

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

PRINTED: 07/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2017
NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		
(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	<p>INITIAL COMMENTS</p> <p>A complaint investigation survey was conducted from 05/10/17 through 05/12/17. Immediate Jeopardy was identified at:</p> <p>CFR 483.24 at tag F309 at a scope and severity (J) CFR 483.35 at tag F353 at a scope and severity (J) CFR 483.70 at tag F490 at a scope and severity (J)</p> <p>Immediate Jeopardy began on 05/08/17 and was removed on 05/12/17. A Partial extended survey was conducted.</p> <p>Per management review, additional information was obtained on 05/18/17, and 5/22/17 through 05/24/17. As a result, immediate jeopardy at CFR 483.12 at tag F224 at a scope and severity (J) was also identified. The facility provided a credible allegation on 05/23/17 and it was validated on 5/24/17.</p> <p>Therefore, the exit date was changed to 5/24/17.</p> <p>The tags F224 J and F309 constituted Substandard Quality of Care.</p>	F 000			
F 157 SS=D	<p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p>	F 157		6/27/17	

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

TITLE

(X6) DATE

Electronically Signed

06/09/2017

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 157	<p>Continued From page 1</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, staff interview, the facility failed to notify the physician of elevated capillary blood glucose (CBG) levels of an insulin dependent brittle diabetic resident. This was evident in 1 of 3 diabetic residents (Resident #2).</p> <p>Findings included:</p> <p>1. Resident #2 was admitted to the facility on 02/27/17 with diagnoses including Type I Diabetes Mellitus (DM) with Chronic Kidney Disease.</p> <p>A review of the initial Minimum Data Set (MDS) dated 03/06/17 revealed that Resident #2 was cognitively intact.</p> <p>A review of the medical records revealed the following: A physician order dated 02/28/17 at 6:32 AM read "NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: if (CBG) 150 - 210 = 1 (NovoLOG) unit; 211 - 270 = 2 units; 271 - 330 = 3 units; 331 - 390 = 4 units; 391 - 450 = 5 units; notify MD (physician) if CBG is greater than 450, subcutaneously before meals and at bedtime for DM."</p> <p>Review of Resident #2 handwritten physician order dated 03/06/17 revealed the following new order: New SSI (sliding scale insulin) for patient (resident) with meals 151-200=2 units, 201-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=9 units, 401-450=11 units, if greater</p>	F 157	<p>Resident #2 no longer resides in the facility.</p> <p>The Director of Nursing and/or Nurse Manager will review current residents identified as receiving CBG in past thirty days to ensure that physician orders were followed for current residents with elevated CBG and/or physician notification if indicated per orders by 6/27/17.</p> <p>Current facility residents identified as receiving capillary blood glucose monitoring will be reviewed five times a week for one month then weekly times two months to ensure that physicians were notified as stated in physician's orders of elevated capillary blood glucose.</p> <p>The facility licensed nurses will be provided re-education regarding notification of change, to include notification of elevated capillary blood glucose per physician orders and completed by Staff Development Coordinator by 6/27/17.</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Process Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional</p>	

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F 157	<p>Continued From page 3 than 450 call MD.</p> <p>Review of the Medication Administration Record (MAR) 03/06/17 through 03/31/17 revealed the new SSI order of 3/6/17 was not transcribed on the MAR. The transcribed Novolog SSI order was the following: Novolog solution 100unit/ml, inject as per sliding scale: if 150-210=1 unit, 211-270=2 units, 271-330=3 units, 331-390=4 units, 391-450=5 units. Notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM. Order date 02/27/17.</p> <p>Review of the March 2017 MAR revealed the following CBG readings and SSI coverage administered to Resident #2: MAR date 03/06/17 at 11:30 AM, CBG 508. Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record. No documentation that the physician was notified.</p> <p>On 05/18/17 at 11:10 AM, an interview was conducted with Nurse #8 who worked with Resident #2 on 3/6/17 and documented the blood glucose of 508 mg/dL at 11:30 AM. The nurse confirmed that the resident blood glucose was 508 and stated she received an order for Novolog 20 units one time from physician #1. She stated that she knew to place a progress note in the medical records for interventions related to high or low CBGs and new orders, but, she did not do it that day.</p> <p>MAR date 03/08/17 at 6:30 AM, CBG 570, Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p>	F 157	<p>interventions as needed to ensure continued compliance.</p>		

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F 157	Continued From page 4 Review of the Nursing Note dated 03/08/17 at 5:37 AM revealed CBG was 570. There was no documentation of sliding scale insulin given or if the physician was notified. The nurse that wrote the note was not available for interview because he was out of the country at the time of investigation. An interview on 05/12/17 at 1:15 PM with Director of Nursing (DON) and Administrator revealed that they did not know why the physician order of 03/06/17 with the SSI order and insulin changes did not get placed on the MAR. It was the expectation that every order was written on the physician's order sheet, signed off, placed in the computer and confirmed on the MAR. There was no indication that the physician was notified of the elevated CBG as ordered.	F 157			
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 224		6/27/17	

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F 224	<p>Continued From page 5</p> <p>(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and physician interview, the facility neglected a resident by not following physician orders for sliding scale insulin (SSI), by not monitoring and reassessing an insulin dependent brittle diabetic resident that had a critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and vomiting. The facility failed to initiate emergency medical services (EMS) for the resident when he became in distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility neglected residents by not providing wound care for two days for 2 of 3 residents who were supposed to have daily treatments as ordered by the physician (Resident #4 and Resident #5).</p> <p>Immediate jeopardy for Resident #2 began on 5/8/17 when Resident #2 blood glucose registered HI on the glucometer (blood glucose was more than 600 mg/dL.) and the resident was showing signs of lethargy, low blood pressure, vomiting, and unusual bowel incontinence. EMS was not immediately initiated and nursing did not continue to assess the resident. The immediate jeopardy was removed on 5/23/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of</p>	F 224	<p>Nurse #2 has received education on 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention, implementation, and physician notification. Nurse #2 is no longer an employee and will not receive education about initiating EMS.</p> <p>All residents with changes in condition have the potential to be affected by the alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have had an acute change in condition related to high blood sugar levels in the last 30 days and reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented according to the Physician's Orders and the care plan, including emergency medical services initiated immediately as directed by physician completed May 12, 2017.</p> <p>Beginning May 12, 2017 the Director of Nursing and Nurse Managers will review those residents who have exhibited acute</p>		

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F 224	<p>Continued From page 6</p> <p>compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The facility is also out of compliance at the D scope and severity for Resident #4 and Resident # 5.</p> <p>Findings included:</p> <p>1. Resident #2 was admitted to the facility on 02/27/17 with diagnoses including Type I Diabetes Mellitus (DM) with Chronic Kidney Disease.</p> <p>A review of the initial Minimum Data Set (MDS) dated 03/06/17 revealed that Resident #2 was cognitively intact and required supervision with the physical assistance of one person with activities of daily living (ADL), was independent with walking and dressing, was not steady but able to stabilize without staff assistance and utilized a wheelchair as a mobility device when needed. It also revealed that he was occasionally incontinent of bladder and was continent of bowel.</p> <p>A review of the care plan dated 05/03/17 revealed Resident #2 had Diabetes Mellitus with interventions to include: diabetes medication as ordered by doctor, observe/document for side effects and effectiveness, Fasting Serum Blood sugar as ordered by doctor, observe/ document/report prn (as needed) any sign/symptoms of hyperglycemia; increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul (deep and</p>	F 224	<p>changes in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered or care planned, and the attending physician was notified.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017 regarding the facility's existing policy for identification and assessment of changes in condition, Diabetic Management including monitoring of residents following intervention implementation, and physician notification. Education included clarification of existing policy: Beginning May 11, 2017 of the following:</p> <ul style="list-style-type: none"> - When a resident's blood sugar read HI on the glucometer, Residents will be re-assessed within 30 minutes to 1 hour following insulin administration and according to the physician's orders. -Physician's Orders for sliding scale insulin administration and blood sugar monitoring will include parameters for physician notification. - Identification of an obvious critical acute change in condition, and appropriate response and physician notification. - Ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. - EMS will be initiated by physician order and/or advanced directives. 		

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F 224	<p>Continued From page 7</p> <p>labored breathing associated with diabetes) breathing, acetone breath, stupor and coma.</p> <p>A review of the medical records revealed progress/nursing notes, CBG level order changes and insulin regimen changes: A physician order dated 02/28/17 at 6:32 AM read "NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: if (CBG) 150 - 210 = 1 (NovoLOG) unit; 211 - 270 = 2 units; 271 - 330 = 3 units; 331 - 390 = 4 units; 391 - 450 = 5 units; notify MD (physician) if CBG is greater than 450, subcutaneously before meals and at bedtime for DM."</p> <p>Review of Resident #2 handwritten physician order dated 03/06/17 revealed the following new order: New SSI (sliding scale insulin) for patient (resident) with meals 151-200=2 units, 201-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=9 units, 401-450=11 units, if greater than 450 call MD.</p> <p>Review of the Medication Administration Record (MAR) 03/06/17 through 03/31/17 revealed the new SSI order of 3/6/17 was not transcribed on the MAR. The transcribed Novolog SSI order was the following: Novolog solution 100unit/ml, inject as per sliding scale: if 150-210=1 unit, 211-270=2 units, 271-330=3 units, 331-390=4 units, 391-450=5 units. Notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM. Order date 02/27/2017.</p> <p>Review of the March 2017 MAR revealed the following CBG readings and SSI coverage administered to Resident #2:</p>	F 224	<p>Licensed nursing staff, and agency licensed nursing staff will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Certified Nursing Assistants beginning May 11, 2017 regarding reporting an observation of a resident's change of condition to the Nurse immediately. Nursing assistants will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted education with Licensed Nursing staff and nurses aides on Abuse and Neglect Prevention on May 22, 2017 including prompt response to resident's change of condition. Beginning May 22nd, Licensed Nursing staff, nurses' aides and Agency Licensed nursing staff will not be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect.</p> <p>Beginning May 22, 2017 Licensed nursing staff and Agency Licensed nursing staff will not be allowed to work until the training for Abuse and Neglect Prevention, including prompt response to resident's change of condition is completed. This education also includes ensuring staff awareness that failure to provide care and services, including when to initiate EMS,</p>		

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F 224	<p>Continued From page 8</p> <p>MAR date 03/06/17 at 6:30 AM, CBG 71. MAR date 03/06/17 at 11:30 AM, CBG 508. Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>On 05/18/17 at 11:10 AM, an interview was conducted with Nurse #8 who worked with Resident #2 on 3/6/17 and documented the blood glucose of 508 mg/dL at 11:30 AM. The nurse confirmed that the resident blood glucose was 508 and stated she received an order for Novolog 20 units one time from physician #1. She stated that she knew to place a progress note in the medical records for interventions related to high or low CBGs and new orders, but, she did not do it that day.</p> <p>MAR date 03/06/17 at 4:30 PM, CBG 271, 3 units given instead of 5 units as ordered on 03/06/17 MAR date 03/06/17 at 9:00 PM, CBG 220, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/07/17 at 6:30 AM, CBG 83. MAR date 03/07/17 at 11:30 AM, CBG 180, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/07/17 at 4:30 PM, CBG 206, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/07/17 at 9:00 PM, CBG 209, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/08/17 at 6:30 AM, CBG 570, Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>Review of the Nursing Note dated 03/08/17 at 5:37AM revealed CBG was 570. There was no documentation of sliding scale insulin given or if the physician was notified. The nurse that wrote the note was not available for interview because</p>	F 224	<p>can constitute resident neglect. 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>Resident #4 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>Resident #5 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>Facility audit will be completed of residents identified with physician orders for daily wound care to ensure that wound treatments were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager.</p> <p>Facility audit will be completed by a member of the nurse administration team of the treatment administration record for wound care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order.</p> <p>Facility audit will be completed of residents identified with physician orders for sliding scale insulin to ensure that any</p>		

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F 224	Continued From page 9 he was out of the country at the time of investigation. MAR date 03/09/17 at 11:30 AM, CBG 168, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/09/17 at 4:30 PM, CBG 414, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/09/17 at 9:00 PM, CBG 431, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/10/17 at 6:30AM, CBG 74. MAR date 03/10/17 at 11:30 AM, CBG 270, 2 units given instead of 5 units as ordered on 03/06/17 MAR date 03/10/17 at 4:30 PM, CBG 310, 3 units given instead of 7 units as ordered on 03/06/17 MAR date 03/10/17 at 9:00 PM, CBG 176, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/11/17 at 6:30 AM, CBG 123. MAR date 03/11/17 at 11:30 AM, CBG 440, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/11/17 at 4:30 PM, CBG 335, 4 units given instead of 7 units as ordered on 03/06/17 MAR date 03/11/17 at 9:00 PM, CBG 154, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/12/17 at 6:30 AM, CBG 143. MAR date 03/12/17 at 11:30 AM, CBG 68. MAR date 03/12/17 at 4:30 PM, CBG 225, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/12/17 at 9:00 PM, CBG 158, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/13/17 at 6:30 AM, CBG 436, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/13/17 at 11:30 AM, CBG 254, 2 units given instead of 5 units as ordered on 03/06/17. An interview on 05/12/17 at 1:15 PM with Director	F 224	readings above 600 (HI) have physician notification, reassessment and monitoring five times a week for one month and weekly times two months. Residents who require EMS transport for emergencies will be audited to ensure there was not a delay in initiating services five times a week for one month and weekly times two months. The facility licensed nurses will be provided re- education regarding following physician's orders regarding wound care treatment by the Staff Development Coordinator to be completed by 6/27/17 The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2017
NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		
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F 224	<p>Continued From page 10</p> <p>of Nursing (DON) and Administrator revealed that they did not know why the physician order of 03/06/17 with the SSI order and insulin changes did not get placed on the MAR. It was the expectation that every order was written on the physician's order sheet, signed off, placed in the computer and confirmed on the MAR.</p> <p>Review of the current physician orders of start date of 3/21/17 revealed the following: NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: If CBG 150 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 5 units; 301 - 350 = 7 units; 351 - 400 = 11 units, notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM.</p> <p>On 5/10/17 at 4:55 PM, Nurse #1 and Nurse #3 were interviewed. Nurse #1 was a unit manager/administrative nurse and Nurse #3 was a MDS nurse. Nurse #1 and Nurse #3 said on 5/8/17, three nurses called in sick on the first shift. The facility called Nurse #1 and Nurse #3 to come in and work on the 100 hall, where Resident #2 resided. They both came around 8 AM and worked from around 8 AM to 3 PM. Nurse #1 and Nurse #3 manned the carts on 100 Hall. Resident #2 was doing okay on their shift. He was a brittle diabetic.</p> <p>On 5/11/17 at 11:23 AM, an interview was conducted with NA #1 who worked on 5/8/17 from 7 AM to 3 PM. She worked on the 100 Hall and was responsible for Resident #2's care. The</p>	F 224			

