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ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/10/17 through 10/13/17. Immediate Jeopardy was identified at: CFR 483.10 at tag F157 at a scope and severity (J) CFR 483.25 at tag F309 at a scope and severity (J) The tag F309 constituted Substandard Quality of Care. Immediate Jeopardy began on 09/04/17 for resident #3 and was removed on 10/13/17. An extended survey was conducted.	F 000		
F 157 SS=J	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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);	F 157		11/6/17

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

Electronically Signed | 11/03/2017

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F 157	Continued From page 1 (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff, physician and family interviews and record review, the facility failed to notify the physician of a change in condition for one of three residents reviewed (Resident #3) for notification, when Resident #3 had recurring low blood sugars over a period of 24 hours; and the facility failed to notify a resident's Responsible Party (Resident #6) when the Resident was sent to the hospital,	F 157	The statements included in this allegation of compliance are not an admission and do not constitute an agreement with the alleged deficiencies herein. The allegation of compliance is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	

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F 157	Continued From page 2 for one of three residents reviewed for notification. The Immediate Jeopardy began 9/4/2017 at 1:06 AM when Nurse #2 checked Resident #3's blood sugar and documented the reading as 39. The Immediate Jeopardy was removed on 10/13/2017 at 7:15 PM when the facility provided a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education to ensure monitoring systems are in place that are effective. Example #2 for Resident #6 is no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is isolated (D). Findings included: 1.A review of the medical record revealed Resident #3 was admitted from the local hospital on 9/1/2017 with diagnoses of fractured vertebrae, low back pain, chronic obstructive pulmonary disease (COPD) and Type II Diabetes Mellitus. A review of the signed physician orders for Resident #3 dated 9/1/2017 revealed the diabetic medications were: Levemir (long acting insulin) 15 units subcutaneously (under the skin) daily, Glyburide (oral medication for Type II diabetes control) 3 milligrams (mg) by mouth (po) twice daily and Metformin (oral medication for Type II diabetes control) 500 mg po twice daily. Also listed was a standing order for Novolog (rapid acting insulin) to be injected three times daily	F 157	regulations, the center has taken or will take the actions set forth in the following allegation of compliance. F157 Resident # 3 no longer resides in the facility. Resident #6's responsible party was updated on #6's current condition on 10/30/17. Residents that reside in the facility have the potential to be affected by failure to notify physician of significant change. In-servicing of licensed nurses regarding following Physician orders, and notification of change was completed on 10-13-2017 by the staff development coordinator and the Director of Nursing. The Unit managers will review progress notes daily to capture significant changes and ensure there is MD/RP notification for 12 weeks. The Director of Nursing will audit progress notes twice weekly for twelve weeks to validate notification and documentation of assessments. Findings from the audits will be reviewed in the monthly quality assurance committee and quality monitoring will be modified based on the findings.	

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before meals with the dose depending on a blood sugar check and ordered by a sliding scale (blood sugar 0-199 = 0 units insulin and blood sugar < 60 call MD, 200 - 300 = 5 units insulin; 301 - 400 = 10 units insulin; 401 - 450 =15 units insulin, 451 - 500 = 20 units insulin; > 500 Call MD.

A review of progress notes revealed a note on 9/4/2017 at 1:06 AM which stated Resident #3 complained of weakness. Resident's blood sugar was checked and documented at 39 milligrams per deciliter (mg/dl). Documentation indicated Resident #3 was given 2 cups apple juice and pudding and the blood sugar would be rechecked. This note was written by Nurse #2.

A review of a Medication Administration Note written by Nurse #1 on 9/4/2017 at 8:05 AM noted 240 cubic centimeters (cc) orange juice with sugar was given and documented in the note was the 8:30 AM blood sugar was rechecked to be 59 mg/dl.

A review of Medication Administration Note dated 9/4/2017 at 9:10 AM indicated long acting insulin was not administered due to blood sugars of 39 - 59. Documentation was by Nurse #1.

A review of a Daily Skilled Note written by Nurse #1, on 9/4/2017 at 4:00 PM revealed documentation of Resident #3 had blood sugar checks 4 times and no insulin coverage. Nurse #1 noted the blood sugar at 8:30 AM was 82 mg/dl and was rechecked to register 59 mg/dl and orange juice with sugar was given. The note also documented Resident #3 had a blood sugar of 81 mg/dl at 11:30 AM and another check at 1:00 PM noted the blood sugar was 53 mg/dl and orange juice with sugar was documented as

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given and blood sugar noted to be up to 64 mg/dl and Nurse #1 indicated Resident #3 was alert and oriented.

A review of a Medication Administration Note dated 9/4/2017 at 5:00 PM and written by Nurse #3 revealed documentation the Metformin 500 mg had been held due to a low blood sugar of 60 mg/dl and it was indicated Resident #3 was given orange juice and sugar.

