of Immediate Jeopardy on 12/29/14 at 6:32 PM for Resident #139.</p> <p>A Credible Allegation of Compliance was accepted on 12/31/14 at 11:54 AM as follows:</p> <p>Credible Allegation of Compliance: Significant Medication Error</p> <p>1. Residents identified to be affected by the deficient practice.</p> <p>On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The licensed nurse failed to follow the resident identification procedures of validating the resident's identity via name or confirming the</p>	F 333			

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F 333	<p>Continued From page 51</p> <p>resident's identity with another nurse prior to the administration of medication. The licensed nurse also failed to acknowledge the resident's advising that she (the resident) was not on insulin. The facility identified the medication error on 12/12/14 and began an investigation into the causes of the deficient practice. The licensed nurse was suspended on 12/12/14 pending the outcome of the investigation. One to one education regarding medication administration practices and prevention of medication errors was completed on 12/15/14 for the licensed nurse by the Area Staff Development Manager. A total of three medication pass observations were completed for this nurse; one by the Area Staff Development Manager on 12/15/14 and two by the second shift Supervisor on 12/16/14 and 12/18/14.</p> <p>2. Residents with the potential to be affected by the deficient practice.</p> <p>Residents who require the administration of medications have the potential to be affected by the deficient practice. The Director of Nursing will complete an audit of all current residents' Medication Administration Records for the last 30 days to review for significant medication errors to be completed by 12/30/14. A Medication Variance Report and investigation will be completed for any identified errors and any affected resident will be evaluated by the physician for side effects.</p> <p>3. Systemic Measures</p> <p>The Director of Nursing, Administrator, and Unit Managers will review on a daily basis, Monday through Friday, Medication Variance Reports and conduct investigations to identify corrective actions necessary. The Director of Nursing and</p>	F 333			

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

PRINTED: 01/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 333	<p>Continued From page 52</p> <p>Unit Managers will review the 24-hour Report to identify that nurses have monitored the resident. If Medication Variances occur on weekends, the nurse will report the variance to the Supervisor or Director of Nursing.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training with all scheduled licensed nurses beginning December 29, 2014 regarding prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. This education also included examples of errors and factors affecting the potential for medication errors, such as, systemic issues, distraction, poor habits, lack of medication knowledge, knowledge deficits, and performance deficits, and what to do if a resident questions the medications being given. This education included the reporting process for medication variances that includes completion of a Medication Variance Report, notification of the physician, Nursing Supervisor, if applicable, responsible party, and the Director of Nursing. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Area Staff Development Manager. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. Medication Pass Observations by the Director of Nursing, Unit Manager, Unit Coordinator, or Area Staff Development Manager will begin on 12/30/14 for at least three (3) licensed nurses per week until all nurses have been observed and then will be conducted</p>	F 333			

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F 333	Continued From page 53 randomly at least twice per month ongoing.  Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when interviews with nurses revealed awareness of the prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. They verified they had received in-service training and were made aware of the reporting process for medication variances to include a mediation variance report, notification of the physician, family, nursing supervisor, and DON. The nurses further indicated the in-service training included observations of administering medications to residents in the facility, and included examples and potential factors for medication errors, such as, distraction, knowledge deficits, and what should be done if a resident questions the medications for which they are to be given.	F 333			