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F 224	<p>Continued From page 11</p> <p>resident was his usual self except he slept in during the last two mornings. On the morning of 5/8/17, he shaved and showered and he said he felt like a "million bucks" after that. He usually wheeled himself in the wheelchair. He ate well that morning and he ate well for lunch.</p> <p>A review of the Nursing Note, written by Nurse #2, dated 5/8/17 at 9:25 PM, revealed at 4 PM on 5/8/17, Nurse #2 walked in Resident #2's room and noticed that the resident was not responding "properly." His skin was cool and clammy. His blood glucose was checked using a glucometer (a machine used to measure how much glucose (a type of sugar) is in the blood). The glucometer registered "HI" (the glucometer registered "HI" when blood glucose was more than 600 mg/dL.) Vital signs were checked and blood pressure was low. Nurse #2 called Physician #1 and she gave an order to give 17 units of Novolog and 4 mg of Zofran every 8 hours for nausea. At 7 PM, Nurse #2 checked the resident's blood glucose again and the glucometer registered "HI." Nurse #2 called Physician #2 and she received a verbal order to give 14 units of Novolog and if the resident's status did not get better then to send to the hospital. Resident's condition did not improve. He was incontinent of bowel and bladder and remained lethargic. The resident's family was notified of the resident's status and agreed to send him to the hospital. 911 was called. The resident complained of an ache in his abdomen. Resident was sent to the hospital. Vital signs were as follows: temperature 98.3 Fahrenheit, blood pressure was 98/46, heart beat 82/minute, respiration 20, O2 saturation 92%.</p> <p>Review of the Emergency Medical Service (EMS) report revealed EMS was called at 8:25 PM on</p>	F 224			

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F 224	<p>Continued From page 12</p> <p>5/8/17. The EMS personnel checked the resident blood glucose and it registered "HI" on their glucometer. The resident was not alert to surrounding but was alert to verbal stimuli to person, time, and event. It was also noticed the resident's pupils were pin point and not reactive to light. Multiple attempts were made without success to administer intravenous (IV) fluids.</p> <p>A telephone interview was conducted with Nurse #2 on 5/11/17 at 11:19 AM. Nurse #2 said she usually worked from 7 PM to 7 AM. But on 5/8/17, the facility called her and asked her to work from 3 PM to 7 PM on the 100 Hall. It was busy. At around 4 PM, she went to Resident #2's room. The resident was in bed which was unusual for him. He was lethargic. His speech was slurred and he had vomitus dried up on his face and in the trash can. The nurse asked him what was wrong, he told her he was not feeling well. She checked his vital signs. His blood pressure was low and his blood sugar registered high on the glucometer so she called physician #1 and notified him of the resident's condition, including the "HI" blood glucose, lethargy, nausea, slurred speech, unusual incontinence, and unresponsiveness. The physician told her to give the resident 17 units of insulin and Zofran for nausea. The resident was able to swallow the Zofran pill and she gave him the insulin injection. The nurse said she did not go back to check on the resident until 15 minutes till 7 PM. Nurse #2 checked the blood glucose and it still registered HI. She called physician #2 (On call) and the physician ordered 14 more units of sliding scale insulin and to recheck blood glucose in 30 minutes and send him to the hospital if not improved. When she came back to check on him, he had a bowel movement on himself which</p>	F 224			

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F 224	<p>Continued From page 13</p> <p>was unusual for him. She sent the aide to clean him up. Nurse #2 said usually she was able to complete her tasks if nothing came up out of the ordinary. She said she did not have enough time to take care of the resident. When asked what prevented her from checking on the resident after she gave him insulin around 4 PM, she said she was trying to get a change of shift report, stock the medication cart, check on tube feeding, talk about taking over medication cart of the other hall, had to get Zofran and needed to document in residents' medical record. She had been employed at the facility for only three months and she did not know how to put in a physician order for Zofran. So she needed help with that. She said there was no extra administrative staff to help when something unexpected came up.</p> <p>An interview with NA #4 on 5/12/17 at 12:35 PM revealed she usually worked from 3 PM -11 PM. She stated, on average, she had 12-14 residents which was a manageable load. On 5/8/17, it was different with a lot of things going on. There were a lot of staff assignment changes. New staff started that day and they were confused about where they worked. There were one new nurse and the other nurse was not familiar with the residents on the hall. NA #4 stated she did not work with the resident. She just took him his tray. He was in bed and he told her he did not feel like eating and he would not eat. It was around 6 or 6:30 PM. She reported to the nurse that he would not eat. The nurse said okay.</p> <p>On 5/11/17 at 5:15 PM, Physician #1 was interviewed. The physician stated the resident had a history of being found unconscious because of high blood glucose. He was a brittle diabetic (the person experiences frequent,</p>	F 224			

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F 224	<p>Continued From page 14</p> <p>extreme swings in blood glucose levels). The resident wanted to go home. The physician was shown the 5/8/17 Nursing Note written by Nurse #2 regarding the resident's change in condition. The physician stated she did not remember being called on 5/8/17 about this resident and she did not remember giving the order for 17 units of insulin. The physician said "I was never called." She said if they called her and told her the resident had vomiting, slurred speech, lethargic and blood glucose registering "HI", she would have sent the resident right away to the hospital because the nursing home could not manage the resident in that condition. The physician repeated this statement more than one time. The physician said "no way I would have kept the patient without intravenous fluids." The physician said she reviewed the resident's hospital record and his blood glucose was 1123 mg/dL at the hospital and he died of myocardial infarction.</p> <p>Review of the hospital emergency room department (ED) dated 5/8/17 revealed laboratory test results from the resident's urine sample collected on 5/8/17 at 10:44 PM were as follows: Resident's urine glucose was more than 1000 mg/dL (reference range was negative). The urine ketones was 15 mg/dL (reference range was negative).</p> <p>The ED laboratory test results of blood collected on 5/8/17 at 11:43 PM were as follows:</p> <p>Blood glucose was 1123 mg/dL, The resident died on 5/8/17 at 12:55 AM.</p> <p>The administrator was notified of the immediate jeopardy on 5/22/17 at 12:18 PM. The administrator provided the following credible</p>	F 224			

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F 224	<p>Continued From page 15</p> <p>allegation of compliance effective 5/23/17 at 2:47 PM.</p> <p>Residents identified to be affected by the alleged deficient practice.</p> <p>At 4:00 PM on 5/8/17 Nurse #2 went into Resident #2 room and noticed that he was not responding as usual. His skin was cool and clammy. His Blood glucose was checked and read "HI" with no value on the monitor. The manufacturer insert for this glucometer stated that a reading of "HI" indicated a blood glucose value of greater than 600 mg/dL. The Physician was notified and orders were received to administer 17 units of Novolog one time and Zofran 4 mg every 6 hours for nausea.</p> <p>At approximately 4:30 PM NA#3 entered room to check on Resident #2 who was resting in bed with no new changes.</p> <p>At approximately 6-6:30 PM, NA #4 delivered Resident #2 his dinner tray. Resident #2 reported he was not feeling good and didn't want to eat. NA#4 stated this was then reported to Nurse #2. Resident #2 remained in the bed and the tray was set up.</p> <p>At 7:00 PM, Nurse #2 rechecked the resident blood sugar and it again read "HI". Nurse #2 notified the Physician and received orders to administer 14 units of Novolog and instructions to transport to the hospital if not improved. Resident status did not improve. Resident was incontinent of bowel and bladder and remained lethargic. Resident complained of an ache in his abdomen. Family was notified of resident status, 911 was called at 8:25 PM, and resident arrived at the hospital at 9:26 PM.</p> <p>The nurse reported she was too busy to check on the resident more frequently to reassess following</p>	F 224			

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F 224	<p>Continued From page 16</p> <p>insulin administration for a "HI" blood sugar reading with nausea and a low blood pressure and that she did not communicate with a manager that she was not able to recheck on the resident.</p> <p>Nurse #2 has received education on 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention implementation, and physician notification. Nurse #2 is no longer an employee and will not receive education about initiating EMS.</p> <p>Residents with the potential to be affected by the alleged deficient practice.</p> <p>All residents with changes in condition have the potential to be affected by the alleged deficient practice. On 5/12/17, the Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days and reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented according to the Physician's Orders and the care plan, including emergency medical services initiated immediately as directed by physician completed May 12, 2017.</p> <p>Systemic Measures</p> <p>Beginning May 12, 2017 the Director of Nursing</p>	F 224			

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F 224	<p>Continued From page 17</p> <p>and Nurse Managers will review those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered or care planned, and the attending physician was notified.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017 regarding the facility's existing policy for identification and assessment of changes in condition, Diabetic Management including monitoring of residents following intervention implementation, and physician notification.</p> <p>Education included clarification of existing policy: Beginning May 11, 2017 of the following:</p> <ul style="list-style-type: none"> - When a resident's blood sugar read HI on the glucometer, Residents will be re-assessed within 30 minutes to 1 hour following insulin administration and according to the physician's orders. -Physician's Orders for sliding scale insulin administration and blood sugar monitoring will include parameters for physician notification. - Identification of an obvious critical acute change in condition, and appropriate response and physician notification. - Ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. - EMS will be imitated by physician order and/or advanced directives. <p>Licensed nursing staff, and agency licensed nursing staff will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development</p>	F 224			

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F 224	<p>Continued From page 18</p> <p>Coordinator and Nurse Managers have conducted training with Certified Nursing Assistants beginning May 11, 2017 regarding reporting an observation of a resident's change of condition to the Nurse immediately. Nursing assistants will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted education with Licensed Nursing staff and nurses aides on Abuse and Neglect Prevention on May 22, 2017 including prompt response to resident's change of condition. Beginning May 22nd, Licensed Nursing staff, nurses' aides and Agency Licensed nursing staff will not be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect.</p> <p>Beginning May 22, 2017 Licensed nursing staff and Agency Licensed nursing staff will not be allowed to work until the training for Abuse and Neglect Prevention, including prompt response to resident's change of condition is completed. This education also includes ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. 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>	F 224			

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F 224	<p>Continued From page 19</p> <p>Date of Immediate Jeopardy Removal: May 23, 2017.</p> <p>On 5/24/17 at 1:27 PM, the credible allegation of compliance was validated to ensure the facility implemented their corrective actions to remove the immediate jeopardy. The facility provided evidence of an audit, on 5/12/17, of current insulin dependent diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days. The facility reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented. Record reviews of diabetic residents were reviewed to ensure that they received care to manage diabetes as ordered by the physician. The facility provided evidence of inservice training to nursing staff on how to manage diabetic residents. This was validated by interviews with nurses and nursing assistants.</p> <p>On 5/24/17 at 1:27 PM, 4 nurses and 4 nursing assistants were interviewed regarding their knowledge of neglect and change of condition. One of the nurses was an agency nurse. Nurses and nursing assistants confirmed that they received inservices regarding neglect and change in condition in the last few two days and they were all able to identify what constituted neglect and what to do when a resident has a change in condition.</p> <p>2. Record review showed that resident #4 re-entered the facility on 01/3/17. Current diagnoses included Cerebral Infarction, Dementia, Mood Disorder, Cerebral Vascular Accident, Hyperlipidemia, Alcohol Abuse with Alcohol Induced Mood Disorder, Hypertension,</p>	F 224			

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F 224	<p>Continued From page 20</p> <p>Major Depression, Peripheral Vascular Disease, Cardiac Arrest, Resistance to Vancomycin, Vitamin B12 Deficiency Anemia, Urinary Tract Infection, Wound Botulism, Pressure Ulcer (Hip), Dysphagia and Epilepsy.</p> <p>Review of the most recent care plan on 05/10/17 documented that the resident had a pressure area to her right hip and her right heel. Interventions included to apply dressings per orders, complete labs as ordered, monitor intake, assist to turn and reposition on rounds and prn, provide supplements as ordered, and see the wound care doctor as scheduled. The most recent MDS dated 4/10/17 indicated the resident had (2) facility acquired Stage 4 pressure ulcers, pressure reducing devices for her chair and bed, and nutrition and hydration intervention to manage skin problems. Cognition was intact.</p> <p>The most recent physician orders on 05/10/17 related to skin integrity included:</p> <ol style="list-style-type: none"> 1. Apply to right hip Dakins Solution 0.25% wet to moist dressing twice daily 2. Apply Santyl Ointment to right heel topically every day shift 3. Multivitamin one tab daily 4. House Shakes 4 ounces at lunch and dinner 5. Pro Stat Liquid 30ml twice daily 6. House 2.0 Med Pass 120cc three times daily 7. Geri-Sleeves to both arms <p>Review of the most recent wound care specialist progress notes dated 05/05/17 documented that there was no change in wound healing progress for either wound on that date. Further review revealed that both wounds are smaller in size and have improved.</p>	F 224			

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F 224	<p>Continued From page 21</p> <p>Wound care for resident #4 was observed on 05/10/17 at 2:40 PM. Care was provided by Nurse #6. Proper hand washing and glove donning was observed. Clean technique was used. It was observed that the old dressing removed from the Stage 4 right hip pressure ulcer was dated 05/07/17. The dressing was malodorous with a large amount of brown exudate present. The skin surrounding the wound was reddened. The wound was packed with gauze soaked in Dakins Solution 0.25% and covered with a dry dressing as ordered by the physician. Nurse #6 then removed the old dressing from the resident's Stage 4 pressure ulcer on her right heel. The old dressing was dated 05/07/17. It was malodorous with a large amount of brown exudate. The skin surrounding the wound was white. Santyl ointment was applied to the wound and a dry dressing was applied. The used dressings were disposed of properly.</p> <p>In an interview with Nurse #6 on 05/10/17 at 2:50 PM she revealed that she had called out on 05/08/17 and 05/09/17. She stated that the nurses working the hall were responsible for doing the dressing changes in her absence. She agreed that the dressings had not been changed and the wounds were not treated on 05/08/17 and 05/09/17. Nurse #1 was also present and agreed that the dressings were not changed and the wounds were not treated on 05/08/17 and 05/09/17.</p> <p>In an interview with Nurse #7 on 05/11/17 at 2:30 PM she stated that she had care for resident #4 on 05/09/17 during the day shift. She said that the day had been very busy. She stated that her first priority was to keep the residents safe and</p>	F 224			