A Health Status note was reviewed, dated 9/4/2017 at 5:32 PM by Nurse #3. The note indicated Resident #3's blood sugar was 60 mg/dl at 4:30 PM. The note described the resident as alert, verbal with the complaint of feeling bad. The note also indicated Resident #3 was talking on the phone with a family member. The on-call Physician was notified and an order was obtained to administer Glucagon for blood sugar less than 60 mg/dl. The note further indicated Resident #3 was notified of the order.

An additional Health Status note was reviewed, written by Nurse #3, on 9/4/2017 at 11:44 PM. The note stated Resident #3's blood sugar was 50 mg/dl at 8:00 PM. Glucagon was given one time Intra Muscular (IM) and at 10:00 PM Resident #3's blood sugar was 60 mg/dl. This note also documented Resident #3 as being alert and verbal and having skin warm and dry to touch. The note indicated a fax was sent to the physician with information about Resident #3 having low blood sugars.

A Health Status note written on 9/5/2017 at 2:07 AM by Nurse #6 was reviewed and revealed documentation that a nurse entered Resident #3's room and called to Resident #3 who did not

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respond. The note indicated the blood sugar was checked at 12:35 AM and was 36 mg/dl. Also noted was the Nurse called for assistance and another nurse administered Glucagon at 12:37 AM and Resident #3's blood sugar was documented at 54 mg/dl. Nurse #6 also documented a nurse called 911, the physician was notified and a code was initiated. It was indicated in the note Emergency Medical Services (EMS) arrived and assumed care at approximately 12:50 AM. Documentation indicated the EMS noted the time of death at 12:53 AM.

The Admission Minimum Data Set (MDS) dated 9/5/2017 was partially completed and noted Resident #3 was not assessed for cognition and needed extensive to total assistance for Activities of Daily Living. Resident #3 could eat independently after the tray was set up.

The care plan dated 9/5/2017 noted a focus of risk of hypo / hyperglycemia. One of the interventions was:" Orange juice / honey / sugar / milk etc. to counteract hypoglycemic reaction & notify MD."

On 10/11/2017 at 8:50 AM in a telephone interview, Resident #3's family member stated Resident #3 had lived with her for ten years and she was the care giver for Resident #3. The family member stated Resident #3 was completely alert and oriented, could feed herself and could tell you how she was feeling. The family member also stated Resident #3 could perform a lot of her own care before she fell and fractured her back.

On 10/12/2017 at 12:20 PM in a telephone

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interview, Nurse #1 stated she did not get report from the 11 PM to 7 AM nurse on 9/4/2017. Nurse #1 stated when she got the low blood sugar reading on Resident #3 she asked the RN Supervisor if she should call the physician, and was told the blood sugar for Resident #3 had gone up and down since admission and to give Resident #3 orange juice with sugar to try and raise the blood sugar.

In a telephone interview with the RN Supervisor on 10/12/2017 at 2:15 PM, the Supervisor stated she did not remember Resident #3 or anything about low blood sugar. The RN Supervisor stated if she had been told about a blood sugar of 39 mg/dl, she would have said to call the physician immediately.

On 10/12/2017 at 3:20 PM in an interview, Nurse #3 stated when she checked Resident #3's blood sugar at 4:30 PM on 9/4/2017, and it was 60, she called the on-call physician and got an order for Glucagon for blood sugar less than 60 mg/dl. Nurse #3 stated she did not give the Glucagon because the blood sugar was 60. When the blood sugar was checked at 8:00 PM and noted to be 50 mg/dl, Nurse #3 stated the Glucagon was given one time and the blood sugar was checked again at 10:00 PM and was 60 mg/dl. Nurse #3 stated she faxed information about Resident #3's low blood sugars to the physician, so that he would know Resident #3 was having low blood sugar readings.

On 10/12/2017 at 5:01 PM, in a telephone interview, Nurse #2 stated he had no recollection of the low blood sugar for Resident #3 on 9/4/2017 at 1:06 AM. Nurse #2 stated he was sure that he rechecked the blood sugar after one

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F 157	Continued From page 7 or two hours, but failed to record it. In an interview by telephone on 10/13/2017 at 2:05 PM, the physician stated he did not have any records there in front of him but recalled Resident #3 as having some fractured vertebrae with a lot of pain, COPD and possible pneumonia and Diabetes. The physician stated he would expect to be called if Resident #3 had a blood sugar of 39 mg/dl and he expected a recheck would be done. The physician stated he had no recollection of being called at any time about Resident #3's low blood sugar. The physician stated someone should be called whether it was the on-call physician or not. The Administrator was notified of the Immediate Jeopardy on 10/13/2017 at 1:25 PM. The facility provided a credible allegation of immediate jeopardy removal on 10/13/2017 at 6:43 PM. The Credible Allegation of immediate jeopardy removal indicated: The procedure for implementing the acceptable plan of correction for the specific deficiency cited; An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 10/11/17 and included the Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager and Physician's Assistant, to analyze incident occurring on 9-4-2017. Licensed nurse re-education regarding Notification of changes on 10/11/2017 and continued until 100% of the nurses were educated on 10/13/2017. An Ad Hoc QAPI meeting was conducted on	F 157		

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10/13/2017 and included the Administrator, Director of Nursing, Staff Development Coordinator for Notification of Change and Following MD orders. The Ad hoc committee reviewed F157 IJ and allegation of compliance.