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F 000	INITIAL COMMENTS  483.25 (F309) at J Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the nurse failed to initiate the blood sugar monitoring protocol, and treatment, and clocked out and left the facility without informing another nurse, supervisor, Director of Nursing, or the physician of Resident #139's condition. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.  Also refer to Event ID #YPES11 for additional tags.	F 000			
{F 309} SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and physician interviews the facility failed to assess, monitor closely, and consult with the physician for the	{F 309}	1. On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The licensed nurses	2/2/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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 309}	<p>Continued From page 1</p> <p>continuum of care for a resident after the administration of a long acting insulin with no physician's order for 1 of 4 sampled residents (Resident #139).</p> <p>Immediate Jeopardy began on 12/11/14 when Resident #139 received a long acting insulin with no physician's order and the nurse failed to initiate the blood sugar monitoring protocol, and treatment, and clocked out and left the facility without informing another nurse, supervisor, Director of Nursing, or the physician of Resident #139's condition. Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.</p> <p>The findings included:</p> <p>Review of the facility's undated document titled "Diabetic Protocol" read in part:</p> <p>C. Insulin is to be given as per (physician) MD's orders.</p> <p>D. FSBS - if lower than 80, notify MD, hold insulin until MD gives specific orders. Inform MD of any nursing interventions, such as giving sugar &amp; orange juice. Note what the resident has eaten and general condition of the resident.</p> <p>E1. If resident is alert and FSBS is low give Oral Glucose Gel 15 Gm (grams), give per manufacturer's directions.</p> <p>E2. If consciousness is diminished or impaired in a diabetic whose FSBS is low, an IV (intravenous) of D5-1/2 NS (Dextrose 5% and 1/2 Normal</p>	{F 309}	<p>caring for the resident on second and third shifts on the evening of 12/11/14 failed to notify the supervisor and the physician per the facility's Diabetic Protocol of the medication error and low blood sugar level so that interventions could be put in place to provide for the resident's wellbeing. The physician was notified on the morning of 12/12/14 and interventions were continued based on his direction. Resident #139 continued to be monitored and orders were implemented to address any future low blood sugar levels through the remainder of her stay. The resident was discharged on 12/16/14 in stable condition.</p> <p>2. Residents with the potential to be affected by the deficient practice-Resident who exhibit acute changes in condition related to finger sticks indicating low blood sugar levels requiring intervention have the potential to be affected by the alleged deficient practice.</p> <p>The Director of Nursing has identified current residents who have had an acute change in condition related to low blood sugar levels in the past 30 days and reviewed their corresponding documentation to determine that a nursing assessment has been documented and interventions were implemented in a timely fashion.</p> <p>A Medication Variance report was completed by the Unit Manager on 12/12/14. One to One counseling with the nurses regarding the requirement for notification of the physician and supervisor in the event of a medication</p>		



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{F 309}	<p>Continued From page 2</p> <p>Saline) at 100 ml (milliliters) per hour is to be started and 1 amp (ampule) of D50 (Dextrose 50) is to be pushed while trying to contact the attending MD. If unable to start an IV with 1st stick, give Glucagon 1 mg (milligrams) IM (intramuscular). Then continue to place IV. Recheck FSBS in 15 minutes after pushing D50. Continue IV until otherwise ordered by MD, but D/C (discontinue) in 24 hours if FSBS is staying greater than 125.</p> <p>Resident #139 was admitted to the facility on 12/11/14 with diagnoses which included shoulder joint replacement, high blood pressure, and diabetes mellitus type 2. The 5 day admission Minimum Data Set (MDS) dated 12/16/14 indicated Resident #139 was cognitively intact and was capable of daily decision making.</p> <p>A review of the physician's orders dated 12/11/14 indicated Metformin 500 milligrams (mg) one tablet by mouth three times a day for prophylaxis related to complications of type 2 diabetes. Further review of the physician's orders indicated finger stick blood sugars (FSBS) twice daily (6:30 AM and 9:00 PM) related to diabetes. Further review revealed there was no physician's order for Levemir indicated for Resident #139. (Levemir is a long acting insulin which starts to work in 1 to 3 hours, with a peak in 8 to 10 hours, and lasts for 18 to 26 hours).</p> <p>A review of the nurse's notes dated 12/11/14 through 12/12/14 revealed the following entries:</p> <ul style="list-style-type: none"> <li>12/11/14 at 11:38 PM--Nurse #3, working the 3PM until 11PM shift, did not document in her notes or on the Medication Administration Record (MAR) any FSBS had been checked or that the</li> </ul>	{F 309}	<p>error, as well as implementing interventions to maintain the resident's wellbeing was conducted by the Director of Nursing on 12/12/14.</p> <p>3. Systemic Measures-The Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator or Unit Manager, and Resident Care Management Director) will review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to ensure that assessment or observations of symptoms have been documented, interventions were initiated timely, and the attending physician was contacted as appropriate. On weekends, the RN on Duty will perform the review of the 24-Hour Report to identify residents who have experienced acute changes in condition and ensure assessment or observations have been documented, interventions initiated timely, and the attending physician has been contacted as appropriate. Adjustments to the plan of care and Care Grids will be made based on these reviews and the input of medical professionals.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning 12/29/14 regarding the identification of changes in condition, use of Change of Condition tools as guidelines for assessment/evaluation components,</p>		