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F 224	<p>Continued From page 22</p> <p>give out the medicines. She revealed that she had looked at the dressings on wounds to make sure everything was intact but did not have time to do the treatments on her assignment. She revealed that it was her intention to do the treatments but that there was too much going on during the day shift to get everything done.</p> <p>3. Record review shows that resident #5 re-entered the facility on 05/14/16. Current diagnoses included Type 2 Diabetes Mellitus with Hyperglycemia, Anxiety Disorder, Mood Disorder, Major Depressive Disorder, Essential Hypertension, Hyperlipidemia, Chronic Pain Syndrome, Venous Insufficiency Chronic Peripheral, Muscle Spasms and Personal History of Diabetic Foot Ulcer.</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment dated 03/06/17 documented that the resident had venous, arterial, and diabetic foot ulcers. Cognition was documented as intact. He was extensive assist for bed mobility, personal hygiene and toilet use. He was totally dependent for dressing and bathing. The assessment indicated that he did not walk. Care plan interventions on 05/10/17 included to apply dressings per orders, complete labs as ordered, monitor intake, assist to turn and reposition on rounds and prn, provide supplements as ordered, and see the wound care doctor as scheduled.</p> <p>The physician orders on 05/10/17 related to skin integrity included:</p> <ol style="list-style-type: none"> 1. Decubi-Vite Capsule (2) daily 2. Ensure air mattress is functioning properly with setting locked at 5 every shift 3. Pro Stat sugar free liquid 30cc twice daily 	F 224			

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F 224	<p>Continued From page 23</p> <p>4. Cleanse top of left foot with Normal Saline, dry, apply Silver Sulfa Cream 1%, apply 4 x 4, wrap with Kerlix daily</p> <p>5. Apply Santyl Ointment 250 unit/gm to outer LLE topically every day</p> <p>6. Apply Mupirocin Ointment 2% to left great toe topically every day shift for skin alteration</p> <p>7. Apply Hydrocolloid to left heel Stage 2 venous wound every 3 days</p> <p>Review of the most recent wound care specialist progress notes dated 04/28/17 documented that there was no change in the wound healing progress for the (2) arterial and (1) venous wounds on that date. Further review revealed that the measurements for all wounds have remained the same since 3/31/17.</p> <p>An observation on 05/10/17 at 4:45 PM revealed that the dressing on the left foot and left lower extremity of Resident #5 were dated 05/07/17. The surveyor was unable to observe wound care because the resident refused treatment until he was medicated for pain and it became effective.</p> <p>In an interview with Nurse #6 on 05/10/17 at 4:50 PM she revealed that she had called out on 05/08/17 and 05/09/17. She stated that the nurses working the hall were responsible for doing the dressing changes in her absence. She agreed that the dressings had not been changed and the wounds were not treated on 05/08/17 and 05/09/17.</p> <p>In an interview with Nurse #1 and Nurse #3 on 05/10/17 at 5:15 PM they stated that they had worked together on the 100 Hall on 05/08/17 day shift. They both stated that they did not have time to do the treatments and had passed the duty on</p>	F 224			

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F 224	Continued From page 24 to the second shift nurse. In an interview with Nurse #2 on 05/11/17 at 11:20 AM she revealed that she had cared for resident #5 on 05/08/17 from 3:00 PM to 11:00 PM. She stated that she did not get report when coming on shift. She said she did not do the treatments on her shift because she had too much to do. She said for part of the shift she was caring for forty-two residents until 11:00 PM when she was relieved by an Agency Nurse. In an interview with the Director of Nursing on 05/12/17 at 5:00 PM she stated that she expected the treatments to be done as ordered by the physician.	F 224			
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to implement the care plan for a sliding scale insulin (SSI) order. This was evident in 1 of 3 diabetic residents (Resident #2). The facility failed to follow the care plans to provide wound care for two days for 2 of 3 residents who were supposed to have daily treatments as ordered by the physician (Resident #4 and Resident #5).	F 282	Resident #2 no longer resides in the facility. Resident #4 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments. Resident #5 attending physician and responsible party were notified on 5/10/17	6/27/17	

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F 282	<p>Continued From page 25</p> <p>Findings included:</p> <p>1. Resident #2 was admitted to the facility on 02/27/17 with diagnoses including Type I Diabetes Mellitus (DM) with Chronic Kidney Disease.</p> <p>A review of the initial Minimum Data Set (MDS) dated 03/06/17 revealed that Resident #2 was cognitively intact.</p> <p>A review of the Care Plan dated 05/03/17 revealed Resident #2 had Diabetes Mellitus with interventions to include: observe/document the resident/family's current level of understanding about the disease process, diabetes medication as ordered by doctor, observe/document for side effects and effectiveness, Fasting Serum Blood sugar as ordered by doctor, observe/document/report prn (as needed) any sign/symptoms of hyperglycemia; increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul (deep and labored breathing associated with diabetes) breathing, acetone breath, stupor and coma.</p> <p>A review of the medical records revealed the following:</p> <p>A physician order dated 02/28/17 at 6:32 AM read "NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: if (CBG) 150 - 210 = 1 (NovoLOG) unit; 211 - 270 = 2 units; 271 - 330 = 3 units; 331 - 390 = 4 units; 391 - 450 = 5 units; notify MD (physician) if CBG is greater than 450, subcutaneously before meals and at bedtime for DM."</p>	F 282	<p>of two questionable missed treatments.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents receiving sliding scales by 6/27/17 to validate correct sliding scale usage.</p> <p>Facility audit will be completed of residents identified with physician orders for daily wound care to ensure that wound treatments were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review new insulin sliding scale physician orders from previous day to ensure that order transcribed correctly for five times a week for one month and weekly times two months.</p> <p>Facility audit will be completed by a member of the nurse administration team of the treatment administration record for wound care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order.</p> <p>The facility licensed nurses will be provided re- education regarding process</p>		

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F 282	<p>Continued From page 26</p> <p>Review of Resident #2 handwritten physician order dated 03/06/17 revealed the following new order: New SSI (sliding scale insulin) for patient (resident) with meals 151-200=2 units, 201-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=9 units, 401-450=11 units, if greater than 450 call MD.</p> <p>Review of the Medication Administration Record (MAR) 03/06/17 through 03/31/17 revealed the new SSI order of 3/6/17 was not transcribed on the MAR. The transcribed Novolog SSI order was the following: Novolog solution 100unit/ml, inject as per sliding scale: if 150-210=1 unit, 211-270=2 units, 271-330=3 units, 331-390=4 units, 391-450=5 units. Notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM. Order date 02/27/17.</p> <p>Review of the March 2017 MAR revealed the following CBG readings and SSI coverage administered to Resident #2:</p> <p>MAR date 03/06/17 at 11:30 AM, CBG 508. Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>On 05/18/17 at 11:10 AM, an interview was conducted with Nurse #8 who worked with Resident #2 on 3/6/17 and documented the blood glucose of 508 mg/dL at 11:30 AM. The nurse confirmed that the resident blood glucose was 508 and stated she received an order for Novolog 20 units one time from physician #1. She stated that she knew to place a progress note in the</p>	F 282	<p>for transcribing physician orders, following physician wound care orders by the Staff Development Coordinator by 6/27/17</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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F 282	<p>Continued From page 27</p> <p>medical records for interventions related to high or low CBGs and new orders, but, she did not do it that day.</p> <p>MAR date 03/06/17 at 4:30 PM, CBG 271, 3 units given instead of 5 units as ordered on 03/06/17 MAR date 03/06/17 at 9:00 PM, CBG 220, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/07/17 at 6:30 AM, CBG 83. MAR date 03/07/17 at 11:30 AM, CBG 180, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/07/17 at 4:30 PM, CBG 206, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/07/17 at 9:00 PM, CBG 209, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/08/17 at 6:30 AM, CBG 570, Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>Review of the Nursing Note dated 03/08/17 at 5:37 AM revealed CBG was 570. There was no documentation of sliding scale insulin given or if the physician was notified. The nurse that wrote the note was not available for interview because he was out of the country at the time of investigation.</p> <p>MAR date 03/09/17 at 11:30 AM, CBG 168, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/09/17 at 4:30 PM, CBG 414, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/09/17 at 9:00 PM, CBG 431, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/10/17 at 6:30 AM, CBG 74. MAR date 03/10/17 at 11:30 AM, CBG 270, 2 units given instead of 5 units as ordered on 03/06/17 MAR date 03/10/17 at 4:30 PM, CBG 310, 3 units</p>	F 282			

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F 282	<p>Continued From page 28</p> <p>given instead of 7 units as ordered on 03/06/17 MAR date 03/10/17 at 9:00 PM, CBG 176, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/11/17 at 6:30 AM, CBG 123. MAR date 03/11/17 at 11:30 AM, CBG 440, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/11/17 at 4:30 PM, CBG 335, 4 units given instead of 7 units as ordered on 03/06/17 MAR date 03/11/17 at 9:00 PM, CBG 154, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/12/17 at 6:30 AM, CBG 143. MAR date 03/12/17 at 11:30 AM, CBG 68. MAR date 03/12/17 at 4:30 PM, CBG 225, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/12/17 at 9:00 PM, CBG 158, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/13/17 at 6:30 AM, CBG 436, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/13/17 at 11:30 AM, CBG 254, 2 units given instead of 5 units as ordered on 03/06/17.</p> <p>An interview on 05/12/17 at 1:15 PM with Director of Nursing (DON) and Administrator revealed that they did not know why the physician order of 03/06/17 with the SSI order and insulin changes did not get placed on the MAR. It was the expectation that every order was written on the physician's order sheet, signed off, placed in the computer and confirmed on the MAR.</p> <p>2. Record review showed that resident #5 re-entered the facility on 05/14/16. Current diagnoses included Type 2 Diabetes Mellitus with Hyperglycemia, Venous Insufficiency, Chronic Peripheral, and Personal History of Diabetic Foot Ulcer.</p> <p>Review of the most recent Minimum Data Set</p>	F 282			

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F 282	<p>Continued From page 29</p> <p>(MDS) Assessment dated 03/06/17 documented that the resident had venous, arterial, and diabetic foot ulcers. Cognition was documented as intact. He needed extensive assistance for bed mobility, personal hygiene and toilet use. The assessment indicated that he did not walk.</p> <p>The care plan interventions on 05/10/17 included to apply dressings per orders, complete labs as ordered, monitor intake, assist to turn and reposition on rounds and as needed, provide supplements as ordered, and see the wound care doctor as scheduled.</p> <p>Physician orders on 05/10/17 related to skin integrity included:</p> <ol style="list-style-type: none"> 1. Cleanse top of left foot with Normal Saline, dry, apply Silver Sulfa Cream 1%, apply 4 x 4, wrap with Kerlix daily 2. Apply Santyl Ointment 250 unit/gm to outer LLE topically every day 3. Apply Mupirocin Ointment 2% to left great toe topically every day shift for skin alteration 4. Apply Hydrocolloid to left heel Stage 2 venous wound every 3 days <p>An observation on 05/10/17 at 4:45 PM revealed that the dressing on the left foot and left lower extremity of Resident #5 were dated 05/07/17. The surveyor was unable to observe wound care because the resident refused treatment until he was medicated for pain and it became effective.</p> <p>In an interview with Nurse #6 on 05/10/17 at 4:50 PM she revealed that she had called out on 05/08/17 and 05/09/17. She stated that the nurses working the hall were responsible for doing the dressing changes in her absence. She</p>	F 282			

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F 282	<p>Continued From page 30</p> <p>agreed that the dressings had not been changed and the wounds were not treated on 05/08/17 and 05/09/17.</p> <p>In an interview with Nurse #1 and Nurse #3 on 05/10/17 at 5:15 PM they stated that they had worked together on the 100 Hall on 05/08/17 day shift. They both stated that they did not have time to do the treatments and had passed the duty on to the second shift nurse.</p> <p>In an interview with Nurse #2 on 05/11/17 at 11:20 AM she revealed that she had cared for resident #5 on 05/08/17 from 3:00 PM to 11:00 PM. She stated that she did not get report when coming on shift. She said she did not do the treatments on her shift because she had too much to do. She said for part of the shift she was caring for forty-two residents until 11:00 PM when she was relieved by an Agency Nurse.</p> <p>In an interview with the Director of Nursing on 05/12/17 at 5:00 PM she stated that she expected the treatments to be done as ordered by the physician.</p> <p>3. Record review showed that resident #4 re-entered the facility on 01/3/17. Current diagnoses included Cerebral Vascular Accident, Peripheral Vascular Disease, Resistance to Vancomycin, Vitamin B12 Deficiency Anemia, Wound Botulism, Pressure Ulcer (Hip), and Dysphagia.</p> <p>Review of the care plan on 05/10/17 documented that the resident had a pressure area to her right hip and her right heel. Interventions included to apply dressings per orders, complete labs as ordered, monitor intake, assist to turn and</p>	F 282			

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F 282	<p>Continued From page 31</p> <p>reposition on rounds and prn (as needed), provide supplements as ordered, and see the wound care doctor as scheduled.</p> <p>The most recent Minimum Data Set (MDS) dated 4/10/17 indicated the resident had (2) facility acquired Stage 4 pressure ulcers, pressure reducing devices for her chair and bed, and nutrition and hydration intervention to manage skin problems. Cognition was intact.</p> <p>Physician orders on 05/10/17 related to skin integrity included:</p> <ol style="list-style-type: none"> 1. Apply to right hip Dakins Solution 0.25% wet to moist dressing twice daily 2. Apply Santyl Ointment to right heel topically every day shift <p>Wound care for resident #4 was observed on 05/10/17 at 2:40 PM. Care was provided by Nurse #6. It was observed that the old dressing removed from the Stage 4 right hip pressure ulcer was dated 05/07/17. The dressing was malodorous with a large amount of brown exudate present. The skin surrounding the wound was reddened. The wound was packed with gauze soaked in Dakins Solution 0.25% and covered with a dry dressing as ordered by the physician. Nurse #6 then removed the old dressing from the resident's Stage 4 pressure ulcer on her right heel. The old dressing was dated 05/07/17. It was malodorous with a large amount of brown exudate. The skin surrounding the wound was white. Santyl ointment was applied to the wound and a dry dressing was applied.</p> <p>In an interview with Nurse #6 on 05/10/17 at 2:50</p>	F 282			