On 10-13-2017 progress notes were reviewed for any changes and contact was made to the MD and RP were necessary.

In-servicing of 100% of all licensed nurses regarding the facility policy on following Physician Orders was completed on 10-13-2017. The education consisted of the fundamental information necessary for transcribing and following physician orders. Any licensed nurse who was not in-serviced will not work and will be removed from the schedule until this in-servicing is completed with them. The certified nursing assistance were educated on reporting notification of change and s/s of hypoglycemia to the licensed nurse this started on 10/13/17 and will continue until all staff educated by the DON. These in-services will be added to the general orientation of all licensed nurses from this point forward.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

To remain in compliance and under the direction of the Administrator, beginning 10-13-17;

The unit managers will review physician order report daily to ensure that orders were followed as written by checking the medication administration record. Director of nursing will

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audit physician order report twice weekly for 12 weeks to validate orders are being followed as written by checking the medication administration record.

Director of Nursing, Unit Managers, Staff Development and Weekend Supervisor will validate the staff's retention of the education presented by conducting education validation audits randomly throughout all three shifts including weekends. Those noted with opportunities will be immediately re-educated. The Administrator and/or Staff Development Coordinator will review these audits weekly for 12 weeks.

The title of the person responsible for implementing the acceptable plan of correction:

Administrator.

The Credible Allegation was validated by:

The survey team reviewed the in-service documentation conducted by the RN Consultant and the Director of Nursing. Licensed Nurses were interviewed and confirmed the in-service information on notification of change and procedure for response to hypoglycemia had been provided and demonstrated their knowledge of the in-service information.

The survey team reviewed the documentation of in-service to all Nursing Assistants on signs and symptoms of hypoglycemia with signs and symptoms listed and to report these to the nurse. Nursing Assistants in the facility were interviewed and confirmed the in-service regarding signs and

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symptoms of hypoglycemia had been provided and they could demonstrate the in-service information.

2-Record review revealed Resident #6 was admitted to the facility on 5/12/2017 with diagnoses which included Hypertension, Diabetes and muscle weakness.

The Admission Minimum Data Set dated 5/19/2017 indicated the resident was moderately cognitively impaired and required extensive assistance of one person for all activities of daily living (ADLs).

Record review of the Physicians orders for Resident #6 revealed an order dated 9/27/2017 to send the resident to the Emergency Department (ED) for evaluation.

Record review of the nursing notes included an entry by Nurse #5 on 9/27/2017 at 4:38 PM. The note revealed Resident #6 was sent to the hospital per the physician orders for evaluation.

An interview was conducted with Resident #6's responsible party (RP) on 10/13/2017 at 10:20 AM. The RP indicated the resident was sent to the hospital on the evening of 9/27/2017. The RP stated she was not notified of the resident being sent to the hospital until the following morning. The RP indicated she was very involved in the resident's care, visited almost daily and was upset because she was not notified when the resident was sent out of the facility. The RP indicated the nursing staff were very aware of the

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interest she had in the resident's care and knew she was to be notified when the resident was sent to the hospital.

An interview was conducted with Nurse #5 on 10/13/2017 at 11:00 AM. Nurse #5 reported she was Resident #6's primary nurse the evening of 9/27/2017. Nurse #5 indicated shortly after she arrived for her shift on the evening of 9/27/2017, the physician called and ordered to send the resident to the ED for evaluation due to some abnormal laboratory results which were sent to his office earlier in the day. Nurse #6 indicated it was an extremely busy evening and she did not remember to call and notify the resident's RP when the resident was sent to the hospital. Nurse #5 stated she knew part of the process for sending any resident to the hospital included notifying the RP. Nurse #5 indicated she worked a double shift on 9/27/2017 and remembered in the early morning hours of 9/28/2017 that the RP was not notified when Resident #6 was sent to the hospital. Nurse #5 indicated she waited until 7:00 AM to call the RP. Nurse #5 stated the RP was very upset that the resident was sent to the hospital at 4:30 PM the day before and no one notified her.

An interview was conducted with the Director of Nursing (DON) on 10/13/2017 at 2:45 PM. The DON indicated she was unaware of any residents being sent to the ED and the RP not notified until the next day. The DON further indicated it was not an acceptable facility practice for the RP not to be notified at the time a resident is sent out for evaluation. The DON stated the expectation was for the responsible party to be notified at the time a resident was sent out of the facility.