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{F 309}	<p>Continued From page 3</p> <p>physician had been notified that Resident #139 had been administered a long acting insulin without a physician's order.</p> <ul style="list-style-type: none"> <li>12/12/14 at 12:31 AM--Nurse #2, working the 11PM to 7AM shift, documented that Resident #139's FSBS was 48 and that the resident was given 8 ounces (oz.) of orange juice and peanut butter crackers. Nurse #2 documented a re-check FSBS 15 minutes later of 76 at which time she gave Resident #139 an 8 oz. cup of med pass (a fortified nutritional shake) with another re-check FSBS 30 minutes later of 88.</li> <li>12/12/14 at 1:45 AM---Nurse #2 documented a re-check FSBS of 51 and that she gave Resident #139 milk and a tangerine, at which time Resident #139 consumed the entire carton of milk and ate half of the tangerine. Nurse #2 documented a re-check FSBS 20 minutes later of 88 and again provided Resident #139 with milk, another pack of crackers, and a container of yogurt. There was no documentation in Nurse #2's notes that the physician had been notified of the fluctuation in Resident #139's low FSBS throughout her shift.</li> <li>12/12/14 at 7:30 AM---The Unit Manager (UM) documented that she notified the physician of Resident #139's low blood sugars and that the facility's protocol was being followed. The UM documented that the physician had advised her to continue the protocol and monitor Resident #139's urine output for next 24 hours.</li> <li>12/12/14 at 8:00 AM---Nurse #4, working the 7AM to 3PM shift, documented a FSBS of 47 and that Resident #139 was alert and confused. Nurse #4 documented an IV (intravenous) was</li> </ul>	{F 309}	<p>and the expectation of timely intervention and physician involvement for identified acute changes in resident condition. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education. Directed in-service training will be conducted for licensed nursing staff by a practice consultant with the NC Board of Nursing on January 28, 2015 in regards to prevention of medication errors. This education will include discussion of notification of the physician and supervisor in the event of medication error so that interventions can be put in place to provide for the resident's well-being. The Director of Nursing, Unit Coordinator, Unit Manager, or Resident Care Management Director will conduct care rounds at least three (3) times per week for four (4) weeks then at least weekly for three (3) months to include discussion with randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident's need.</p>		

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{F 309}	<p>Continued From page 4</p> <p>started and dextrose 50 (D50) was pushed via the IV and a bag of fluid which contained dextrose 5% (D5) &amp; ½ normal saline (NS) was hung for infusion and was set to run at 100 milliliters (ml) per hour. Nurse #4 documented a re-check FSBS 15 minutes after giving the D50 of 427.</p> <p>A review of a Medication Variance Report written by the UM dated 12/12/14 at 7:30 AM indicated Nurse #3 had administered the wrong medication to the wrong resident. The report noted the medication administered was Levemir insulin 45 Units one time by SQ (subcutaneous) to Resident #139. The report indicated "error/harm: an error occurred that may have contributed to or resulted in temporary resident harm and required intervention." The variance report revealed the Physician was contacted on 12/12/14 at 7:30 AM and orders were received and the Director of Nursing (DON), the Pharmacy, the Family, and the Administrator were contacted on 12/12/14 at 8:15 AM. The report further indicated the findings/actions taken: Nurse #3 was suspended, was re-educated, and required medication administration observations. The report was signed by the DON and the Administrator on 12/12/14.</p> <p>During an interview on 12/29/14 at 10:45 AM the UM verified she had completed the medication variance report. She stated on the morning of 12/12/14 at 7:15 AM she overheard the 3rd shift nurse, Nurse #2, and the 1st shift nurse, Nurse #4, discussing the fluctuation of Resident #139's FSBS. She indicated at that time she went to check on the resident and Resident #139 informed her of the injection of insulin the 2nd shift nurse had administered. The UM further</p>	{F 309}	<p>4. Quality Assurance and Performance Improvement Measures - The Director of Nursing or Administrator will review the data collected from the audits of 24-Hour Reports and care rounds, analyze the data, and report patterns or trends to the QAPI Committee every other month for three months. The QAPI Committee will evaluate the effectiveness of the plan and make changes based on outcomes to ensure continued compliance.</p>		