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F 282	Continued From page 32 PM she revealed that she had called out on 05/08/17 and 05/09/17. She stated that the nurses working the hall were responsible for doing the dressing changes in her absence. She agreed that the dressings had not been changed and the wounds were not treated on 05/08/17 and 05/09/17. Nurse #1 was also present and agreed that the dressings were not changed and the wounds were not treated on 05/08/17 and 05/09/17. In an interview with Nurse #7 on 05/11/17 at 2:30 PM she stated that she had care for resident #4 on 05/09/17 during the day shift. She said that the day had been very busy. She stated that her first priority was to keep the residents safe and give out the medicines. She revealed that she had looked at the dressings on wounds to make sure everything was intact but did not have time to do the treatments on her assignment. She revealed that it was her intention to do the treatments but that there was too much going on during the day shift to get everything done. In an interview with the Director of Nursing on 05/12/17 at 5:00 PM she stated that she expected the treatments to be done as ordered by the physician.	F 282			
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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	F 309		6/27/17	

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F 309	<p>Continued From page 33</p> <p>well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, Nurse Practitioner (NP) interview and physician interview, the facility failed to follow physician orders for sliding scale insulin (SSI), monitor and reassess an insulin dependent brittle diabetic resident that had a critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and vomiting. The</p>	F 309	<p>Nurse #2 has received education 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention implementation, and physician notification. All residents with changes in condition have the potential to</p>		

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F 309	<p>Continued From page 34</p> <p>facility failed to initiate emergency medical services (EMS) for the resident when he became in distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility failed to provide wound care for two days for Resident #5 who was supposed to have daily treatments as ordered by the physician for 1 of 1 sampled residents with wounds.</p> <p>Immediate jeopardy for Resident #2 began on 5/8/17 when Resident #2 blood glucose registered HI on the glucometer (blood glucose was more than 600 mg/dL.) and the resident was showing signs of lethargy, low blood pressure, vomiting, and unusual bowel incontinence. EMS was not immediately initiated and nursing did not continue to assess the resident. The immediate jeopardy was removed on 5/12/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The facility is also out of compliance at the D scope and severity for Resident # 5.</p> <p>Findings included:</p> <p>1. Resident #2 was admitted to the facility on 02/27/17 with diagnoses including Type I Diabetes Mellitus (DM) with Chronic Kidney Disease, difficulty walking, pneumonia, dementia, generalized anxiety disorder, chronic obstructive respiratory disease and muscle weakness.</p> <p>A review of the initial Minimum Data Set (MDS)</p>	F 309	<p>be affected by the alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have had an acute change in condition related to high blood sugar levels in the last 30 days and reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented according to the Physician's Orders and the care plan, including emergency medical services initiated immediately as directed by physician completed May 12, 2017.</p> <p>Beginning May 12, 2017 the Director of Nursing and Nurse Managers will review those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered or care planned, and the attending physician was notified.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017 regarding the facility's existing policy for identification and assessment of changes in condition, Diabetic Management including monitoring of residents following intervention implementation, and physician notification. Education included clarification of existing policy: Beginning May 11, 2017 of the following: - When a resident's blood sugar read HI</p>		

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F 309	<p>Continued From page 35</p> <p>dated 03/06/17 revealed that Resident #2 was cognitively intact and required supervision with the physical assistance of one person with activities of daily living (ADL), was independent with walking and dressing, was not steady but able to stabilize without staff assistance and utilized a wheelchair as a mobility device when needed. It also revealed that he was occasionally incontinent of bladder and was continent of bowel.</p> <p>Review of the Medical Orders for Scope of Treatment (MOST) dated 3/18/17 revealed the resident/family wanted the resident to be DNR (not to attempt resuscitation), and comfort measure only (keep clean and dry, do not transfer to the hospital unless comfort needs cannot be met in current location).</p> <p>A review of the care plan dated 05/03/17 revealed Resident #2 had Diabetes Mellitus with interventions to include: observe/document the resident/family's current level of understanding about the disease process, diabetes medication as ordered by doctor, observe/document for side effects and effectiveness, Fasting Serum Blood sugar as ordered by doctor, observe/document/report prn (as needed) any sign/symptoms of hyperglycemia; increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul (deep and labored breathing associated with diabetes) breathing, acetone breath, stupor and coma.</p> <p>A review of the medical records revealed the following: A physician order dated 02/28/17 at 6:32 AM read "NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: if (CBG) 150 - 210 = 1 (NovoLOG)</p>	F 309	<p>on the glucometer, Residents will be re-assessed within 30 minutes to 1 hour following insulin administration and according to the physician's orders.</p> <p>-Physician's Orders for sliding scale insulin administration and blood sugar monitoring will include parameters for physician notification.</p> <ul style="list-style-type: none"> - Identification of an obvious critical acute change in condition, and appropriate response and physician notification. - Ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. - EMS will be initiated by physician order and/or advanced directives. <p>Licensed nursing staff, and agency licensed nursing staff will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Certified Nursing Assistants beginning May 11, 2017 regarding reporting an observation of a resident's change of condition to the Nurse immediately. Nursing assistants will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted education with Licensed Nursing staff and nurses aides on Abuse and Neglect Prevention on May 22, 2017 including prompt response to resident's change of condition. Beginning May 22nd, Licensed Nursing</p>		

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F 309	<p>Continued From page 36</p> <p>unit; 211 - 270 = 2 units; 271 - 330 = 3 units; 331 - 390 = 4 units; 391 - 450 = 5 units; notify MD (physician) if CBG is greater than 450, subcutaneously before meals and at bedtime for DM."</p> <p>A physician order dated 02/28/17 at 6:33 AM read "NovoLOGPen Fill Solution Cartridge 100 UNIT/ML, inject 4 units subcutaneously with meals for DM."</p> <p>A physician order dated 03/01/17 at 12:19 AM read "ToujeoSolo Star Solution Pen-injector 300 UNIT/ML, inject 12 unit subcutaneously two times a day for DM."</p> <p>A Nursing Note dated 03/02/17 at 2:48 PM read "CBG 407 at 1130 AM, insulin given per MD orders."</p> <p>A Nursing Note dated 03/06/17 at 7:37 AM revealed CBG was 71.</p> <p>A Nursing Note dated 03/06/17 at 8:16 AM revealed CBG was 74. The resident stated that was low for him.</p> <p>Review of Resident #2 handwritten physician order dated 03/06/17 revealed the following new order:</p> <ol style="list-style-type: none"> "Start Toujeo 24 units at bedtime on 03/07/16". "Do not give 03/07/16 AM dose of 12 units. New SSI (sliding scale insulin) for patient (resident) with meals 151-200=2 units, 201-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=9 units, 401-450=11 units, if greater than 450 call MD. <p>Review of the Medication Administration Record</p>	F 309	<p>staff, Certified Nursing Assistants and Agency Licensed nursing staff will not be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect.</p> <p>Beginning May 22, 2017 Licensed nursing staff and Agency Licensed nursing staff will not be allowed to work until the training for Abuse and Neglect Prevention, including prompt response to resident's change of condition is completed. This education also includes ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect.</p> <p>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>Resident #5 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents receiving</p>		

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F 309	<p>Continued From page 37</p> <p>(MAR) 03/06/17 through 03/31/17 revealed the new SSI order of 3/6/17 was not transcribed on the MAR. The transcribed Novolog SSI order was the following: Novolog solution 100unit/ml, inject as per sliding scale: if 150-210=1 unit, 211-270=2 units, 271-330=3 units, 331-390=4 units, 391-450=5 units. Notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM. Order date 02/27/17.</p> <p>Review of the March 2017 MAR revealed the following CBG readings and SSI coverage administered to Resident #2: MAR date 03/06/17 at 6:30 AM, CBG 71. MAR date 03/06/17 at 11:30 AM, CBG 508. Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>On 05/18/17 at 11:10 AM, an interview was conducted with Nurse #8 who worked with Resident #2 on 3/6/17 and documented the blood glucose of 508 mg/dL at 11:30 AM. The nurse confirmed that the resident blood glucose was 508 and stated she received an order for Novolog 20 units one time from physician #1. She stated that she knew to place a progress note in the medical records for interventions related to high or low CBGs and new orders, but, she did not do it that day.</p> <p>MAR date 03/06/17 at 4:30 PM, CBG 271, 3 units given instead of 5 units as ordered on 03/06/17 MAR date 03/06/17 at 9:00 PM, CBG 220, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/07/17 at 6:30 AM, CBG 83. MAR date 03/07/17 at 11:30 AM, CBG 180, 1 unit given instead of 2 units as ordered on 03/06/17</p>	F 309	<p>sliding scales per physician orders by 6/27/17 to validate correct sliding scale usage.</p> <p>Facility audit will be completed of residents identified with physician orders for daily wound care to ensure that wound treatments were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager.</p> <p>Facility audit will be completed of treatment administration record for wound care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order.</p> <p>Facility audit will be completed of residents identified with physician orders for sliding scale insulin to ensure that any readings above 600 (Hi) have physician notification, reassessment and monitoring five times a week for one month and weekly times two months.</p> <p>The facility licensed nurses will be provided re-education regarding following physician's orders regarding wound care treatment by the Staff Development Coordinator by 6/27/17</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be</p>		

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F 309	<p>Continued From page 38</p> <p>MAR date 03/07/17 at 4:30 PM, CBG 206, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/07/17 at 9:00 PM, CBG 209, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/08/17 at 6:30 AM, CBG 570, Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>Review of the Nursing Note dated 03/08/17 at 5:37 AM revealed CBG was 570. There was no documentation of sliding scale insulin given or if the physician was notified. The nurse that wrote the note was not available for interview because he was out of the country at the time of investigation.</p> <p>MAR date 03/09/17 at 11:30 AM, CBG 168, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/09/17 at 4:30 PM, CBG 414, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/09/17 at 9:00 PM, CBG 431, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/10/17 at 6:30 AM, CBG 74. MAR date 03/10/17 at 11:30 AM, CBG 270, 2 units given instead of 5 units as ordered on 03/06/17 MAR date 03/10/17 at 4:30 PM, CBG 310, 3 units given instead of 7 units as ordered on 03/06/17 MAR date 03/10/17 at 9:00 PM, CBG 176, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/11/17 at 6:30 AM, CBG 123. MAR date 03/11/17 at 11:30 AM, CBG 440, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/11/17 at 4:30 PM, CBG 335, 4 units given instead of 7 units as ordered on 03/06/17 MAR date 03/11/17 at 9:00 PM, CBG 154, 1 unit given instead of 2 units as ordered on 03/06/17</p>	F 309	<p>reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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F 309	<p>Continued From page 39</p> <p>MAR date 03/12/17 at 6:30 AM, CBG 143. MAR date 03/12/17 at 11:30 AM, CBG 68. MAR date 03/12/17 at 4:30 PM, CBG 225, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/12/17 at 9:00 PM, CBG 158, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/13/17 at 6:30 AM, CBG 436, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/13/17 at 11:30 AM, CBG 254, 2 units given instead of 5 units as ordered on 03/06/17.</p> <p>An interview on 05/12/17 at 1:15 PM with Director of Nursing (DON) and Administrator revealed that they did not know why the physician order of 03/06/17 with the SSI order and insulin changes did not get placed on the MAR. It was the expectation that every order was written on the physician's order sheet, signed off, placed in the computer and confirmed on the MAR.</p> <p>Review of the current physician orders of start date of 3/21/17 revealed the following: NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: If CBG 150 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 5 units; 301 - 350 = 7 units; 351 - 400 = 11 units, notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM.</p> <p>NovoLOG PenFill Solution Cartridge 100 UNIT/ML, inject 4 unit subcutaneously with meals for DM.</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>ToujeoSolo Star Solution Pen-injector 300 UNIT/ML, inject 10 unit subcutaneously once a day for DM</p> <p>Review of the resident's Medication Administration Record revealed the following range of CBG readings and number of days the resident received insulin per SSI order during the month of April 2017:</p> <p>6:30 AM: CBG ranged from 43 - 450 mg/dL. Sliding scale insulin was administered 11 times during the month.</p> <p>11:30 AM: CBG ranged from 71 - 564 mg/dL. Sliding scale insulin was administered 23 times during the month.</p> <p>4:30 PM: CBG ranged from 68 - 535 mg/dL. Sliding scale insulin was administered 18 times during the month.</p> <p>9:00 PM: CBG ranged from 67 - 450 mg/dL. Sliding scale insulin was administered 19 times during the month.</p> <p>Review of the Nursing Note on 4/28/17 revealed the CBG was 530 at 11:30 AM. Nursing staff administered 11 units of sliding scale insulin and the nurse practitioner (NP) was notified. No new orders were given.</p> <p>Review of the Nursing Note dated 4/29/17 revealed the resident CBG was 200 in the morning, 284 at noon and 397 in the evening. Medication was administered as ordered. No adverse reaction was noted.</p> <p>Review of the resident's Medication Administrator Record revealed the following range of CBG readings and number of days the resident received insulin during the period of May 1-8, 2017:</p>	F 309			