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F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to maintain the dignity of residents when staff spoke disrespectfully to two of three residents reviewed for dignity (Resident #4 and Resident #11). Findings included: 1. A review of medical records revealed Resident #11 was admitted on 5/14/2015 and readmitted 9/7/2017 with diagnoses of Parkinson 's disease, seizure disorder, anxiety and depression. The Significant Change Minimum Data Set (MDS) dated 9/28/2017 noted Resident #11 was cognitively intact and had little interest in doing things and felt down, depressed and hopeless nearly every day. The MDS indicated Resident #11 needed supervision to extensive assistance for all Activities of Daily Living with the physical assistance of one to two persons. A review of grievances revealed Resident #11 had filed a grievance against Nurse #7, for being mean to him. The resolution to the grievance was Nurse #7 would be terminated when a replacement was hired. The grievance was signed by the Administrator.	F 241	F241 1. Nurse 7 is no longer employed at Rocky Mount Rehabilitation. Resident #4 and # 11 are being treated with dignity and respect. 2. Residents that reside in the facility have the potential to be affected. Residents were interviewed between 10/20/2017 and 10/26/2017 by Department Heads to ensure residents were being treated with dignity and respect. All residents interviewed voiced being treated with dignity and respect by staff. 3. Facility staff will be educated on resident abuse and customer service guidelines by the Director Of Nursing/designee by 11/6/2017. Random residents will be interviewed 5x weekly for 4 weeks to ensure all are treated with dignity and respect by the Social Worker/designee then 3x weekly for 4 weeks. 4. Findings from these interviews will be submitted to the Quality Assurance	11/6/17

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F 241	Continued From page 13 On 10/11/2017 at 2:55 PM, in an interview, NA #2 stated she had heard Nurse #7 talk bad to residents and residents had told her that Nurse #7 talked bad to them. On 10/11/2017 at 4:15 PM, in an interview, the facility Administrator was asked what the resolution to the grievance meant. The Administrator stated "Well, her nursing skills are fine, it is her customer service that needs improvement." The Administrator stated Nurse #7 had been reeducated more than one time, but now the grievance had gone through the corporate office. On 10/12/2017 at 2:55 PM, Resident #11 stated he had filed a grievance against Nurse #7 because she was "mean" to him. Resident #11 stated when Nurse #7 was mean to him he felt "bad, I felt real bad." 2. A review of medical records revealed Resident #4 was admitted on 7/24/2017 with diagnoses of chronic obstructive pulmonary disease (COPD), joint pain, anxiety and depression. The Admission Minimum Data Set (MDS) dated 7/31/2017 noted Resident #4 to be cognitively intact and needed extensive assistance for all Activities of Daily Living with the physical assistance of one to two persons. A review of the medical record revealed Resident #4 had a suprapubic indwelling catheter. On 10/11/2017 at 1:35 PM, in an interview, Resident #4 stated Nurse #7 had been very hateful to her and Nurse #7 was hateful to	F 241	Committee for further review and recommendations monthly for a minimum of 3 months and quality monitoring will be modified based on the findings.	

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Nursing Assistant #1 also. Resident #4 stated she had a catheter and her physician told her she should be careful, if the catheter was pulled out she would have to have surgery, therefore, she needed someone to assist her to and from the bathroom. Resident #4 indicated NA #1 took her into the bathroom and told her to pull the call bell cord when she was finished and NA #1 would come back to assist her out of the bathroom. Resident #4 stated she finished in the bathroom and pulled the call bell cord and Nurse #7 came in and said" We don't have time to wait on you like that." Resident #4 stated she was upset and felt like she should have done more for herself, like she was doing wrong.

On 10/11/2017 at 2:30 PM, in a telephone interview, the family member of Resident #4 stated Nurse #7 was not nice to the residents. The family member stated Resident #4's catheter was leaking and the Resident told NA #1. The family member stated NA #1 said that she would tell the 3PM - 11PM nurse, but the catheter was leaking and Resident #4 was getting wet. The family member noted resident #4 told the family member that NA #1 did tell Nurse #7 who came into the room and said "what did you do now?" The family member stated she had seen Nurse #7 roll her eyes at something Resident #4 said, but Nurse #4 did not disrespect Resident #4 in front of the family member.

On 10/11/2017 at 2:55 PM, in an interview, NA #2 stated she had heard Nurse #7 talk bad to residents and residents had told her that Nurse #7 talked bad to them.