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{F 309}	<p>Continued From page 5</p> <p>indicated that during the course of her investigation she "figured out" that Resident #139 was given Resident #134's insulin; Resident #134 was across the hall from Resident #139. She stated she immediately advised the DON of the error and called the physician.</p> <p>During a telephone interview on 12/29/14 at 11:36 AM Nurse #2 indicated she was responsible for the care of Resident #139 on 12/11/14 at 11PM until 12/12/14 at 7AM. She stated during the change of shift report at 11:00 PM, she was not made aware of any concerns and/or problems with Resident #139. She further stated she always checked on her residents at the beginning of her shift and during her initial check that night of Resident #139, when she opened the resident's door, Resident #139 called out to her for assistance to the bathroom. At which time, Nurse #2 stated Resident #139 indicated to her that she was "feeling funny and weird" and advised her that she had been given a shot of insulin. Nurse #2 stated she checked Resident #139's blood sugar and noted it was in the 40's. She further stated she gave Resident #139 carbohydrates to eat and when she re-checked Resident #139's blood sugar it had come up into the 80's. She indicated she did not call the physician during the night because the resident was alert and talking but that she had continued to check Resident #139's blood sugar and gave her carbohydrates to eat throughout her shift.</p> <p>During a telephone interview on 12/29/14 at 11:51 AM Nurse #4 indicated she was responsible for the care of Resident #139 on 12/12/14 from 7AM until 3PM. She stated during the change of shift report at 7AM she was informed by Nurse #2 of Resident #139's fluctuating blood sugars</p>	{F 309}			

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NAME OF PROVIDER OR SUPPLIER  <b>FOREST CITY HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>830 BETHANY CHURCH ROAD</b> <b>FOREST CITY, NC 28043</b>		
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{F 309}	<p>Continued From page 6</p> <p>throughout the night. Nurse #4 indicated after she received report, she and the UM went to assess Resident #139. Nurse #4 stated she checked Resident #139's blood sugar and noted it to be 46. She further indicated the UM called the physician and the physician gave them the orders to start an IV, administer D50, and infuse fluids of D5 ½ NS at 100 ml/hour.</p> <p>During a telephone interview on 12/29/14 at 1:47 PM Nurse #3 indicated she was responsible for the care of Resident #139 on 12/11/14 from 3PM until 11PM. She admitted she gave Resident #139 the wrong medication on 12/11/14 around 9PM. She indicated she gave the resident Levemir insulin 45 Units. She further indicated she did not use any of the resident identifiers nor did she ask the resident to state her name and/or her date of birth. She stated she told Resident #139 she was going to give her an insulin shot and the resident stated "I don't take insulin." Nurse #3 further stated she replied to Resident #139 that the insulin was ordered for her and she was supposed to have it. Nurse #3 stated she realized she had given the wrong medication when she went to back to the Medication Administration Record (MAR) to document that she had given the insulin. Nurse #3 indicated that she did not document that she had given Resident #139 the insulin and she only checked Resident #139's blood sugar 2 more times before her shift ended at 11PM. She further indicated she clocked out and left the facility without telling anyone that she had administered the long acting insulin, Levemir, to Resident #139. She stated she was unaware of what to do at the time she made the error. She further stated she did not talk with anyone about the medication error until the next morning when the DON called her at</p>	{F 309}			

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{F 309}	<p>Continued From page 7</p> <p>home and asked her about the insulin medication error.</p> <p>During an interview on 12/29/14 at 5:26 PM the physician indicated he was not the practicing physician at the time of the insulin medication error. He further indicated the physician that was contacted was no longer at the facility. He stated he was made aware of the error upon his arrival to the facility on 12/15/14. He indicated he would have expected Nurse #3 to have called the physician as soon as she was aware that she had made a medication error. He stated he would have sent the resident to the hospital to be monitored due to the insulin being that of a long acting type and the large dosage amount the was administered to Resident #139.</p> <p>During an interview on 12/29/14 at 6:14 PM the DON stated he was not aware of the medication error until 12/12/14 at 8:15 AM. He indicated the UM told him of the medication error. He stated he expected the nursing staff to use at least two resident identifiers before administering any medications. He further stated he would have expected Nurse #3 to have notified the physician when the insulin medication error was detected and to have not left the facility without informing her supervisor and/or another nurse. He indicated he would have expected Nurse #2 to have also contacted the physician of Resident #139's low and fluctuating FSBS. He stated he would have always expected all of his nursing staff to have contacted him, their supervisor or the nurse on call, and/or the physician with any medication errors and/or concerns that would involve the well-being of a resident.</p>	{F 309}			