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F 309	<p>Continued From page 41</p> <p>6:30 AM: CBG ranged from 96 - 375 mg/dL. Sliding scale insulin was administered 5 times during the month.</p> <p>11:30 AM: CBG ranged from 64 - 400 mg/dL. Sliding scale insulin was administered 7 times during the month of May.</p> <p>4:30 PM: CBG ranged from 202 - 430 mg/dL. Sliding scale insulin was administered 7 times during the month.</p> <p>9:00 PM: CBG ranged from 114 - 320 mg/dL. Sliding scale insulin was administered 5 times during the month of May.</p> <p>Review of Nursing Note dated 5/1/17 revealed the resident's CBG was 56. The resident was unresponsive and diaphoretic. Glucagon was administered and CBG was rechecked in 15 minutes and it was 106. The resident ate lunch after the incident.</p> <p>Review of the progress notes dated 5/2/17 revealed the resident has increased participation in activities and he attended social events.</p> <p>Review of Nursing Note dated 5/2/17 revealed the resident's CBG was 354 at 6 AM. The resident was alert and responsive with confusion. Medication was given whole with water. There was no noted distress.</p> <p>On 5/10/17 at 4:55 PM, Nurse #1 and Nurse #3 were interviewed. Nurse #1 was a unit manager/administrative nurse and Nurse #3 was a MDS nurse. Nurse #1 and Nurse #3 said on 5/8/17, three nurses called in sick on the first shift. The facility called Nurse #1 and Nurse #3 to come in and work on the 100 hall, where Resident #2 resided. They both came around 8 AM and worked from around 8 AM to 3 PM.</p>	F 309			

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F 309	<p>Continued From page 42</p> <p>Nurse #1 and Nurse #3 manned the carts on 100 Hall. Resident #2 was doing okay on their shift. At 6:30 AM his blood glucose was 375. He was given 11 units of insulin as sliding scale and 4 scheduled units of insulin. At noon time his blood glucose was 288, and he was given 5 units of sliding scale insulin and 4 scheduled units of insulin with meals. He was a brittle diabetic.</p> <p>On 5/11/17 at 11:23 AM, an interview was conducted with NA #1 who worked on 5/8/17 from 7 AM to 3 PM. She worked on the 100 Hall and was responsible for Resident #2's care. The resident was his usual self except he slept in during the last two mornings. Resident was independent with toileting and was able to stand and take himself to the bathroom. On the morning of 5/8/17, he shaved and showered and he said he felt like a "million bucks" after that. He usually wheeled himself in the wheelchair. He ate well that morning and he ate well for lunch. He had a good appetite. The aide said typically there were 4 to 6 aides on the 100 hall which was about 10-12 residents. She would not say if there was any care that was not provided, however, she said it was very busy and it was too much.</p> <p>A review of the Nursing Note, written by Nurse #2, dated 5/8/17 at 9:25 PM, revealed at 4 PM on 5/8/17, Nurse #2 walked in Resident #2's room and noticed that the resident was not responding "properly". His skin was cool and clammy. His blood glucose was checked using a glucometer (a machine used to measure how much glucose (a type of sugar) is in the blood). The glucometer registered "HI" (the glucometer registered "HI" when blood glucose was more than 600 mg/dL.) Vital signs were checked and blood pressure was low. Nurse #2 called Physician #1 and she gave</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>an order to give 17 units of Novolog and 4 mg of Zofran every 8 hours for nausea. At 7 PM, Nurse #2 checked the resident's blood glucose again and the glucometer registered "HI." Nurse #2 called Physician #2 and she received a verbal order to give 14 units of Novolog and if the resident's status did not get better then to send to the hospital. Resident's condition did not improve. He was incontinent of bowel and bladder and remained lethargic. The resident's family was notified of the resident's status and agreed to send him to the hospital. 911 was called. The resident complained of an ache in his abdomen. Resident was sent to the hospital. Vital signs were as follows: temperature 98.3 Fahrenheit, blood pressure was 98/46, heart beat 82/minute, respiration 20, O2 saturation 92%.</p> <p>Review of the Emergency Medical Service (EMS) report revealed EMS was called at 8:25 PM on 5/8/17. The EMS personnel checked the resident blood glucose and it registered "HI" on their glucometer. The resident was not alert to surrounding but was alert to verbal stimuli to person, time, and event. The EMS report revealed that throughout the day, and despite insulin coverage, the resident was not acting his norm, which was alert, sitting up and talking without being lethargic. The report revealed the resident was hypotensive. It was also noticed the resident's pupils were pin point and not reactive to light. Multiple attempts were made without success to administer intravenous (IV) fluids.</p> <p>A telephone interview was conducted with Nurse #2 on 5/11/17 at 11:19 AM. Nurse #2 said she usually worked from 7 PM to 7 AM. But on 5/8/17, the facility called her and asked her to work from 3 PM to 7 PM on the 100 Hall. When</p>	F 309			

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F 309	Continued From page 44 she came at 3 PM, tube feeding bags were empty, tube feeding pumps were going off, she needed to flush feeding tubes, and that put her behind. One resident had his feeding tube pulled out so she had to put it back in. It was busy. At around 4 PM, she went to Resident #2's room. The resident was in bed which was unusual for him. He was lethargic. His speech was slurred and he had vomitus dried up on his face and in the trash can. The nurse asked him what was wrong, he told her he was not feeling well. She checked his vital signs. His blood pressure was low and his blood sugar registered high on the glucometer so she called physician #1 and notified him of the resident's condition, including the "HI" blood glucose, lethargy, nausea, slurred speech, unusual incontinence, and unresponsiveness. The physician told her to give the resident 17 units of insulin and Zofran for nausea. The resident was able to swallow the Zofran pill and she gave him the insulin injection. The nurse said she did not go back to check on the resident until 15 minutes till 7 PM. At that time, the incoming nurse and Nurse #2 counted the medications. Nurse #2 asked the incoming nurse to look at the resident with her. The resident condition did not improve and the incoming nurse verified that he was not right. Nurse #2 checked the blood glucose and it still registered HI. She called physician #2 (On call) and the physician ordered 14 more units of sliding scale insulin and to recheck blood glucose in 30 minutes and send him to the hospital if not improved. When she came back to check on him, he had a bowel movement on himself which was unusual for him. She sent the aide to clean him up. Nurse #2 said usually she was able to complete her tasks if nothing came up out of the ordinary. She said that day on 5/8/17, one of the	F 309			

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F 309	<p>Continued From page 45</p> <p>nurses that was working from 3 PM to 6 PM wanted her to take over the carts for two hall. That took some time discussing and going back and forth. That also put her behind. The other nurse ended up not leaving until 15 minutes till 7 PM. She said with all of this going on, she did not have enough time to take care of the resident. When asked what prevented her from checking on the resident after she gave him insulin around 4 PM, she said she was trying to get a change of shift report, stock the medication cart, check on tube feeding, talk about taking over medication cart of the other hall, had to get Zofran and needed to document in residents' medical record. She had been employed at the facility for only three months and she did not know how to put in a physician order for Zofran. So she needed help with that. She said there was no extra administrative staff to help when something unexpected came up.</p> <p>A telephone interview was conducted on 5/11/17 at 3:01 PM with NA #3 who took care of the resident from 3 PM to 7 PM on 5/8/17. The resident was usually independent and mobile. He was cognitively alert and did not need a lot of assistance. He can use the call bell if he needed help or he would ambulate or wheel himself and let the staff know of his needs. On 5/8/17, the aide stated that her assignment changed 2 times due to staffing. She had to wait for a while for the facility staff to figure out staffing. The aide said she did rounds at about 3:30 PM to 4 PM and saw the resident. She did not see any vomiting on the resident. He was asleep, which was normal for him. She did not go back any more because she was busy taking care of other residents. She did not deliver his meal tray since she was feeding other residents in the dining</p>	F 309			

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F 309	<p>Continued From page 46 room.</p> <p>On 5/11/17 at 8:54 AM, a telephone interview was conducted with NA #2 who provided care to the resident on 5/8/17 from 7 PM to 7 AM. She said usually she worked from 11 PM through 7 AM. But she was called that day on 5/8/17 to come early. She said that usually she did not have a permanent assignment but she was assigned wherever was needed. On 5/8/17, she went to the resident room shortly after she started her shift, she saw the resident mumbling. She asked him how he was feeling, he told her he was not feeling well. She said he usually fed himself but the meal tray was not touched. When she asked him if he was going to eat his dinner, he told her he did not feel well and he did not want to eat but he wanted unsweetened tea. The aide said she went and told the nurse, then she came back and cleaned the resident from a bowel movement. The nurse called EMS and the resident was sent to the hospital. The resident usually was up in his wheelchair and moving around. But when she came to the facility he was in bed which was unusual for him.</p> <p>An interview with NA #4 on 5/12/17 at 12:35 PM revealed she usually worked from 3 PM -11 PM. She stated, on average, she had 12-14 residents which was a manageable load. On 5/8/17, it was different with a lot of things going on. There were a lot of staff assignment changes. New staff started that day and they were confused about where they worked. There were one new nurse and the other nurse was not familiar with the residents on the hall. NA #4 stated she did not work with the resident. She just took him his tray. He was in bed and he told her he did not feel like eating and he would not eat. It was around 6 or</p>	F 309			

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F 309	<p>Continued From page 47</p> <p>6:30 PM. She reported to the nurse that he would not eat. The nurse said okay.</p> <p>On 5/11/17 at 5:15 PM, Physician #1 was interviewed. The physician stated the resident had a history of being found unconscious because of high blood glucose. He was a brittle diabetic (the person experiences frequent, extreme swings in blood glucose levels). The resident wanted to go home. The physician was shown the 5/8/17 Nursing Note written by Nurse #2 regarding the resident's change in condition. The physician stated she did not remember being called on 5/8/17 about this resident and she did not remember giving the order for 17 units of insulin. The physician said "I was never called." She said if they called her and told her the resident had vomiting, slurred speech, lethargic and blood glucose registering "HI", she would have sent the resident right away to the hospital because the nursing home could not manage the resident in that condition. The physician repeated this statement more than one time. The physician said "no way I would have kept the patient without intravenous fluids." The physician said she reviewed the resident's hospital record and his blood glucose was 1123 mg/dL at the hospital and he died of myocardial infarction. An interview was conducted on 05/12/17 at 10:44 AM with the nurse practitioner (NP), she stated orders were written on the physician order sheet and they should be followed by the facility.</p> <p>Review of the hospital emergency room department (ED) dated 5/8/17 revealed laboratory test results from the resident's urine sample collected on 5/8/17 at 10:44 PM were as follows: Resident's urine glucose was more than 1000 mg/dL (reference range was negative).</p>	F 309			

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F 309	<p>Continued From page 48</p> <p>The urine ketones was 15 mg/dL (reference range was negative).</p> <p>The ED laboratory test results of blood collected on 5/8/17 at 11:43 PM were as follows:</p> <p>Blood glucose was 1123 mg/dL, The ED note revealed on 5/9/17 at 12:50 AM, the resident's heart rate was at 27 beats per minute and blood pressure was 48/38. The resident was having agonal (abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, accompanied by strange vocalizations) breathing 4-5 times a minute. The resident was lying still with pale skin color. The resident died on 5/8/17 at 12:55 AM. The administrator was notified of the immediate jeopardy on 5/11/17 at 5:00 PM. The administrator provided the following credible allegation of compliance effective 5/12/17 at 6:30 PM.</p> <p>Residents identified to be affected by the alleged deficient practice.</p> <p>At 4:00 PM on 5/8/17 Nurse #2 went into Resident #2 room and noticed that he was not responding as usual. His skin was cool and clammy. His Blood glucose was checked and read "HI" with no value on the monitor. The manufacturer insert for this glucometer stated that a reading of "HI" indicated a blood glucose value of greater than 600 mg/dL. The Physician was notified and orders were received to administer 17 units of Novolog one time and Zofran 4 mg every 6 hours for nausea. At approximately 4:30 PM NA#3 entered room to check on Resident #2 who was resting in bed with no new changes.</p>	F 309			

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F 309	<p>Continued From page 49</p> <p>At approximately 6-6:30 PM, NA #4 delivered Resident #2 his dinner tray. Resident #2 reported he was not feeling good and didn't want to eat. NA#4 stated this was then reported to Nurse #2. Resident #2 remained in the bed and the tray was set up.</p> <p>At 7:00 PM, Nurse #2 rechecked the resident blood sugar and it again read "HI". Nurse #2 notified the Physician and received orders to administer 14 units of Novolog and instructions to transport to the hospital if not improved. Resident status did not improve. Resident was incontinent of bowel and bladder and remained lethargic. Resident complained of an ache in his abdomen. Family was notified of resident status, 911 was called at 8:25 PM, and resident arrived at the hospital at 9:26 PM.</p> <p>The nurse reported she was too busy to check on the resident more frequently to reassess following insulin administration for a "HI" blood sugar reading with nausea and a low blood pressure and that she did not communicate with a manager that she was not able to recheck on the resident.</p> <p>Nurse #2 has received education on 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention implementation, and physician notification.</p> <p>Residents with the potential to be affected by the alleged deficient practice.</p> <p>All residents with changes in condition have the potential to be affected by the alleged deficient</p>	F 309			

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F 309	<p>Continued From page 50</p> <p>practice. On 5/12/17, the Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days and reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented according to the Physician's Orders and the care plan.</p> <p>Systemic Measures</p> <p>On 5/12/17, the Director of Nursing and Nurse Managers will review those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered or care planned, and the attending physician was notified.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017 regarding the facility's existing policy for identification and assessment of changes in condition, Diabetic Management including monitoring of residents following intervention implementation, and physician notification.</p> <p>Education included clarification of existing policy:</p> <ul style="list-style-type: none"> - When a resident's blood sugar read HI on the glucometer, Residents will be re-assessed within 30 minutes to 1 hour following insulin administration and according to the physician's orders. -Physician's Orders for sliding scale insulin administration and blood glucose monitoring will include parameters for physician notification. <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have</p>	F 309			

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F 309	<p>Continued From page 51</p> <p>conducted training with Certified Nursing Assistants beginning May 11, 2017 regarding reporting an observation of a resident's change of condition to the Nurse.</p> <p>Beginning May 12, 2017 Licensed nursing staff and Agency 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>Date of Immediate Jeopardy Removal: May 12, 2017</p> <p>On 5/12/17 at 6:30 PM, the credible allegation of compliance was validated to ensure the facility implemented their corrective actions to remove the immediate jeopardy. The facility provided evidence of an audit, on 5/12/17, of current insulin dependent diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days. The facility reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented. Record reviews of diabetic residents were reviewed to ensure that they received care to manage diabetes as ordered by the physician. The facility provided evidence of inservice training to nursing staff on how to manage diabetic residents. This was validated by interviews with nurses and nursing assistants.</p>	F 309			