A review of grievances on 10/11/2017 revealed a grievance had been filed against Nurse #7 by a

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F 241	Continued From page 15 resident in the facility. A review of the grievance investigation revealed the resident stated Nurse #7 had been mean to him on more than one occasion. The resolution to the grievance stated: "Employee will be terminated when replacement is hired." On 10/11/2017 at 4:15 PM, in an interview, the facility Administrator was asked what the resolution meant. The Administrator stated "well, her nursing skills are fine, it is her customer service that needs improvement." The Administrator stated Nurse #7 had been reeducated more than one time, but now the grievance had gone through the corporate office. When the Administrator was informed of Resident #4's statement, the Administrator stated he was suspending Nurse #7 immediately. The Administrator stated he expected staff to treat residents with dignity.	F 241		
F 309 SS=J	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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 well-being, consistent with the resident's comprehensive assessment and plan of care. 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	F 309		11/6/17

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F 309	Continued From page 16 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: (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. (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 family, staff and physician interview and record review, the facility failed to provide interventions to manage diabetic care for one of one residents reviewed with Diabetes (Resident #3) when the Resident had recurring low blood sugars over a 24-hour period. The Resident expired in the facility. Immediate Jeopardy began 9/4/2017, when Nurse #2 noted Resident #3 complained of weakness. Nurse #2 checked Resident #3's blood sugar and documented it as 39 milligrams per deciliter (mg/dl) and would be rechecked. Resident #3's blood sugar was not documented as rechecked. Resident #3 expired in the facility on 9/5/2017. Immediate Jeopardy was removed on 10//13/2017, when the facility provided a	F 309	F309 Resident #3 no longer resides in the facility. Residents that reside in the facility have the potential to be affected by failure to manage diabetes. On 10-11-2017 and 10-12-2017 residents residing in the facility were assessed to ensure adequate orders for diabetic management were in place as it relates to outlined parameters and MD orders by the Director of Nursing. In-servicing of licensed nurses regarding diabetic management, following Physician orders, and notification of change was completed on 10-13-2017 by the staff	

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F 309	Continued From page 17 Credible Allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and to ensure monitoring systems are in place that are effective. Findings included: A review of the medical record revealed Resident #3 was admitted to the facility from a local hospital on 9/1/2017 with diagnoses of fractured vertebrae, low back pain, chronic obstructive pulmonary disease (COPD), Type II Diabetes Mellitus. The hospital discharge summary dated 9/1/2017 was reviewed and revealed Resident #3 was noted to have documented hypoglycemia and Levemir (long acting insulin) on hold. Included in the discharge summary was information stating Glyburide (oral medication for Type II diabetes control) was discontinued. The admission assessment dated 9/1/2017 noted Resident #3 understands and is understood. Resident is alert. Resident needed set up help only for eating. There was no interim care plan noted. A review of the signed physician orders for Resident #3 dated 9/1/2017 revealed the diabetic medications were: Levemir (long acting insulin) 15 units subcutaneously (under the skin) daily, Glyburide (oral medication for Type II diabetes control) 3 milligrams (mg) by mouth (po) twice daily and Metformin (oral medication for Type II diabetes control) 500 mg po twice daily. Also	F 309	development coordinator and the Director of Nursing. The Unit managers will review progress notes daily to capture significant changes and ensure there is MD/RP notification. The Director of Nursing will audit progress notes twice weekly for 12 weeks to validate notification and documentation. The Director of Nursing will pull the report for all diabetic blood glucose readings daily for 12 weeks to ensure that any levels that are not therapeutic have MD notification and interventions in place. Findings from the audits will be reviewed in the monthly quality assurance committee and quality monitoring will be modified based on the findings.	

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listed was a standing order for Novolog (rapid acting insulin) to be injected three times daily before meals with the dose depending on a blood sugar check and ordered by a sliding scale (blood sugar 0-199 = 0 units insulin and blood sugar below 60 call physician (MD), 200 - 300 = 5 units insulin; 301 - 400 = 10 units insulin; 401 - 450 =15 units insulin, 451 - 500 = 20 units insulin; above 500 Call MD.

Progress notes were reviewed for Resident #3 and revealed a Medication Administration Note dated 9/2/2017 which indicated Glyburide 3 mg was on order.

A review of the Medication Administration Record (MAR) revealed blood sugars were checked for Resident #3 before meals and at bedtime. Documentation in the MAR indicated on 9/2/2017 Resident #3 had blood sugars of 84 mg/dl, 100 mg/dl, 139 mg/dl, 165 mg/dl and no insulin was given. The MAR noted on 9/3/2017 blood sugars were recorded as 101 mg/dl, 90 mg/dl, 84 mg/dl, 87 mg/dl and no insulin was recorded as given. On the MAR dated 9/4/2017 Resident #3 had documentation of blood sugars of 52 mg/dl, 81 mg/dl, 60 mg/dl, 50 mg/dl and no insulin was noted as given.
The MAR further indicated Resident #3 refused the Levemir insulin on 9/2/2017, the MAR indicated the Levemir was given on 9/3/2017 and was held on 9/4/2017. According to the MAR Resident #3 received the Glyburide twice on 9/3/2017 and once on 9/4/2017. Metformin was indicated in the MAR as refused for the AM dose on 9/2/2017, the PM dose was given, two doses were given on 9/3/2017, and both doses were indicated to have been held on 9/4/2017.

