STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRABTREE VALLEY REHAB CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 9/14/15 IDR panel deleted F 157 and F 281	F 000		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to keep accurate medical records for one of four sampled residents with diabetes, Resident #4. Findings included: 1a. Resident #4 was admitted to the facility on 01/15/13 and readmitted on 01/20/15. January 2015 physician orders revealed the resident was on Lantus insulin 100 units/ml, 45 units subcutaneously twice daily, Humalog insulin 100 units/ml, 5 units subcutaneously three times a day before meals and a sliding scale insulin order for Novolog 100 units/ml. The pharmacist "Consultation Report" of 03/12/15 stated "Please consider improving glycemic control by discontinuing sliding scale	F 514	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON clarified the order received by the physician and developed a MD fax order form and blood glucose flow sheet to ensure proper procedures and documentation are in place. No negative outcome was noted for Resident #4. Implementation of these forms will ensure proper documentation is in place and physician orders are appropriately documented and carried out in a timely manner. The staff member who failed to	8/13/15

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

Electronically Signed | 08/05/2015

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F 514	Continued From page 1 insulin Novolog and starting Novolog 4 units before lunch and dinner." The physician accepted the recommendations and asked to implement them as written. The physician signed the report on 03/26/15. The report had a handwritten note dated 03/31/15 that read "on POS" (physician order sheet). This note was signed by Nurse #4. According to the April 2015 Medication Administration Record (MAR), the resident Novolog sliding scale order (including the fingersticks four times a day) was discontinued on 03/31/15 (a line was drawn across the order and D/c (discontinued) 3/31/15 was written beside the line). Review of the resident ' s medical record revealed the resident did not receive the Novolog sliding scale after 03/31/15. Review of the April 2015 MAR indicated that the resident did receive Novolog 4 units before lunch and dinner starting 04/01/15. However, there was no telephone physician order written to discontinue the Novolog sliding scale and start the scheduled Novolog twice a day until 04/08/15 when a physician order was written to discontinue Novolog sliding scale and to start Novolog 4 units before lunch and before dinner. Nurse #4 was interviewed on 07/16/15 at 4 PM. Nurse #4 revealed that she did not write a telephone order to discontinue the Novolog sliding scale and to start on Novolog 4 units twice a day because she did not believe that she needed a telephone order for that. 1b. Resident #4 was admitted to the facility on 01/15/13 and readmitted on 01/20/15. January 2015 physician orders revealed resident was on Lantus insulin 100 units/ml, 45 units subcutaneously twice daily, Humalog insulin 100 units/ml, 5 units subcutaneously three times a day before meals and a sliding scale insulin order	F 514	write the physician order, to discontinue sliding scale insulin and to start scheduled insulin therapy and to change the frequency of the blood sugar finger sticks was educated, by the DON, on the proper professional standard regarding transcribing orders. Education for this staff member occurred 7-16-15 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. A review of residents receiving finger stick blood sugars will be conducted by DON/designee to ensure no other residents of sugars less than 60 have occurred without MD notification and documentation. The facility will implement new documentation procedures, update education of staff in regards to transcribing physician orders. This will establish MD fax order form and blood glucose flow sheets are in place for all residents receiving finger stick blood sugars and that orders match the MAR. All nurses will be educated on procedures for notification of changes in regards to communicating with the physician and there responsibility with charting. This education will be conducted by the DON/designee 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.	

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F 514	Continued From page 2 for Novolog 100 units/ml. Blood sugar fingersticks were to be done before meals and at bedtime, at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM. The pharmacist "Consultation Report" of 03/12/15 stated "Please consider improving glycemic control by discontinuing sliding scale insulin Novolog and starting Novolog 4 units before lunch and dinner." The physician accepted the recommendations and asked to implement them as written. The physician signed the report on 03/26/15. The report had a handwritten note dated 03/31/15 that read "on POS" (physician order sheet). This note was signed by Nurse #4. According to the April 2015 Medication Administration Record (MAR), the resident Novolog sliding scale order (including the fingersticks four times a day) was discontinued on 03/31/15 (a line was drawn across the order and written D/C (discontinued) 03/31/15). A document titled "Fingerstick Blood Sugar Record" revealed the resident continued to get fingersticks at 6:30 AM, 11:30 AM, 4:30 PM and 9 PM on 04/01/15 and 04/02/15. The Fingersticks records also revealed the resident was given 4 units of insulin (the type was not specified) on 04/01/15 at 4:30 PM. Review of the April 2015 MAR indicated the resident was given 4 units of Novolog on 04/01/15 at 4:30 PM with no site of injection specified. Even though the pharmacist "Consultation Report" of 03/12/15 indicated the physician agreed to discontinue the sliding scale insulin, and the MAR indicated the sliding scale insulin was discontinued on 03/31/15. The resident continued to have fingersticks four times a day on 04/01/15 and 04/02/15. There was no order to do fingersticks on 04/01/15 or 04/02/15 four times a day and the fingersticks readings	F 514	MD fax order sheets and blood glucose flow sheets will be put in place to ensure nurses follow up with communication procedures. The DON/designee will verify standing orders for diabetic events and ensure orders are updated and nursing staff have been educated. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. Monitoring of the new procedures by review of the new forms and medical records to ensure medical records are complete and have been updated in a timely manner to reflect all physician communication and orders and appropriate notification of the physician will be performed by the DON/designee weekly x4, bi-monthly x2 months and monthly x1. The facility QA committee and administrator/designee will review monitoring during QA meetings. DON/designee will be responsible for monitoring and reporting.	

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F 514	Continued From page 3	F 514		

were not documented on the MAR.
Review of a statement written by Nurse #4 dated 04/03/15 revealed that Nurse #5 expressed to her that she continued to do fingersticks for 04/01/15 and 04/02/15. However, Nurse #5 said that she was unsure if the new orders meant to discontinue the sliding scale insulin only or the sliding scale and the fingersticks.
Review of the 24-Hour Report of Resident Condition of 04/03/15 revealed that Nurse #5 wrote a note that read "clarification BS (blood sugar (fingerstick)) q (every) 0630 (6:30 AM) and (zero) sliding scale." However, there was no physician telephone order written on 04/03/15 regarding the change in the fingersticks order and it was not transcribed on the MAR.
Record review of the statement from Nurse #4 dated 04/03/15 revealed that Nurse #5 asked the pharmacy consultant on 04/03/15 to clarify what the consultant meant. The physician was contacted and he gave an order to do BS (blood sugar) once daily at 6:30 AM. Nurse #5 stated she was in the middle of shift change when the attending physician called back. She wrote the new order on the 24 hour report sheet. The new physician order was not written as a telephone order and was not transcribed to the chart or the MAR.
A telephone physician order was written on 04/08/15 to start Novolog 4 units before lunch and before dinner. There was no physician telephone order for doing fingersticks once daily at 6:30 AM.
Review of April, 2015 MAR showed no documentation of blood sugar fingersticks. However, the daily fingersticks continued to be documented on the Fingerstick Blood Sugar Record for once a day at 6:30 AM.
Review of pharmacist consultant sheet dated

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F 514	Continued From page 4 05/12/15 revealed she realized there was no monitoring of blood sugar fingersticks on the MARs and wrote a recommendation for monitoring. On 05/12/15 Nurse #5 wrote the telephone order "order clarification for MAR/POS-Check blood sugar once a day at 6:30 AM d/t (Due to) insulin use."	F 514		