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F 309	Continued From page 52 2. Record review shows that resident #5 re-entered the facility on 05/14/16. Current diagnoses included Type 2 Diabetes Mellitus with Hyperglycemia, Anxiety Disorder, Mood Disorder, Major Depressive Disorder, Essential Hypertension, Hyperlipidemia, Chronic Pain Syndrome, Venous Insufficiency Chronic Peripheral, Muscle Spasms and Personal History of Diabetic Foot Ulcer. Review of the most recent MDS Assessment dated 03/06/17 documented that the resident had venous, arterial, and diabetic foot ulcers. Cognition was documented as intact. He was extensive assist for bed mobility, personal hygiene and toilet use. He was totally dependent for dressing and bathing. The assessment indicated that he did not walk. The care plan interventions on 05/10/17 included to apply dressings per orders, complete labs as ordered, monitor intake, assist to turn and reposition on rounds and prn, provide supplements as ordered, and see the wound care doctor as scheduled. Physician orders on 05/10/17 related to skin integrity included: 1. Decubi-Vite Capsule (2) daily 2. Ensure air mattress is functioning properly with setting locked at 5 every shift 3. Pro Stat sugar free liquid 30cc twice daily 4. Cleanse top of left foot with Normal Saline, dry, apply Silver Sulfa Cream 1%, apply 4 x 4, wrap with Kerlix daily 5. Apply Santyl Ointment 250 unit/gm to outer LLE topically every day 6. Apply Mupirocin Ointment 2% to left great toe	F 309			

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F 309	<p>Continued From page 53</p> <p>topically every day shift for skin alteration</p> <p>7. Apply Hydrocolloid to left heel Stage 2 venous wound every 3 days</p> <p>Review of the most recent wound care specialist progress notes dated 04/28/17 documented that there was no change in the wound healing progress for the (2) arterial and (1) venous wounds on that date. Further review revealed that the measurements for all wounds have remained the same since 3/31/17.</p> <p>An observation on 05/10/17 at 4:45 PM revealed that the dressing on the left foot and left lower extremity of Resident #5 were dated 05/07/17. The surveyor was unable to observe wound care because the resident refused treatment until he was medicated for pain and it became effective.</p> <p>In an interview with Nurse #6 on 05/10/17 at 4:50 PM she revealed that she had called out on 05/08/17 and 05/09/17. She stated that the nurses working the hall were responsible for doing the dressing changes in her absence. She agreed that the dressings had not been changed and the wounds were not treated on 05/08/17 and 05/09/17.</p> <p>In an interview with Nurse #1 and Nurse #3 on 05/10/17 at 5:15 PM they stated that they had worked together on the 100 Hall on 05/08/17 day shift. They both stated that they did not have time to do the treatments and had passed the duty on to the second shift nurse.</p> <p>In an interview with Nurse #2 on 05/11/17 at 11:20 AM she revealed that she had cared for resident #5 on 05/08/17 from 3:00 PM to 11:00 PM. She stated that she did not get report when</p>	F 309			

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F 309	Continued From page 54 coming on shift. She said she did not do the treatments on her shift because she had too much to do. She said for part of the shift she was caring for forty-two residents until 11:00 PM when she was relieved by an Agency Nurse. In an interview with the Director of Nursing on 05/12/17 at 5:00 PM she stated that she expected the treatments to be done as ordered by the physician.	F 309			
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide pressure ulcer care for two days for a resident who was supposed to have daily treatments as ordered by the physician for 1 of 2 sampled residents with pressure ulcers, Resident #4.	F 314	Resident #4 attending physician and responsible party were notified on 5/10/17 of two questionable treatments missed. Facility audit will be completed of residents identified with physician orders	6/27/17	

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F 314	<p>Continued From page 55</p> <p>Findings include:</p> <p>Record review shows that resident #4 re-entered the facility on 01/3/17. Current diagnoses included Cerebral Infarction, Dementia, Mood Disorder, Cerebral Vascular Accident, Hyperlipidemia, Alcohol Abuse with Alcohol Induced Mood Disorder, Hypertension, Major Depression, Peripheral Vascular Disease, Cardiac Arrest, Resistance to Vancomycin, Vitamin B12 Deficiency Anemia, Urinary Tract Infection, Wound Botulism, Pressure Ulcer (Hip), Dysphagia and Epilepsy.</p> <p>Review of the care plan on 05/10/17 documented that the resident had a pressure area to her right hip and her right heel. Interventions included to apply dressings per orders, complete labs as ordered, monitor intake, assist to turn and reposition on rounds and prn, provide supplements as ordered, and see the wound care doctor as scheduled. The most recent MDS dated 4/10/17 indicated the resident had (2) facility acquired Stage 4 pressure ulcers, pressure reducing devices for her chair and bed, and nutrition and hydration intervention to manage skin problems. Cognition was intact.</p> <p>The physician orders on 05/10/17 related to skin integrity included:</p> <ol style="list-style-type: none"> 1. Apply to right hip Dakins Solution 0.25% wet to moist dressing twice daily 2. Apply Santyl Ointment to right heel topically every day shift 3. Multivitamin one tab daily 4. House Shakes 4 ounces at lunch and dinner 5. Pro Stat Liquid 30ml twice daily 	F 314	<p>for daily wound care to ensure that wound treatment were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager.</p> <p>Facility audit will be completed by a member of the nurse administration team of the treatment administration record for wound care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order.</p> <p>The facility licensed nurses will be provided re- education regarding following physician orders regarding wound care treatment by the Staff Development Coordinator by 6/27/17.</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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F 314	<p>Continued From page 56</p> <p>6. House 2.0 Med Pass 120cc three times daily</p> <p>7. Geri-Sleeves to both arms</p> <p>Review of the most recent wound care specialist progress notes dated 05/05/17 documented that there was no change in wound healing progress for either wound on that date. Further review revealed that both wounds are smaller in size and have improved.</p> <p>Wound care for resident #4 was observed on 05/10/17 at 2:40 PM. Care was provided by Nurse #6. Proper hand washing and glove donning was observed. Clean technique was used. It was observed that the old dressing removed from the Stage 4 right hip pressure ulcer was dated 05/07/17. The dressing was malodorous with a large amount of brown exudate present. The skin surrounding the wound was reddened. The wound was packed with gauze soaked in Dakins Solution 0.25% and covered with a dry dressing as ordered by the physician. Nurse #6 then removed the old dressing from the resident's Stage 4 pressure ulcer on her right heel. The old dressing was dated 05/07/17. It was malodorous with a large amount of brown exudate. The skin surrounding the wound was white. Santyl ointment was applied to the wound and a dry dressing was applied. The used dressings were disposed of properly.</p> <p>In an interview with Nurse #6 on 05/10/17 at 2:50 PM she revealed that she had called out on 05/08/17 and 05/09/17. She stated that the nurses working the hall were responsible for doing the dressing changes in her absence. She agreed that the dressings had not been changed and the wounds were not treated on 05/08/17 and 05/09/17. Nurse #1 was also present and agreed</p>	F 314			

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

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FORM APPROVED
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F 314	Continued From page 57 that the dressings were not changed and the wounds were not treated on 05/08/17 and 05/09/17. In an interview with Nurse #7 on 05/11/17 at 2:30 PM she stated that she had care for resident #4 on 05/09/17 during the day shift. She said that the day had been very busy. She stated that her first priority was to keep the residents safe and give out the medicines. She revealed that she had looked at the dressings on wounds to make sure everything was intact but did not have time to do the treatments on her assignment. She revealed that it was her intention to do the treatments but that there was too much going on during the day shift to get everything done. In an interview with the Director of Nursing on 05/12/17 at 5:00 PM she stated that she expected the treatments to be done as ordered by the physician.	F 314			
F 353 SS=J	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will	F 353		6/27/17	

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F 353	Continued From page 58 be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, Nurse Practitioner (NP) interview and physician interview, the facility failed to provide sufficient staffing to deliver care and services, including emergency medical services (EMS), to an insulin dependent brittle diabetic who was	F 353	Nurse #2 has received education 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes		

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F 353	<p>Continued From page 59</p> <p>having critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter) and symptoms of distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility failed to have sufficient staffing to provide wound care for two days for Resident #4 and Resident #5 who were supposed to have daily treatments as ordered by the physician for 1 of 3 sampled residents with wounds.</p> <p>Immediate jeopardy for Resident #2 began on 5/8/17 when the facility did not have sufficient staffing and Resident #2 blood glucose registered HI on the glucometer (blood glucose was more than 600 mg/dL.) and the resident was showing signs of lethargy, low blood pressure, vomiting, and unusual bowel incontinence. EMS was not immediately initiated and nursing did not continue to assess the resident. The immediate jeopardy was removed on 5/23/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The facility is also out of compliance at the D scope and severity for Resident #4 and Resident # 5. This tag was cross referenced to tags F224, F309 and F314.</p> <p>Findings included:</p> <p>1. Cross referenced at F224: Based on observations, record review, staff interview, and physician interview, the facility neglected a</p>	F 353	<p>including monitoring of residents following intervention implementation, and physician notification. Nurse #2 is no longer an employee and will not receive education about initiating EMS.</p> <p>All residents have the potential to be affected by the alleged deficient practice. The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager or Shift Supervisor.</p> <p>The Administrator has secured contracts with multiple staffing agencies since December of 2016 to fill staffing needs as required. The Administrator and Director of Nursing have the authority to contact the staffing agency to fill vacant shift for Licensed Nurses and Certified Nursing Assistants. The Nursing Supervisor will notify the Administrator or Director of Nursing of a staffing need and authority to contact the staffing agency to fill vacancies may be delegated to the Nursing Supervisor at the discretion of the Administrator or Director of Nursing.</p> <p>The Administrator and Director of Nursing with the Interdisciplinary Team including input from Nursing Staff completed a root cause analysis regarding coverage for vacant shifts a utilizing Agency staff, offering shift bonuses to current staff and</p>		

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F 353	<p>Continued From page 60</p> <p>resident by not following physician orders for sliding scale insulin (SSI), by not monitoring and reassessing an insulin dependent brittle diabetic resident that had a critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and vomiting. The facility failed to initiate emergency medical services (EMS) for the resident when he became in distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility neglected residents by not providing wound care for two days for 2 of 3 residents who were supposed to have daily treatments as ordered by the physician (Resident #4 and Resident #5).</p> <p>2. Cross referenced at F309: Based on observations, record review, staff interview, Nurse Practitioner (NP) interview and physician interview, the facility failed to follow physician orders for sliding scale insulin (SSI), monitor and reassess an insulin dependent brittle diabetic resident that had a critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and vomiting. The facility failed to initiate emergency medical services (EMS) for the resident when he became in distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility failed to provide wound care for two days for Resident #5 who was supposed to have daily treatments as ordered by the physician for 1 of 1 sampled residents with wounds.</p>	F 353	<p>scheduling dedicated Nursing Supervision daily for all shifts by May 12, 2017. Based on this review it was determined that multiple Nurses had called out for 3 shifts on May 8, 2017 requiring Administrative Nursing staff to cover these shifts and therefore reducing the amount of available Nursing Supervision.</p> <p>The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. The Administrator and Director of Nursing will conduct a daily meeting to review Nursing and Certified Nursing Assistant staffing and scheduling for each day to ensure adequate coverage to include a dedicated Supervisor for each shift. All attempts to assign familiar caregivers to maintain continuity of care for high risk residents will be discussed during this meeting.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017, in the event the Nursing Supervisor is required to move to a resident care assignment as a result of a staffing shortage the Administrator and Director of Nursing will be notified immediately to make further staffing adjustments as necessary. If a Nurse is feeling overwhelmed with completing the tasks due on their current assignment the Nurse will report to the Supervisor for</p>		

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F 353	Continued From page 61 3. Cross referenced at F314: Based on observations, staff interviews and record review, the facility failed to provide pressure ulcer care for two days for a resident who was supposed to have daily treatments as ordered by the physician for 1 of 2 sampled residents with pressure ulcers (Resident #4.) The administrator was notified of the immediate jeopardy on 5/11/17 at 5:00 PM. The administrator provided the following credible allegation of compliance effective 5/12/17 at 6:30 PM. Residents identified to be affected by the alleged deficient practice. At 4:00 PM on 5/8/17 Nurse #2 went into Resident #2 room and noticed that he was not responding as usual. His skin was cool and clammy. His Blood glucose was checked and read "HI" with no value on the monitor. The manufacturer insert for this glucometer stated that a reading of "HI" indicated a blood glucose value of greater than 600 mg/dL. The Physician was notified and orders were received to administer 17 units of Novolog one time and Zofran 4 mg every 6 hours for nausea. At approximately 4:30 PM NA#3 entered room to check on Resident #2 who was resting in bed with no new changes. At approximately 6-6:30 PM, NA #4 delivered Resident #2 his dinner tray. Resident #2 reported he was not feeling good and didn't want to eat. NA#4 stated this was then reported to Nurse #2. Resident #2 remained in the bed and the tray was set up. At 7:00 PM, Nurse #2 rechecked the resident	F 353	assistance. In the event the Nursing Supervisor has a resident care assignment the Director of Nursing will be notified. Beginning May 12, 2017 Licensed nursing staff and Agency 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. All residents with changes in condition have the potential to be affected by the alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have had an acute change in condition related to high blood sugar levels in the last 30 days and reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented according to the Physician's Orders and the care plan, including emergency medical services initiated immediately as directed by physician completed May 12, 2017. Beginning May 12, 2017 the Director of Nursing and Nurse Managers will review those residents who have exhibited acute		