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A review of progress notes revealed a note on 9/4/2017 at 1:06 AM which stated Resident #3 complained of weakness. Resident's blood sugar was checked and documented at 39 milligrams per deciliter (mg/dl). Documentation indicated Resident #3 was given 2 cups apple juice and pudding and the blood sugar would be rechecked. This note was written by Nurse #2.

On 10/12/2017 at 5:01 PM, in a telephone interview, Nurse #2 stated he had no recollection of the low blood sugar for Resident #3 on 9/4/2017 at 1:06 AM. Nurse #2 stated he was sure that he rechecked the blood sugar after one or two hours, but failed to record it. Nurse #2 stated the blood sugar must have been normal when he rechecked it or he would have called the physician.

A review of a Medication Administration Note written by Nurse #1 on 9/4/2017 at 8:05 AM noted 240 cubic centimeters (cc) orange juice with sugar was given and documented in the note was the 8:30 AM blood sugar was rechecked to be 59 mg/dl.

On 10/12/2017 at 12:20 PM in a telephone interview, Nurse #1 stated she did not get report from the 11 PM to 7 AM nurse on 9/4/2017. Nurse #1 stated when she got the low blood sugar reading on Resident #3, which was documented to be 52 mg/dl at 8:30 AM on 9/4/2017, she asked the RN Supervisor if she should call the physician, and was told the blood sugar for Resident #3 had gone up and down since admission and to give Resident #3 orange juice with sugar to try and raise the blood sugar. Nurse #1 stated she did not call Resident #3's MD to report the Resident's blood sugar was below 60

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mg/dl on 9/4/2017 at 8:30 AM.

A review of a Medication Administration Note dated 9/4/2017 at 9:10 AM indicated long acting insulin was not administered due to blood sugars of 39 - 59. Documentation was by Nurse #1.

A review of a Daily Skilled Note written by Nurse #1, on 9/4/2017 at 4:00 PM revealed documentation of Resident #3 had blood sugar checks 4 times and no insulin coverage. Nurse #1 noted the blood sugar at 8:30 AM was 82 mg/dl and was rechecked to register 59 mg/dl and orange juice with sugar was given. The note also documented Resident #3 had a blood sugar of 81 mg/dl at 11:30 AM and another check at 1:00 PM noted the blood sugar was 53 mg/dl and orange juice with sugar was documented as given and the blood sugar was noted to be up to 64 mg/dl and Nurse #1 indicated Resident #3 was alert and oriented.

A review of a Medication Administration Note dated 9/4/2017 at 5:00 PM written by Nurse #3 revealed documentation the Metformin 500 mg had been held due to a low blood sugar of 60 mg/dl. and indicated Resident #3 was given orange juice and sugar.

A Health Status note was reviewed, dated 9/4/2017 at 5:32 PM by Nurse #3. The note indicated Resident #3's blood sugar was 60 mg/dl at 4:30 PM. The note described the resident as alert, verbal with the complaint of feeling bad. The note also indicated Resident #3 was talking on the phone with a family member. The on-call Physician was notified and an order was obtained to administer Glucagon for blood sugar less than 60 mg/dl. The note further indicated Resident #3

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was notified of the order.

An additional Health Status note was reviewed, written by Nurse #3, on 9/4/2017 at 11:44 PM. The note stated Resident #3's blood sugar was 50 mg/dl at 8:00 PM. Glucagon was given one time Intra Muscular (IM) and at 10:00 PM Resident #3's blood sugar was 60 mg/dl. This note also documented Resident #3 as being alert and verbal and having skin warm and dry to touch. The note indicated a fax was sent to the physician with information about Resident #3 having low blood sugars.

A Health Status note written by Nurse #4 on 9/5/2017 at 2:07 AM was reviewed and revealed documentation that a nurse entered Resident #3's room and called to Resident #3 who did not respond. The note indicated the blood sugar was checked at 12:35 AM and was 36 mg/dl. Also noted was the Nurse called for assistance and another nurse administered Glucagon at 12:37 AM and Resident #3's blood sugar was documented at 54 mg/dl. Nurse #4 also documented a nurse called 911, the physician was notified and a code was initiated. It was indicated in the note Emergency Medical Services (EMS) arrived and assumed care at approximately 12:50 AM. Documentation indicated the EMS noted time of death at 12:53.

A review of the Emergency Medical Services report dated 9/5/2017 revealed Resident #3 was pulseless
and had no respirations when they arrived. The EMS documented leads were applied to Resident #3's chest to record heartbeat, but no heartbeat was present and extremities were cold. The report noted Resident #3 was not transported to

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the hospital and the physician was notified to allow EMS to pronounce Resident #3 dead. The report indicated the facility would contact the funeral home to transport the body.

