STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted from 8/20/2018 through 8/23/20018. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity J CFR 483.10 at tag F580 at a scope and severity J The tags F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/14/2018 and was removed on 8/23/2018. An extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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); (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).	F 580		10/2/18

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

Electronically Signed | 09/05/2018

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F 580	Continued From page 1 (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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner, physician interviews, and dialysis staff interviews, the facility failed to notify a physician to report a resident with a high blood glucose level for 1 of 7 residents reviewed for diabetic management (Resident #1). Resident #1 experienced sustained high blood glucose levels which resulted in a hospitalization for diabetic ketoacidosis (a serious complication of diabetes).	F 580	F580 1. The plan should address the processes that lead to the deficiency cited: Resident #1 has had physician orders related to diabetic management as follows: On 8/3/18 reads as follows:	

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F 580	Continued From page 2 Immediate jeopardy began on 8/14/2018 when Nurse #1 failed to notify a physician of a blood glucose level which was elevated above 450 milligrams per deciliter (mg/dl) and administered insulin without a physician order. The Immediate Jeopardy was removed on 8/23/2018 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to notifying physician of resident changes. Findings included: A review of the facility policy titled "Physician Services" with a revision date of November 2017 revealed an on-call physician service was available for "times when the attending physician is not generally available", for example after 6:00 PM and on the weekends before noon. Resident #1 was admitted to the facility on 12/22/2017 with diagnoses to include diabetes, end stage renal disease, high blood pressure and dementia. A review of the medical record revealed Resident #1 received dialysis treatment three times per week on Tuesday, Thursday and Saturday. A review of the care plans for Resident #1 revealed a care plan in place dated 1/11/2018 and revision date of 2/28/2018 that addressed her diagnosis of Diabetes and non-compliance with dietary choices, with interventions to include report all signs and symptoms of hyperglycemia	F 580	Check fasting blood sugar one-time a day at 3 am. Novolog 10 unit before meals, and per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 15 units; 401 - 450 = 18 units; 451+ = 20 units, after meals and at bedtime. A new order dated 8/9/18 read as follows: Novolog 6 unit subcutaneously before each meals AND Inject as per sliding scale: if 0 - 60 Notify NP/MD; 61 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units & recheck FSBS in 2 hours; if FSBS still > 400, notify NP/MD; 451+ Notify NP/MD, subcutaneously before meals and at bedtime. On August 18, 2018 at approximately 3:13 am Nurse #1 obtained FBS of 454 and administered 20 units of Novolog insulin based on previous instruction from physician, however she did not notify the physician of the results or receive any new orders. Nurse # 1 rechecked FBs at 6:45 am of 531 and administered 20 units of Novolog. Nurse # 4 obtained FBS at 9:30 am of 450 and administered 10 units of Novolog sliding scale and 6 units of scheduled 70/30 per order (8-9-18). Nurse #4 reported to Dialysis the fasting blood sugar of 450 at 9:30 are and insulin coverage per dialysis communication	

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F 580	Continued From page 3 (high blood glucose) to the physician and administer medications for diabetes as ordered by the physician. A review of the training attendance log dated 6/22/2018 for the in-service entitled "Changes in Condition" was signed as attended by Nurse #1 and Nurse #2. The most recent quarterly Minimum Data Set (MDS) dated 7/10/2018 assessed Resident #1 to be cognitively intact without behaviors or rejection of care. The medical chart was reviewed, and physician orders dated 8/3/2018 revealed an order to check Resident #1 ' s blood glucose level before meals, at bedtime and as needed. A physician order dated 8/9/2018 specified blood glucose to be checked at 3:00 AM daily due to unstable blood glucose levels. There were no orders to administer insulin at that time. There was no stop date on the order. A physician order dated 8/9/2018 for Novolog insulin, inject subcutaneously before meals and at bedtime per sliding scale: blood glucose results 0-60 notify nurse practitioner (NP) or physician (MD); 201-250 mg/dl, inject 2 units of Novolog insulin; 251-300 mg/dl, inject 4 units of Novolog insulin; 301-350 mg/dl, inject 6 units of Novolog insulin; 351-400 mg/dl, inject 8 units of Novolog insulin; 401-450 mg/dl; inject 10 units of Novolog insulin and recheck blood glucose, if remained above 400 mg/dl call NP/MD, if greater than 451 mg/dl, notify NP/MD. The nursing notes were reviewed, and a note	F 580	form. On August 18, 2018 approximately 10:30 am resident transported to dialysis Center by wheelchair. Nurse # 4 reports per progress note dated 8-18-18 resident alert and oriented but complained of lower back pain . Tylenol was administrated per resident request. Nurse # 4 received call from resident #1 husband at approximately 2 pm to inform the facility that dialysis was transferring resident to the hospital. Nurse # 4 called Dialysis to determine if resident was transferred to the hospital. The Dialysis center informed facility resident was transferred to the hospital due to pain on left side and resident request to be transferred to the hospital. Resident #1 was admitted to the hospital with admitting diagnosis of Diabetic Ketoacidosis. Nurse #1 was suspended on 8/23/18. A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) which included the Administrator (NHA), the Director of Nursing (DON), the Nurse Manager, and the District Director of Clinical Services on 8/23/18 and it was determined that Nurse #1 did not have physician orders for resident #1 to administer Novolog Insulin 20 units on August 18 2018. Nurse #1 failed to notify the attending physician on August 18, 2018 per the physician order. The root cause analysis identified that Nurse #1 failed to review Resident #1 physicians	