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F 353	<p>Continued From page 62</p> <p>blood sugar and it again read "HI". Nurse #2 notified the Physician and received orders to administer 14 units of Novolog and instructions to transport to the hospital if not improved. Resident status did not improve. Resident was incontinent of bowel and bladder and remained lethargic. Resident complained of an ache in his abdomen. Family was notified of resident status, 911 was called at 8:25 PM, and resident arrived at the hospital at 9:26 PM.</p> <p>The nurse reported she was too busy to check on the resident more frequently to reassess following insulin administration for a "HI" blood sugar reading with nausea and a low blood pressure and that she did not communicate with a manager that she was not able to recheck on the resident.</p> <p>Nurse #2 has received education on 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention implementation, and physician notification.</p> <p>Residents with the potential to be affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice. The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager or</p>	F 353	<p>changes in condition to assure that assessments or observations of symptoms have been assessed, interventions were initiated as ordered or care planned, and the attending physician was notified.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017 regarding the facility's existing policy for identification and assessment of changes in condition, Diabetic Management including monitoring of residents following intervention implementation, and physician notification. Education included clarification of existing policy: Beginning May 11, 2017 of the following: - When a resident's blood sugar read HI on the glucometer, Residents will be re-assessed within 30 minutes to 1 hour following insulin administration and according to the physician's orders. -Physician's Orders for sliding scale insulin administration and blood sugar monitoring will include parameters for physician notification. - Identification of an obvious critical acute change in condition, and appropriate response and physician notification. - Ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. - EMS will be initiated by physician order and/or advanced directives.</p>		

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F 353	<p>Continued From page 63 Shift Supervisor.</p> <p>3. The Administrator has secured contracts with multiple Staffing Agencies since December of 2016 to fill staffing needs as required. The Administrator and Director of Nursing have the authority to contact the staffing agency to fill vacant shift for Licensed Nurses and Certified Nursing Assistants. The Nursing Supervisor will notify the Administrator or Director of Nursing of a staffing need and authority to contact the staffing agency to fill vacancies may be delegated to the Nursing Supervisor at the discretion of the Administrator or Director of Nursing.</p> <p>The Administrator and Director of Nursing with the Interdisciplinary Team including input from Nursing Staff completed a root cause analysis regarding coverage for vacant shifts a utilizing Agency staff, offering shift bonuses to current staff and scheduling dedicated Nursing Supervision daily for all shifts by May 12, 2017. Based on this review it was determined that multiple Nurses had called out for 3 shifts on May 8, 2017 requiring Administrative Nursing staff to cover these shifts and therefore reducing the amount of available Nursing Supervision.</p> <p>The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. The Administrator and Director of Nursing will conduct a daily meeting to review Nursing and Certified Nursing Assistant staffing and scheduling for each day to ensure adequate coverage to include a dedicated Supervisor for each shift. All attempts to assign familiar caregivers to maintain continuity of care for high</p>	F 353	<p>Licensed nursing staff, and agency licensed nursing staff will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Certified Nursing Assistants beginning May 11, 2017 regarding reporting an observation of a resident's change of condition to the Nurse immediately. Nursing assistants will not be allowed to work until this training is complete.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted education with Licensed Nursing staff and nurses aides on Abuse and Neglect Prevention on May 22, 2017 including prompt response to resident's change of condition. Beginning May 22nd, Licensed Nursing staff, nurses' aides and Agency Licensed nursing staff will not be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect.</p> <p>Beginning May 22, 2017 Licensed nursing staff and Agency Licensed nursing staff will not be allowed to work until the training for Abuse and Neglect Prevention, including prompt response to resident's change of condition is completed. This education also includes ensuring staff awareness that failure to provide care and services, including when to initiate EMS,</p>		

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F 353	<p>Continued From page 64</p> <p>risk residents will be discussed during this meeting.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017, in the event the Nursing Supervisor is required to move to a resident care assignment as a result of a staffing shortage the Administrator and Director of Nursing will be notified immediately to make further staffing adjustments as necessary. If a Nurse is feeling overwhelmed with completing the tasks due on their current assignment the Nurse will report to the Supervisor for assistance. In the event the Nursing Supervisor has a resident care assignment the Director of Nursing will be notified.</p> <p>Beginning May 12, 2017 Licensed nursing staff and Agency 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>On 5/12/17 at 6:30 PM, the credible allegation of compliance was validated to ensure the facility implemented their corrective actions to remove the immediate jeopardy. The facility provided evidence of an audit, on 5/12/17, of current insulin dependent diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days. The</p>	F 353	<p>can constitute resident neglect. 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>Resident #2 no longer resides at the facility.</p> <p>Resident #4 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>Resident #5 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents identified receiving sliding scales per physician orders to validate by 6/27/17.</p> <p>Facility audit will be completed of residents identified with physician orders for daily wound care to ensure that wound treatment were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager.</p> <p>A member of nurse administration team</p>		

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F 353	Continued From page 65 facility reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented. Record of diabetic residents were reviewed to ensure that they received care to manage diabetes as ordered by the physician. The facility provided evidence of inservice training to nursing staff on how to manage diabetic residents and regarding sufficient staffing. This was validated by interviews with nurses and nursing assistants.	F 353	(Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review treatment record of residents identified with daily wound care orders to ensure that treatments were completed five times a week for one month then weekly times two months. A member of nurse administration team (Staff development coordinator, Assistant Director of Nursing and /or Director of Nursing) will review new physician orders from previous day to ensure that order transcribed correctly for five times a week for one month and weekly times two months. Facility audit will be completed of treatment administration record for wound care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order. Facility audit will be completed of residents identified with physician orders for sliding scale insulin to ensure that any readings above 600 (HI) have physician notification, reassessment and monitoring five times a week for one month and weekly times two months. Residents who require EMS transport for emergencies will be audited to ensure there was not a delay in initiating services five times a week for one month and weekly times two months.		

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F 353	Continued From page 66	F 353	<p>Administrator/Director of Nursing and / or Nurse Management will review the schedule for seven days forward for five days a week for one month then weekly times two months to ensure sufficient staffing and supervision.</p> <p>The facility licensed nurses will be provided re- education regarding following physician orders regarding wound care treatment by the Staff Development Coordinator by 6/27/17.</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		
F 428 SS=E	<p>483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>c) Drug Regimen Review</p> <p>(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p>	F 428		6/27/17	

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F 428	<p>Continued From page 67</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.</p> <p>(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p>	F 428			

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F 428	<p>Continued From page 68</p> <p>Based on record review, staff interview and consultant pharmacist interview, the consultant pharmacist failed to report to the facility that physician orders for sliding scale insulin (SSI) for an insulin dependent brittle diabetic resident. This was evident in 1 of 3 diabetic residents (Resident #2.)</p> <p>Findings included:</p> <p>1. Resident #2 was admitted to the facility on 02/27/17 with diagnoses including Type I Diabetes Mellitus (DM) with Chronic Kidney Disease.</p> <p>A review of the medical records revealed progress/nursing notes, CBG level order changes and insulin regimen changes: A physician order dated 02/28/17 at 6:32 AM read "NovoLOG Solution 100 UNIT/ML, inject as per sliding scale: if (CBG) 150 - 210 = 1 (NovoLOG) unit; 211 - 270 = 2 units; 271 - 330 = 3 units; 331 - 390 = 4 units; 391 - 450 = 5 units; notify MD (physician) if CBG is greater than 450, subcutaneously before meals and at bedtime for DM."</p> <p>Review of Resident #2 handwritten physician order dated 03/06/17 revealed the following new order: New SSI (sliding scale insulin) for patient (resident) with meals 151-200=2 units, 201-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=9 units, 401-450=11 units, if greater than 450 call MD.</p> <p>Review of the Medication Administration Record (MAR) 03/06/17 through 03/31/17 revealed the new SSI order of 3/6/17 was not transcribed on</p>	F 428	<p>Resident #2 no longer resides in the facility</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of resident identified with capillary blood glucose monitoring, to ensure that the resident receiving sliding scales per physician orders by 6/27/17</p> <p>The Director of Nursing will provide re-education to the facility consulting regarding documentation of residents identified with physician orders for sliding scale insulin on the consultant review record, to include any recommendation and no changes to current sliding scale regiment by 6/27/17.</p> <p>The Director of Nursing or Assistant Director of Nursing will review residents identified with sliding scale insulin with consulting pharmacist monthly, to ensure review has been completed by pharmacist monthly times three months.</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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F 428	<p>Continued From page 69</p> <p>the MAR. The transcribed Novolog SSI order was the following: Novolog solution 100unit/ml, inject as per sliding scale: if 150-210=1 unit, 211-270=2 units, 271-330=3 units, 331-390=4 units, 391-450=5 units. Notify MD if CBG is greater than 450, subcutaneously before meals and at bedtime for DM. Order date 02/27/17.</p> <p>Review of the March 2017 MAR revealed the following CBG readings and SSI coverage administered to Resident #2:</p> <p>MAR date 03/06/17 at 11:30 AM, CBG 508. Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>On 05/18/17 at 11:10 AM, an interview was conducted with Nurse #8 who worked with Resident #2 on 3/6/17 and documented the blood glucose of 508 mg/dL at 11:30 AM. The nurse confirmed that the resident blood glucose was 508 and stated she received an order for Novolog 20 units one time from physician #1. She stated that she knew to place a progress note in the medical records for interventions related to high or low CBGs and new orders, but, she did not do it that day.</p> <p>MAR date 03/06/17 at 4:30 PM, CBG 271, 3 units given instead of 5 units as ordered on 03/06/17 MAR date 03/06/17 at 9:00 PM, CBG 220, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/07/17 at 6:30 AM, CBG 83. MAR date 03/07/17 at 11:30 AM, CBG 180, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/07/17 at 4:30 PM, CBG 206, 1 unit given instead of 2 units as ordered on 03/06/17</p>	F 428			

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F 428	<p>Continued From page 70</p> <p>MAR date 03/07/17 at 9:00 PM, CBG 209, 1 unit given instead of 2 units as ordered on 03/06/17</p> <p>MAR date 03/08/17 at 6:30 AM, CBG 570, Code "8" was written which meant "other/see progress note." No written progress note or order found in the medical record.</p> <p>Review of the Nursing Note dated 03/08/17 at 5:37 AM revealed CBG was 570. There was no documentation of sliding scale insulin given or if the physician was notified. The nurse that wrote the note was not available for interview because he was out of the country at the time of investigation.</p> <p>MAR date 03/09/17 at 11:30 AM, CBG 168, 1 unit given instead of 2 units as ordered on 03/06/17</p> <p>MAR date 03/09/17 at 4:30 PM, CBG 414, 5 units given instead of 11 units as ordered on 03/06/17</p> <p>MAR date 03/09/17 at 9:00 PM, CBG 431, 5 units given instead of 11 units as ordered on 03/06/17</p> <p>MAR date 03/10/17 at 6:30 AM, CBG 74.</p> <p>MAR date 03/10/17 at 11:30 AM, CBG 270, 2 units given instead of 5 units as ordered on 03/06/17</p> <p>MAR date 03/10/17 at 4:30 PM, CBG 310, 3 units given instead of 7 units as ordered on 03/06/17</p> <p>MAR date 03/10/17 at 9:00 PM, CBG 176, 1 unit given instead of 2 units as ordered on 03/06/17</p> <p>MAR date 03/11/17 at 6:30 AM, CBG 123.</p> <p>MAR date 03/11/17 at 11:30 AM, CBG 440, 5 units given instead of 11 units as ordered on 03/06/17</p> <p>MAR date 03/11/17 at 4:30 PM, CBG 335, 4 units given instead of 7 units as ordered on 03/06/17</p> <p>MAR date 03/11/17 at 9:00 PM, CBG 154, 1 unit given instead of 2 units as ordered on 03/06/17</p> <p>MAR date 03/12/17 at 6:30 AM, CBG 143.</p> <p>MAR date 03/12/17 at 11:30 AM, CBG 68.</p>	F 428			

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F 428	<p>Continued From page 71</p> <p>MAR date 03/12/17 at 4:30 PM, CBG 225, 2 units given instead of 3 units as ordered on 03/06/17 MAR date 03/12/17 at 9:00 PM, CBG 158, 1 unit given instead of 2 units as ordered on 03/06/17 MAR date 03/13/17 at 6:30 AM, CBG 436, 5 units given instead of 11 units as ordered on 03/06/17 MAR date 03/13/17 at 11:30 AM, CBG 254, 2 units given instead of 5 units as ordered on 03/06/17.</p> <p>An interview on 05/12/17 at 1:15 PM with Director of Nursing (DON) and Administrator revealed that they did not know why the physician order of 03/06/17 with the SSI order and insulin changes did not get placed on the MAR. It was the expectation that every order was written on the physician's order sheet, signed off, placed in the computer and confirmed on the MAR.</p> <p>Review of the "Clinical Pharmacist Medication Regimen Review Summary" revealed the consultant pharmacist did a drug regimen review on 3/10/17 and 04/12/17. The review dated 3/10/17 included that the resident was a brittle diabetic and insulin doses were adjusted. The plan was to monitor the resident for blood glucose. Neither drug regimen review addressed that the resident did not receive SSI as ordered by the physician on 3/6/17.</p> <p>An interview of the consultant Pharmacist on 5/22/17 at 4:12 PM revealed that she usually checked the hard copy of physician order sheets against the MAR in the computer to make sure physician orders were transcribed correctly to the MAR. She said the nurses were responsible for entering the hand written physician order into the computer. She could not explain why she did not</p>	F 428			

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F 428	Continued From page 72 identify that the facility staff did not transcribe the 3/6/17 SSI order into the MAR and as a result, the order was not followed. She said it was either the hand written copy of the physician order was not in the resident medical records or she just missed it.	F 428			
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, Nurse Practitioner (NP) interview and physician interview, the facility's administration failed to ensure care and services, including emergency medical services (EMS), were provided to an insulin dependent brittle diabetic who was having critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter) and signs of distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility administration failed to ensure wound care was provided for two days for Resident #4 and Resident #5 who were supposed to have daily treatments as ordered by the physician for 1 of 3 sampled residents with wounds. Immediate jeopardy for Resident #2 began on 5/8/17 when the facility did not have sufficient staffing and Resident #2 blood glucose registered	F 490	Nurse #2 has received education 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention implementation, and physician notification. Nurse #2 is no longer an employee and will not receive education about initiating EMS. All residents have the potential to be affected by the alleged deficient practice. The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing,	6/27/17	