On 10/11/2017 at 8:50 AM in a telephone interview, Resident #3's family member stated Resident #3 had lived with her for ten years and she was the care giver for Resident #3. The family member stated Resident #3 was completely alert and oriented, could feed herself and could tell you how she was feeling. The family member also stated Resident #3 could perform a lot of her own care before she fell and fractured her back. The family member stated Resident #3 was interested in lots of different things and was not like most people of the same age. The family member stated Resident #3 would refuse her diabetic medication in the facility because it had been discontinued when she was at home. Resident #3's family member stated when Resident #3 had low blood sugar, she would sometimes, have cold sweat on her skin, or may act as though she was sleepy while having a conversation.

On 10/12/2017 at 2:15 PM a telephone interview was conducted with the RN Supervisor who worked on 9/4/2017 during the 7:00 AM to 3:00 PM shift. The RN Supervisor stated she did not remember Resident #3 or anything about low blood sugar. The RN Supervisor stated if she had been told about a blood sugar of 39, she would have said to call the physician immediately.

On 10/12/2017 at 3:20 PM in an interview, Nurse #3 stated when she checked Resident #3's blood sugar at 4:30 PM on 9/4/2017, and it was 60 mg/dl, she called the on-call physician and got an

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order for Glucagon for blood sugar less than 60 mg/dl. Nurse #3 stated she did not give the Glucagon because the blood sugar was 60. When the blood sugar was checked at 8:00 PM and noted to be 50 mg/dl, Nurse #3 stated the Glucagon was given one time and the blood sugar was checked again at 10:00 PM and was 60 mg/dl. Nurse #3 stated she faxed information about Resident #3's low blood sugars to the physician, so that he would know Resident #3 was having low blood sugar readings. Nurse #3 stated she did not know if a response was received from the MD.

In an interview by telephone on 10/13/2017 at 2:05 PM, the physician stated he did not have any records there in front of him but recalled Resident #3 as having some fractured vertebrae with a lot of pain, COPD and possible pneumonia and Diabetes. The physician stated he would expect to be called if Resident #3 had a blood sugar of 39 mg/dl and he expected a recheck would be done. The physician stated he had no recollection of being called at any time about Resident #3's low blood sugar. The physician stated someone should be called whether it was the on-call physician or not and he expected to be called if a blood sugar was below 60 mg/dl.

The Administrator was notified of the Immediate Jeopardy on 10/13/2017 at 1:25 PM.

The facility provided a credible allegation of immediate jeopardy removal on 10/13/2017 at 6:28 PM. The credible allegation of immediate jeopardy removal indicated:

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The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 10/11/17 and included the Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager and Physician's Assistant, to analyze incident occurring on 9-4-2017. Licensed nurse re-education regarding Diabetic Management began on 10/11/2017 and continued until 100% of the nurses were educated on 10/13/2017.

An Ad Hoc QAPI meeting was conducted on 10/13/2017 and included the Administrator, Director of Nursing, Staff Development Coordinator for Notification of Change and Following MD orders. The Ad hoc committee reviewed F309 IJ and allegation of compliance.

On 10-11-2017 and 10/12/2017 residents residing in the facility were assessed to ensure adequate orders for diabetic management as it relates to outlined parameters and MD notification completed by DON and nursing management. Residents with diabetes were also reviewed to ensure that orders were in place for interventions to be initiated if and when their blood sugar level was found to be in non-therapeutic range.

In-servicing of 100% of all licensed nurses regarding the facility policy on following Physician Orders, Notification of Change, and Hypoglycemia was completed on10-13-17, by the Staff Development Coordinator and the Director of Nursing. The education consisted of the

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ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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definition of significant change: Significant change is defined as a decline in the resident's medical status to include decline in cognition, decline in activities of daily living, and any condition causing further impairment. The licensed nurses were also in-serviced regarding the process for transcribing physician orders to the electronic medical record. Any licensed nurse who was not in-serviced will not work and will be removed from the schedule until this in-servicing is completed with them. The certified nursing assistance were educated on reporting notification of change and s/s of hypoglycemia to the licensed nurse this started on 10/13/17 and will continue until all staff educated by the DON. These in-services will be added to the general orientation of all licensed nurses from this point forward.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

To remain in compliance and under the direction of the Administrator, beginning 10-13-17;

The unit managers will review progress notes daily to capture any significant changes and ensure there is MD/RP notification. DON will audit progress notes twice weekly for 12 weeks to validate notification and documentation of assessments. DON will pull report of all diabetic blood sugar readings daily to ensure that any levels that are not therapeutic have MD notification and interventions in place. The licensed nurse has had disciplinary action in place of 10/13/2017.

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Director of Nursing, Unit Managers, Staff Development and Weekend Supervisor will validate the staff's retention of the education presented by conducting education validation audits randomly throughout all three shifts including weekends. Those noted with opportunities will be immediately re-educated. The Administrator and/or Staff Development Coordinator will review these audits weekly for 12 weeks.

The title of the person responsible for implementing the acceptable plan of correction:

Administrator.