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F 580	Continued From page 4 dated 8/13/2018 written by Nurse #1 noted a blood glucose result of 533 mg/dl at 3:00 AM. The note documented contacting the on-call physician (MD #2) and the order of 20 units of Novolog insulin to be administered and the blood glucose to be monitored. A note written by MD #2 on 8/13/2018 at 3:50 AM documented a one-time order had been given to administer 20 units of Novolog insulin and to monitor the blood glucose for Resident #1. The nurse documented at 6:07 AM the blood glucose had been rechecked at 6:00 AM with a "High" result. Nurse #1 documented she administered 20 units of Novolog insulin. Nurse #1 documented "no sign/symptoms of diabetic distress observed." There was no physician contact documented in the medical record for the documented blood glucose level of "High" at 6:00 AM 8/13/2018. There was no further documentation by MD #2 in the patient progress notes after 8/13/2018 to indicate the on-call service had been notified of an elevated blood glucose. A note dated 8/14/2018 at 6:07 AM written by Nurse #1 documented a blood glucose result of "High" and the administration of 20 units of Novolog insulin by sliding scale at that time. Nurse #1 documented "NAD" (no apparent distress) in her note. The medical record contained no information that the physician was notified of Resident #1 ' s blood glucose of "High". A nursing note dated 8/15/2018 at 3:19 AM written by Nurse #1 documented a blood glucose reading of "High" at 3:00 AM. Nurse #1 documented the administration of 20 units of Novolog insulin "per sliding scale" and that Resident #1 had NAD noted. The medical record contained no information that the physician had been notified on 8/15/2018 of Resident #1 ' s	F 580	orders prior to administration of Novolog insulin 20 units. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All residents who have physician orders to perform fasting blood sugar and /or insulin administration have a potential to be affected by this alleged deficient practice. On 8/23/18 the Director of Nursing and Nurse Managers conducted an audit of residents identified with orders for insulin and/or obtaining fasting blood sugars for the last 30 days to validate FBS and insulin administration was completed according to the current physicians orders. The twenty four hour reports and physician orders were reviewed by the Director of Nursing and Nurse Managers to ensure residents that have a change in condition during the last 30 days had been identified and appropriate action had been taken. The resident's medical records were then reviewed by the Director of Nursing and Nurse Managers to validate there is nursing documentation present supporting the completion of a nursing assessment following of a significant change in condition and notification to the Physician following the significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review. On August 13, 2018 at approximately 3:00 am Nurse 1 obtained fasting blood sugar	