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{F 309}	<p>Continued From page 8</p> <p>The Administrator was informed of Immediate Jeopardy on 12/29/14 at 6:32 PM for Resident #139.</p> <p>A Credible Allegation of Compliance was accepted on 12/31/14 at 11:54 AM as follows:</p> <p>Credible Allegation of Compliance: Quality of Care</p> <p>1. Residents identified to be affected by the deficient practice.</p> <p>On 12/11/14, Resident #139 was administered long-acting insulin without a physician's order. The licensed nurses caring for the resident on second and third shifts on the evening of 12/11/14 failed to notify the supervisor and the physician per the facility's Diabetic Protocol of the medication error and low blood sugar level so that interventions could be put in place to provide for the resident's wellbeing. The facility identified the medication error on 12/12/14 and began an investigation into the causes of the deficient practice. The physician was notified on the morning of 12/12/14 and interventions were continued based on his direction. A Medication Variance Report was completed by the Unit Manager on 12/12/14. One to one counseling with the nurses regarding the requirement for notification of the physician and supervisor in the event of a medication error, as well as implementing interventions to maintain the resident's wellbeing was conducted by the Director of Nursing on 12/12/14.</p> <p>2. Residents with the potential to be affected by</p>	{F 309}			

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{F 309}	<p>Continued From page 9 the deficient practice.</p> <p>Residents who exhibit acute changes in condition related to finger sticks indicating low blood sugar levels requiring intervention have the potential to be affected by the alleged deficient practice. The Director of Nursing has identified current residents who have had an acute change in condition related to low blood sugar levels in the last 30 days and reviewed their corresponding documentation to a determine that a nursing assessment has been documented and interventions were implemented in a timely fashion. Plans of care will continue to be reviewed by the Interdisciplinary Team quarterly, annually and with significant change of condition.</p> <p>3. Systemic Measures</p> <p>The Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator or Unit Manager, and Resident Care Management Director) will review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms have been documented, interventions were initiated timely, and the attending physician was contacted as appropriate. On weekends, the RN on Duty will perform the review of the 24-hour Report to identify residents who have experienced acute changes in condition and ensure assessment or observations have been documented, interventions initiated timely, and the attending physician has been contacted as appropriate. Adjustments to the plan of care and Care Grids will be made based on these reviews</p>	{F 309}			



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{F 309}	<p>Continued From page 10 and the input of medical professionals.</p> <p>The Division Director of Clinical Services and the Director of Nursing have conducted training with licensed nurses beginning December 29, 2014 regarding the identification of changes in condition, use of Change of Condition tools as guidelines for assessment/evaluation components, and the expectation of timely intervention and physician involvement for identified acute changes in resident condition. Licensed nursing staff will not be allowed to work until the training is completed. Licensed nursing staff will be provided this education at least annually via the Director of Nursing or Resident Care Management Director. This education will be included in the facility's new hire orientation and newly hired licensed nursing staff will not be permitted to assume their floor responsibilities until they have completed this education.</p> <p>Immediate Jeopardy was removed on 12/31/14 at 11:54 AM when interviews with nurses revealed awareness of the prevention of medication errors by using the Rights of Administration which include Right Resident, Right Dose, Right Time, Right Drug, and Right Route. They verified they had received in-service training and were made aware of the importance of the notification of the physician, family, nursing supervisor, and DON, which included actively listening to the residents when they inform them of a potential error in medication administration, and the reporting process for medication variances to include a mediation variance report. The nurses further indicated the in-service training included the definition of neglect and to ensure the residents' needs and well-being have been met and not</p>	{F 309}			

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{F 309}	Continued From page 11 neglected before leaving the facility, as well as observations of administering medications to residents in the facility, and included examples and potential factors for medication errors, such as, distraction, knowledge deficits, and what should be done if a resident questions the medications for which they are to be given.	{F 309}		