The credible allegation was validated by:

The survey team reviewed the documentation for in-service for licensed nurses began on 10/13/2017 and is ongoing. The in-service included:
Signs and symptoms of hypoglycemia (this was in-serviced to facility Nursing Assistants and validated via interviews by the survey team.)
Procedure was explained for testing blood sugar, treating the immediate need for glucose and notification of the physician.
The survey team reviewed the in-service documentation conducted by the RN Consultant and the Director of Nursing. Licensed Nurses were interviewed and confirmed the in-service information on diabetic management and procedure following identification of hypoglycemia by interviews with licensed nurses who could demonstrate knowledge of the information provided by the in-service on diabetic

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F 309	Continued From page 27 management and treatment procedures for hypoglycemia.	F 309		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to have a medication error rate below 5% as evidenced by 2 medication errors out of 26 opportunities which resulted in a medication error rate of 7.7% for 1 of 3 residents observed during medication pass (Resident #5). Findings included: Resident #5 was admitted to the facility on 12/16/16. His active diagnoses included hypertension, hyperlipidemia, and insomnia. Review of Resident #5's physician's orders revealed on 4/5/17 an order was written for the resident to receive Calcium Carbonate 500 milligrams three times a day. On 4/5/17 Resident #5 was also ordered Vitamin B-12 1,000 micrograms daily. Review of Resident #5's current physician's orders on 10/13/17 revealed both of these medication orders were still in place as originally written. During a medication administration observation	F 332	F332 1. Nurse #5 is no longer employed at Rocky Mount Rehabilitation. Resident #5 medications have been reviewed by physician and Resident #5 is receiving his calcium carbonate and vitamin B-12 as ordered. 2. Residents that reside in the facility have the potential to be affected. Residents with orders for calcium carbonate and vitamin b 12 will be reviewed by 11-3-2017 to ensure the medications are available and are being administered as per physician's order. 3. Licensed nurses will be re-educated on proper medication administration by the Director of Nursing/designee on 10/27/17. The DON/designee will conduct random medication administration observations 5X weekly for 4 weeks, then 3 times a week for 4 weeks to ensure proper medication administration.	11/6/17

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F 332	Continued From page 28 on 10/13/17 at 9:02 AM, Nurse #5 was observed to give Resident #5 1,000 milligrams of Calcium Carbonate and 500 micrograms of Vitamin B-12. During an interview on 10/13/17 at 10:18 AM, Nurse #5 stated that she gave Resident #5 1,000 milligrams of Calcium Carbonate. After checking the physician's order, she stated she needed to get clarification of the order but believed it could have been a medication error. She further stated that she should have given one more Vitamin B-12 500 microgram tablet to Resident #5 for the dose to be correct. She further stated she would give the second tablet to Resident #5 immediately. During an interview on 10/13/17 at 10:32 AM the Director of Nursing stated that Resident #5 should have received 500 milligrams of Calcium Carbonate during the medication administration pass of 10/13/17 and the dose of 1,000 milligrams which was administered by Nurse #5 was incorrect. She further stated that the 500 microgram dose of Vitamin B-12 Resident #5 was given by Nurse #5 was incorrect as well. The Director of Nursing further stated it was her expectation that the medication error rate would be less than 5% and that medications would be administered per the physician's order.	F 332	4. Findings from the observations will be submitted to the Quality Assurance Committee for further review and recommendations monthly for a minimum of 3 months and quality monitoring will be modified based on the findings.	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		11/6/17

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law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of

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F 431	Continued From page 30 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to keep an unattended medication cart locked for 1 of 4 medication carts reviewed (North Wing Medication Cart). Findings included: During observation on 10/13/17 at 2:27 PM the North Wing Medication Cart was observed to be at the nurse's station unlocked and unattended. Three visitors were observed to pass by the unlocked medication cart at 2:28 PM. At 2:29 PM, Nurse #4 returned to the medication cart and pulled open a drawer without having to unlock the medication cart. During an interview on 10/13/17 at 2:30 PM Nurse #4 stated that the North Wing Medication Cart was his medication cart. He further stated that it was the policy of the facility that medication carts be locked when out of the nurses' eyesight and the medication cart should have been locked and was not. During an interview on 10/13/17 at 2:40 PM the Director of Nursing stated that it was her expectation that when medication carts were not in the nurses' line of sight, they would be locked at all times.	F 431	F431 1. Nurse #4 was educated on keeping med cart locked when it is unattended. 2. This has the potential to affect all residents. An audit was conducted by the Director of Nursing on 11/3/17 to ensure all medication carts are secured when unattended. All medication carts were noted to be properly locked. 3. Nursing staff will be educated on properly securing medication carts by Staff Development Coordinator by 10/19/17. Staff Development Coordinator/designee will perform med cart audits 5 days a week for 4 weeks then 3 days a week for the next month. 4. Results of weekly med cart audits will be submitted to the Quality Assurance Committee for further review and recommendations monthly for a minimum of 3 months and quality monitoring will be modified based on the findings.	