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F 580	Continued From page 5 blood glucose level of "High". A nursing note dated 8/15/2018 at 6:36 AM written by Nurse #1 documented a blood glucose of 508 mg/dl at 6:00 AM. The nurse administered 20 units of Novolog insulin "per sliding scale" and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/15/2018 of Resident #1 ' s blood glucose level of 508 mg/dl. A nursing note dated 8/16/2018 at 6:36 AM written by Nurse #1 documented a blood sugar result of 485 mg/dl at 6:30 AM, the administration of 20 units of Novolog insulin and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/16/2018 of Resident #1 ' s blood glucose level of 485 mg/dl. Nurse #1 wrote a note dated 8/18/2018 at 3:16 AM that documented a blood glucose result of 454 mg/dl at 3:00 AM, the administration of 20 units of Novolog insulin and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/18/2018 at 3:16 AM of Resident #1 ' s blood glucose level of 454 mg/dl. A nursing note dated 8/18/2018 at 6:52 AM written by Nurse #1 revealed a blood glucose result of 531 mg/dl at 6:30 AM. Nurse #1 documented the administration of 20 units of Novolog insulin and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/18/2018 at 6:52 AM of Resident #1 ' s blood glucose level of 531	F 580	(FBS) reading of HIGH for Resident #1. Nurse #1 contacted Tele Health physician services and order was received to administrated Novolog 20 units insulin (subq). At approximately 6:00 am on August 13, 2018 Nurse #1 rechecked the resident fasting blood sugar (FBS) with reading of High. Nurse #1 administrated 20 units of Novolog insulin (subq). On August 15, 2018 at approximately 3:00 am Nurse #1 obtained fasting blood sugar reading of HIGH on Resident #1. August 15, 2018 at approximately 6:00 am Nurse #1 obtained fasting blood sugar of 508. Nurse #1 administrated 20 units of Novolog (subq). On 8/23/18 The Director of Nursing and Nurse Managers re-educated current Licensed Nurses regarding the facility policy for Changes in Resident Condition, with a focus on assessment following HIGH blood sugar or blood sugar that is outside physician order parameter. The re- education of current Licensed Nurses also included the 5 steps regarding medication administration, to include validation of resident physician orders prior to administration of insulin, or performing of fasting blood sugars. twenty-two of the facility's licensed nurses received the in-service as of 8/23/18. No staff shall work after 8/23/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work	

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F 580	Continued From page 6 mg/dl. A nursing note written by Nurse #2 dated 8/18/2018 at 3:00 PM documented the blood glucose result of 450 mg/dl at 10:30 AM. Nurse #2 documented administration of 20 units of Novolog insulin via sliding scale orders dated 8/9/2018 and communication of the blood glucose results to the dialysis treatment center. The medical record contained no information that the physician had been notified on 8/18/2018 by Nurse #2 for Resident #1 ' s blood glucose result of 450 mg/dl. A review of the hospital records revealed Resident #1 was admitted to the hospital for recurrent diabetic ketoacidosis (DKA) on 8/18/2018 and received intravenous fluids and intravenous insulin to reduce her blood glucose level. The admission note for the hospitalization dated 8/18/2018 revealed the resident was admitted with abdominal pain, chest discomfort and shortness of breath. Blood glucose level at 5:12 PM was 520 and at 6:58 PM was 581 mg/dl. She was admitted to the Intensive Care Unit for continual monitoring and treatment of DKA with intravenous insulin. Resident #1 was discharged back to the facility on 8/21/2018. The resident ' s primary physician (MD #1) was interviewed on 8/21/2018 at 8:57 AM. MD #1 reported Resident #1 was non-compliant and had unstable blood glucose control. He was not aware that the on-call MD had not been notified of elevated blood glucose levels for Resident #1. An interview was conducted with NP #1 on 8/21/2018 at 2:26 PM. She reviewed the order for sliding scale insulin dated 8/9/2018 and stated that the physician or nurse practitioner should	F 580	after 8/23/18. 3. 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: On 8/24/18 a new process will be initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of Nursing and Nurse Managers, of residents identified with physician orders for fasting blood sugars and/or insulin to validate the following process was completed as implemented. -The attending physician was notified of fasting blood sugar outside physician order parameters and/or change condition -The physician orders for fasting blood sugars and/or insulin are being followed. -Residents receiving insulin and/or fasting blood sugars had current physician orders. -The Director of Nursing will report the results of this monitoring during the monthly QAPI meeting and the committee will make recommendations as needed. 4. Facility Administrator is responsible for implementing this acceptable plan of correction.	

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have been notified of the blood glucose results that were over 450 on 8/14/2018, 8/15/2018, 8/16/2018 and 8/18/2018. She further reported it was her expectation that MD or NP were notified of elevated blood glucose in a diabetic resident due to the potential for complications related to elevated blood glucose levels.