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F 490	<p>Continued From page 73</p> <p>HI on the glucometer (blood glucose was more than 600 mg/dL.) and the resident was showing signs of lethargy, low blood pressure, vomiting, and unusual bowel incontinence. EMS was not immediately initiated and nursing did not continue to assess the resident. The immediate jeopardy was removed on 5/23/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The facility is also out of compliance at the D scope and severity for Resident #4 and Resident # 5. This tag is cross referenced to tags F224, F309, F314 and F353.</p> <p>Findings included:</p> <p>1. Cross referenced at F224: Based on observations, record review, staff interview, and physician interview, the facility neglected a resident by not following physician orders for sliding scale insulin (SSI), by not monitoring and reassessing an insulin dependent brittle diabetic resident that had a critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and vomiting. The facility failed to initiate emergency medical services (EMS) for the resident when he became in distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility neglected residents by not providing wound care for two days for 2 of 3 residents who were supposed to have daily</p>	F 490	<p>Staff Development Coordinator, Unit Manager or Shift Supervisor.</p> <p>The Administrator has secured contracts with multiple staffing agencies since December of 2016 to fill staffing needs as required. The Administrator and Director of Nursing have the authority to contact the staffing agency to fill vacant shift for Licensed Nurses and Certified Nursing Assistants. The Nursing Supervisor will notify the Administrator or Director of Nursing of a staffing need and authority to contact the staffing agency to fill vacancies may be delegated to the Nursing Supervisor at the discretion of the Administrator or Director of Nursing.</p> <p>The Administrator and Director of Nursing with the Interdisciplinary Team including input from Nursing Staff completed a root cause analysis regarding coverage for vacant shifts a utilizing Agency staff, offering shift bonuses to current staff and scheduling dedicated Nursing Supervision daily for all shifts by May 12, 2017. Based on this review it was determined that multiple Nurses had called out for 3 shifts on May 8, 2017 requiring Administrative Nursing staff to cover these shifts and therefore reducing the amount of available Nursing Supervision.</p> <p>The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. The Administrator and Director of Nursing</p>		

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F 490	<p>Continued From page 74</p> <p>treatments as ordered by the physician (Resident #4 and Resident #5).</p> <p>2. Cross referenced at F309: Based on observations, record review, staff interview, Nurse Practitioner (NP) interview and physician interview, the facility failed to follow physician orders for sliding scale insulin (SSI), monitor and reassess an insulin dependent brittle diabetic resident that had a critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter). The resident was also showing signs of lethargy, low blood pressure, unusual bowel incontinence, and vomiting. The facility failed to initiate emergency medical services (EMS) for the resident when he became in distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility failed to provide wound care for two days for Resident #5 who was supposed to have daily treatments as ordered by the physician for 1 of 1 sampled residents with wounds.</p> <p>3. Cross referenced at F314: Based on observations, staff interviews and record review, the facility failed to provide pressure ulcer care for two days for a resident who was supposed to have daily treatments as ordered by the physician for 1 of 2 sampled residents with pressure ulcers (Resident #4.)</p> <p>4. Cross referenced at F353. Based on observations, record review, staff interview, Nurse Practitioner (NP) interview and physician interview, the facility failed to provide sufficient staffing to deliver care and services, including emergency medical services (EMS), to an insulin</p>	F 490	<p>will conduct a daily meeting to review Nursing and Certified Nursing Assistant staffing and scheduling for each day to ensure adequate coverage to include a dedicated Supervisor for each shift. All attempts to assign familiar caregivers to maintain continuity of care for high risk residents will be discussed during this meeting.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017, in the event the Nursing Supervisor is required to move to a resident care assignment as a result of a staffing shortage the Administrator and Director of Nursing will be notified immediately to make further staffing adjustments as necessary. If a Nurse is feeling overwhelmed with completing the tasks due on their current assignment the Nurse will report to the Supervisor for assistance. In the event the Nursing Supervisor has a resident care assignment the Director of Nursing will be notified.</p> <p>Beginning May 12, 2017 Licensed nursing staff and Agency 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</p>		

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F 490	<p>Continued From page 75</p> <p>dependent brittle diabetic who was having critical capillary blood glucose (CBG) above 600 mg/dL (milligram/deciliter) and symptoms of distress. This was evident in 1 of 3 diabetic residents (Resident #2). The resident was sent to the hospital and shortly died of a heart attack. The facility failed to have sufficient staffing to provide wound care for two days for Resident #4 and Resident #5 who were supposed to have daily treatments as ordered by the physician for 1 of 3 sampled residents with wounds.</p> <p>The administrator was notified of the immediate jeopardy on 5/11/17 at 5:00 PM. The administrator provided the following credible allegation of compliance effective 5/12/17 at 6:30 PM.</p> <p>Residents identified to be affected by the alleged deficient practice.</p> <p>At 4:00 PM on 5/8/17 Nurse #2 went into Resident #2 room and noticed that he was not responding as usual. His skin was cool and clammy. His Blood glucose was checked and read "HI" with no value on the monitor. The manufacturer insert for this glucometer stated that a reading of "HI" indicated a blood glucose value of greater than 600 mg/dL. The Physician was notified and orders were received to administer 17 units of Novolog one time and Zofran 4 mg every 6 hours for nausea. At approximately 4:30 PM NA#3 entered room to check on Resident #2 who was resting in bed with no new changes. At approximately 6-6:30 PM, NA #4 delivered Resident #2 his dinner tray. Resident #2 reported he was not feeling good and didn't want to eat.</p>	F 490	<p>permitted to assume their floor responsibilities until they have completed this education</p> <p>The Administrator along with input from the Director of Nursing will oversee and make adjustments to the staffing patterns and scheduling within the facility to meet the resident's needs. The Administrator will ensure staffing resources are allocated appropriately.</p> <p>District Director of Clinical Services and /or the District Director of Operations will provide oversight of the administration by providing onsite visits to the facility every week x 4 weeks, and then a minimum of bimonthly visits X 6 months to ensure implementation of all credible allegations.</p> <p>The Director of Nursing and Nurse Managers conducted an audit of current diabetic residents who have had an acute change in condition related to high blood sugar levels in the last 30 days and reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented according to the Physician's Orders and the care plan, including emergency medical services initiated immediately as directed by physician completed May 12, 2017.</p> <p>Beginning May 12, 2017 the Director of Nursing and Nurse Managers will review those residents who have exhibited acute changes in condition to assure that assessments or observations of</p>		

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NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407		
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F 490	<p>Continued From page 76</p> <p>NA#4 stated this was then reported to Nurse #2. Resident #2 remained in the bed and the tray was set up.</p> <p>At 7:00 PM, Nurse #2 rechecked the resident blood sugar and it again read "HI". Nurse #2 notified the Physician and received orders to administer 14 units of Novolog and instructions to transport to the hospital if not improved. Resident status did not improve. Resident was incontinent of bowel and bladder and remained lethargic. Resident complained of an ache in his abdomen. Family was notified of resident status, 911 was called at 8:25 PM, and resident arrived at the hospital at 9:26 PM.</p> <p>The nurse reported she was too busy to check on the resident more frequently to reassess following insulin administration for a "HI" blood sugar reading with nausea and a low blood pressure and that she did not communicate with a manager that she was not able to recheck on the resident.</p> <p>Nurse #2 has received education on 5/12/17 from the Director of Nursing and Staff Development Coordinator regarding the facility policy for identification and assessment of changes in condition, management of residents with diabetes including monitoring of residents following intervention implementation, and physician notification.</p> <p>Residents with the potential to be affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice. The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is</p>	F 490	<p>symptoms have been assessed, interventions were initiated as ordered or care planned, and the attending physician was notified.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017 regarding the facility's existing policy for identification and assessment of changes in condition, Diabetic Management including monitoring of residents following intervention implementation, and physician notification.</p> <p>Education included clarification of existing policy: Beginning May 11, 2017 of the following:</p> <ul style="list-style-type: none"> - When a resident's blood sugar read HI on the glucometer, Residents will be re-assessed within 30 minutes to 1 hour following insulin administration and according to the physician's orders. -Physician's Orders for sliding scale insulin administration and blood sugar monitoring will include parameters for physician notification. - Identification of an obvious critical acute change in condition, and appropriate response and physician notification. - Ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. - EMS will be initiated by physician order and/or advanced directives. <p>Licensed nursing staff, and agency licensed nursing staff will not be allowed to work until this training is complete.</p>		

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F 490	Continued From page 77 scheduled for all 3 shifts each day including the weekend. Nursing Supervision includes the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager or Shift Supervisor. 3. The Administrator has secured contracts with multiple Staffing Agencies since December of 2016 to fill staffing needs as required. The Administrator and Director of Nursing have the authority to contact the staffing agency to fill vacant shift for Licensed Nurses and Certified Nursing Assistants. The Nursing Supervisor will notify the Administrator or Director of Nursing of a staffing need and authority to contact the staffing agency to fill vacancies may be delegated to the Nursing Supervisor at the discretion of the Administrator or Director of Nursing. The Administrator and Director of Nursing with the Interdisciplinary Team including input from Nursing Staff completed a root cause analysis regarding coverage for vacant shifts a utilizing Agency staff, offering shift bonuses to current staff and scheduling dedicated Nursing Supervision daily for all shifts by May 12, 2017. Based on this review it was determined that multiple Nurses had called out for 3 shifts on May 8, 2017 requiring Administrative Nursing staff to cover these shifts and therefore reducing the amount of available Nursing Supervision. The Administrator and Director of Nursing have reviewed the schedule for the next 7 days ending 5/19/17 to validate dedicated Nursing Supervision is scheduled for all 3 shifts each day including the weekend. The Administrator and Director of Nursing will conduct a daily meeting to review Nursing and Certified Nursing Assistant staffing and scheduling for each day to ensure adequate coverage to include a dedicated Supervisor for	F 490	The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Certified Nursing Assistants beginning May 11, 2017 regarding reporting an observation of a resident's change of condition to the Nurse immediately. Nursing assistants will not be allowed to work until this training is complete. The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted education with Licensed Nursing staff and nurses aides on Abuse and Neglect Prevention on May 22, 2017 including prompt response to resident's change of condition. Beginning May 22nd, Licensed Nursing staff, nurses' aides and Agency Licensed nursing staff will not be allowed to work until the training is complete. This education also included ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. Beginning May 22, 2017 Licensed nursing staff and Agency Licensed nursing staff will not be allowed to work until the training for Abuse and Neglect Prevention, including prompt response to resident's change of condition is completed. This education also includes ensuring staff awareness that failure to provide care and services, including when to initiate EMS, can constitute resident neglect. Licensed nursing staff will be provided this education at least annually via the		

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F 490	<p>Continued From page 78</p> <p>each shift. All attempts to assign familiar caregivers to maintain continuity of care for high risk residents will be discussed during this meeting.</p> <p>The Director of Nursing, Staff Development Coordinator and Nurse Managers have conducted training with Licensed Nurses beginning May 11, 2017, in the event the Nursing Supervisor is required to move to a resident care assignment as a result of a staffing shortage the Administrator and Director of Nursing will be notified immediately to make further staffing adjustments as necessary. If a Nurse is feeling overwhelmed with completing the tasks due on their current assignment the Nurse will report to the Supervisor for assistance. In the event the Nursing Supervisor has a resident care assignment the Director of Nursing will be notified.</p> <p>Beginning May 12, 2017 Licensed nursing staff and Agency 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>The Administrator along with input from the Director of Nursing will oversee and make adjustments to the staffing patterns and scheduling within the facility to meet the residents' needs. The Administrator will ensure staffing resources are allocated appropriately. District Director of Clinical Services and /or the District Director of Operations will provide oversight of the administration to ensure</p>	F 490	<p>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>Current facility residents identified as receiving capillary blood glucose monitoring will be reviewed five times a week for one month then weekly times two months to ensure that physicians were notified as stated in physician's orders of elevated capillary blood glucose.</p> <p>Resident #2 no longer resides in the facility.</p> <p>Resident #4 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>Resident #5 attending physician and responsible party were notified on 5/10/17 of two questionable missed treatments.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review physician orders for past thirty days of residents identified with capillary blood glucose monitoring, to ensure that the resident receiving sliding scales per physician orders by 6/27/17.</p> <p>Facility audit will be completed of residents identified with physician orders for daily wound care to ensure that</p>		

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F 490	<p>Continued From page 79</p> <p>implementation of the credible allegation, by providing on site visits to the facility every week x 4 weeks, and then a minimum of bimonthly visits X 6 months to ensure implementation of all credible allegations.</p> <p>On 5/12/17 at 6:30 PM, the credible allegation of compliance was validated to ensure the facility implemented their corrective actions to remove the immediate jeopardy. The facility provided evidence of an audit, on 5/12/17, of current insulin dependent diabetic residents who have had an acute change in condition related to high blood glucose levels in the last 30 days. The facility reviewed their corresponding documentation to validate that a nursing assessment has been completed and interventions were implemented. Record of diabetic residents were reviewed to ensure that they received care to manage diabetes as ordered by the physician. The facility provided evidence of inservice training to nursing staff on how to manage diabetic residents and regarding sufficient staffing. This was validated by interviews with nurses and nursing assistants.</p>	F 490	<p>wound treatment were completed for the past thirty days per orders by 6/27/17 by the Director of Nursing and / Nurse Manager.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review treatment record of residents identified with daily wound care orders five times a week for one month and weekly for two months.</p> <p>A member of nurse administration team (Staff Development Coordinator, Assistant Director of Nursing and /or Director of Nursing) will review new physician orders from previous day to ensure that order transcribed correctly for five times a week for one month and weekly times two months.</p> <p>Facility audit will be completed of treatment administration record for wound care orders five times a week for one month then weekly times two months. Visual validation that daily wound care treatments occur will be conducted randomly three times a week to ensure completion of physician order.</p> <p>Facility audit will be completed of residents identified with physician orders for sliding scale insulin to ensure that any readings above 600 (HI) have physician notification, reassessment and monitoring five times a week for one month and weekly times two months.</p>		

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

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F 490	Continued From page 80	F 490	<p>Residents who require EMS transport for emergencies will be audited to ensure there was not a delay in initiating services five times a week for one month and weekly times two months.</p> <p>Administrator/Director of Nursing and / or Nurse Management will review the schedule for seven days forward for five days a week for one month then weekly times two months to ensure sufficient staffing and supervision.</p> <p>The facility licensed nurses will be provided re- education regarding following physician orders regarding wound care treatment by the Staff Development Coordinator by 6/27/17.</p> <p>The Director of Nursing will report findings of audits to the Quality Assurance and Performance Improvement Committee monthly times three. Data will be reviewed and analyzed for patterns and trends. The Quality Assurance and Performance Improvement Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		