Nurse #1 was interviewed on 8/22/2018 at 9:19 AM via phone call. Nurse #1 reported she had been assigned to Resident #1 on 8/13/2018, 8/14/2018, 8/15/2018, 8/16/2018 and 8/18/2018 on the third shift (11:00 PM to 7:00 AM). Nurse #1 reported she checked Resident #1 ' s blood glucose at 3:00 AM every night she worked because Residents #1 ' s blood glucose was unstable and sometimes she would have very low blood glucose levels or very high blood glucose levels. Nurse #1 reported that a "High" reading usually indicated a blood glucose over 500 mg/dl. Nurse #1 reported she had called the on-call physician service on 8/13/2018 at 3:25 AM and was asked by the on-call physician (MD #2) about Resident #1 ' s sliding scale. Nurse #1 reported she conveyed the amount of insulin to be administered to Resident #1 for blood glucose over 400 mg/dl and MD #2 instructed her to give 20 units of insulin. Nurse #1 went on to explain she thought that because MD #2 had ordered insulin according to the sliding scale, she had not written a physician order. Nurse #2 reported that she felt MD #2 had told her to use the sliding scale insulin protocol for blood glucose results in the future. Nurse #1 concluded by reporting she had not written a physician order to use the sliding scale insulin protocol for the 3:00 AM blood glucose checks and she had used the facility sliding scale insulin protocol to administer 20 units of insulin when Resident #1 ' s blood glucose was above 450 mg/dl during her shift

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because she did not want to bother the on-call physician.

An interview via phone call was conducted with MD #2 and MD #3 on 8/22/2018 at 11:28 AM. MD #2 reported she was the physician on-call the night of 8/13/2018 and she had given the order to cover the blood glucose result of 533 with 20 units of Novolog insulin. MD #2 went on to explain she had asked Nurse #1 to read the sliding scale to determine the amount of insulin to administer to Resident #1. MD #2 went on to explain she had not given an order to use the sliding scale insulin orders for future 3:00 AM blood glucose checks and her expectation was staff would call for orders for blood glucose results obtained at 3:00 AM. MD #3 added the on-call service was contracted by the facility was to be used for off-hour physician contact for any issues, and he reported it was his expectation that nursing staff would call the on-call agency to provide care for residents during physician off-hours.

Nurse #2 was interviewed on 8/22/2018 at 12:00 PM. Nurse #2 reported she worked day shift (7:00 AM to 3:00 PM) on 8/18/2018 and had received report from Nurse #1 at the beginning of her shift. Nurse #2 reported she had checked the blood glucose two hours after the 6:30 AM blood glucose at 8:30 AM and it was 450. Nurse #2 administered insulin as ordered on the sliding scale orders dated 8/9/2018. Nurse #2 went on to explain the orders for sliding scale insulin on 8/9/2018 ordered for a physician to be called if the blood glucose was more than 450, so she had administered the ordered insulin and had not called a physician. Nurse #2 concluded by reporting Resident #1 had complained of back pain, and she administered Tylenol prior to

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Resident #1 leaving for dialysis treatment.

The dialysis center nurse (Dialysis Nurse #1) was interviewed via phone call on 8/22/2018 at 12:54 PM. She reported she was very familiar with Resident #1 and had been assigned to her to provide dialysis treatment on 8/18/2018. Dialysis Nurse #1 reported that Resident #1 told her she did not feel well and wanted to go to the hospital upon her arrival at the dialysis center on 8/18/2018. The nurse went to describe the edema (swelling) Resident #1 had in her face, her low blood pressure, pain in her abdomen and blood glucose of 464. Dialysis Nurse #1 contacted the dialysis center NP and reported Resident #1 ' s symptoms. The dialysis center NP ordered for Dialysis Nurse #1 to attempt to provide the dialysis treatment to Resident #1 and to send to the emergency room for evaluation after treatment.

The Director of Nursing (DON) was interviewed on 8/21/2018 at 3:39 PM and she reported it was her expectation that nursing would contact a physician for all patient issues, including abnormal blood glucose results.
The DON was interviewed again on 8/23/2018 at 12:15 PM and she further stated she did not know why Nurse #1 had not contacted the on-call physician service for the elevated blood glucose levels of Resident #1. The DON reported Nurse #1 had been suspended until a medication retraining was completed by her.

The Administrator, Director of Nursing, and Area Staff Development Manager were notified of Immediate Jeopardy on 8/22/2018 at 3:10 PM and they provided the following credible allegation of Immediate Jeopardy removal:

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Brian Center Health and Retirement Cabarrus respectfully submits this allegation of compliance to lift the allegation of immediate jeopardy identified on August 14, 2018 for F580

Resident #1 has had physician orders related to diabetic management as follows:
On 8/3/18 reads as follow:
Check fasting blood sugar one-time a day at 3 am.
Novolog 10 unit before meals, and per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 15 units; 401 - 450 = 18 units; 451+ = 20 units, after meals and at bedtime
A new order dated 8/9/18 read as follows:
Novolog 6 unit subcutaneously before each meals AND Inject as per sliding scale: if 0 - 60 Notify NP/MD; 61 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units & recheck FSBS in 2 hours; if FSBS still > 400, notify NP/MD; 451+ Notify NP/MD, subcutaneously before meals and at bedtime.

August 18, 2018 at approximately 3:13 am Nurse #1 obtained FBS of 454 and administered 20 units of Novolog insulin based on previous instruction from physician, however she did not notify the physician of the results or receive any new orders. Nurse # 1 rechecked FBs at 6:45 am of 531 and administered 20 units of Novolog. Nurse #1 did not notify the physician of the resident fasting blood sugar of 531.
On August 18, 2018 approximately 10:30 am resident transported to dialysis Center by wheelchair. Nurse # 4 reports per progress note

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

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dated 8-18-18 resident alert and oriented but complained of lower back pain. Tylenol was administrated per resident request. Nurse # 4 received call from Resident #1 ' s husband at approximately 2 pm to inform the facility that dialysis was transferring resident to the hospital. Nurse # 4 called Dialysis to determine if resident was transferred to the hospital. The Dialysis center informed facility resident was transferred to the hospital due to pain on left side and resident request to be transferred to the hospital. Resident #1 was admitted to the hospital with admitting diagnosis of Diabetic Ketoacidosis. Nurse # 1 was suspended on 8/23/18.
A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) which included the Administrator NHA), the Director of Nursing (DON), the Nurse Manager, and the District Director of Clinical Services on 8/23/18 and it was determined that Nurse #1 failed to notify the attending physician on of the high fasting blood sugar per the physician order. The root cause analysis identified that Nurse #1 failed to review Resident #1 physician ' s orders prior to administration of Novolog insulin 20 units.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

1. All residents who have physician orders to perform fasting blood sugar and /or insulin administration have a potential to be affected by this alleged deficient practice. On 8/23/18 the Director of Nursing and Nurse Managers conducted an audit of residents identified with orders for insulin and/or obtaining fasting blood sugars for the last 30 days to validate that physicians were notified per orders regarding abnormal fasting blood sugars. The twenty-four-hour reports and medical records of

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residents on insulin and fasting blood sugar checks were reviewed by the Director of Nursing and Nurse Managers to ensure physicians were notified of abnormal fasting blood sugars per physician orders. The Nurse Managers completed notification to the Physician for any opportunities identified as a result of this review.
On 8/23/18 The Director of Nursing and Nurse Managers re-educated current Licensed Nurses regarding the facility policy for "Changes in Resident Condition", with a focus on physician notification of abnormal fasting blood sugars per physician orders. Twenty-two of the facility ' s licensed nurses received the in-service as of 8/23/18.
No staff shall work after 8/23/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 8/23/18.
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;

2. On 8/24/18 a new process will be initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of Nursing and Nurse Managers, of residents identified with physician orders for fasting blood sugars to validate that physician were notified of the abnormal blood sugars.
-The attending physician was notified of fasting blood sugar outside physician order parameters and/or change condition
The physician orders for fasting blood sugars and/or insulin are being followed.
Residents receiving insulin and/or fasting blood sugars had current physician orders.

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F 580	Continued From page 13 The Director of Nursing will report the results of this monitoring during the monthly QAPI (Quality Improvement Performance Improvement) meeting and the committee will make recommendations as needed. 3. The Facility Administrator is responsible for implementing this acceptable plan of correction. The facility ' s credible allegation was verified on 8/23/2018 at 7:15 PM. The in-service records were reviewed, and 22 nurses received in-service on fingerstick blood glucose, notifying the physician and the 5 rights of medication administration. The charts of 7 residents with the diagnosis of diabetes were reviewed and found to have current orders for insulin, fingerstick blood glucose monitoring and orders for notifying the physician. Ten out of 22 nurses were interviewed, and all could state the 5 rights of medication administration (right drug, right dose, right time, right route, right documentation) and all could verbalize the steps to notifying a physician for a blood sugar out of parameters or for a change of status. All nurses could state the correct form to complete when notifying a physician of an elevated blood glucose or change in status (Situation Background, Assessment Response - SBAR form).	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		10/2/18

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F 684	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner, physician interviews, and dialysis staff interviews, the facility failed to obtain a physician ' s order to treat a resident with a high blood glucose level for 1 of 7 residents reviewed for diabetic management (Resident #1). Resident #1 experienced sustained high blood glucose levels which resulted in a hospitalization for diabetic ketoacidosis (a serious complication of diabetes). Immediate jeopardy began on 8/14/2018 when Nurse #1 failed to obtain a physician order to treat a resident ' s high blood glucose which was elevated above 450 milligrams per deciliter (mg/dl) and administered insulin without a physician order. The Immediate Jeopardy was removed on 8/23/2018 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to notifying physician of resident changes. Findings included: A review of the facility policy titled "Physician	F 684	F684 1. The plan should address the processes that lead to the deficiency cited: Resident #1 has had physician orders related to diabetic management as follows: On 8/3/18 reads as follows: Check fasting blood sugar one-time a day at 3 am. Novolog 10 unit before meals, and per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 15 units; 401 - 450 = 18 units; 451+ = 20 units, after meals and at bedtime. A new order dated 8/9/18 read as follows: Novolog 6 unit subcutaneously before each meals AND Inject as per sliding scale: if 0 - 60 Notify NP/MD; 61 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units & recheck	

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F 684	Continued From page 15 Services" with a revision date of November 2017 revealed an on-call physician service was available for "times when the attending physician is not generally available", for example after 6:00 PM and on the weekends before noon. Resident #1 was admitted to the facility on 12/22/2017 with diagnoses to include diabetes, end stage renal disease, high blood pressure and dementia. A review of the medical record revealed Resident #1 received dialysis treatment three times per week on Tuesday, Thursday and Saturday. A review of the care plans for Resident #1 revealed a care plan in place dated 1/11/2018 and revision date of 2/28/2018 that addressed her diagnosis of Diabetes and non-compliance with dietary choices, with interventions to include report all signs and symptoms of hyperglycemia (high blood glucose) to the physician and administer medications for diabetes as ordered by the physician. The most recent quarterly Minimum Data Set (MDS) dated 7/10/2018 assessed Resident #1 to be cognitively intact without behaviors or rejection of care. The medical chart was reviewed, and physician orders dated 8/3/2018 revealed an order to check Resident #1 ' s blood glucose level before meals, at bedtime and as needed. A physician order dated 8/9/2018 for Novolog insulin, inject subcutaneously before meals and at bedtime per sliding scale: blood glucose results 0-60 notify nurse practitioner (NP) or physician (MD); 201-250 mg/dl, inject 2 units of Novolog	F 684	FSBS in 2 hours; if FSBS still > 400, notify NP/MD; 451+ Notify NP/MD, subcutaneously before meals and at bedtime. On August 18, 2018 at approximately 3:13 am Nurse #1 obtained FBS of 454 and administered 20 units of Novolog insulin based on previous instruction from physician, however she did not notify the physician of the results or receive any new orders. Nurse # 1 rechecked FBs at 6:45 am of 531 and administered 20 units of Novolog. Nurse # 4 obtained FBS at 9:30 am of 450 and administered 10 units of Novolog sliding scale and 6 units of scheduled 70/30 per order (8-9-18). Nurse #4 reported to Dialysis the fasting blood sugar of 450 at 9:30 are and insulin coverage per dialysis communication form. On August 18, 2018 approximately 10:30 am resident transported to dialysis Center by wheelchair. Nurse # 4 reports per progress note dated 8-18-18 resident alert and oriented but complained of lower back pain . Tylenol was administrated per resident request. Nurse # 4 received call from resident #1 husband at approximately 2 pm to inform the facility that dialysis was transferring resident to the hospital. Nurse # 4 called Dialysis to determine if resident was transferred to the hospital. The Dialysis center informed facility resident was transferred to the hospital due to pain on left side and resident request to be transferred to the hospital.	

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F 684	Continued From page 16 insulin; 251-300 mg/dl, inject 4 units of Novolog insulin; 301-350 mg/dl, inject 6 units of Novolog insulin; 351-400 mg/dl, inject 8 units of Novolog insulin; 401-450 mg/dl; inject 10 units of Novolog insulin and recheck blood glucose, if remained above 400 mg/dl call NP/MD, if greater than 451 mg/dl, notify NP/MD. A physician order dated 8/9/2018 specified blood glucose to be checked at 3:00 AM daily due to unstable blood glucose levels. There were no orders to administer insulin at that time. There was no stop date on the order. The nursing notes were reviewed, and a note dated 8/13/2018 written by Nurse #1 noted a blood glucose result of 533 mg/dl at 3:00 AM. The note documented contacting the on-call physician (MD #2) and the order of 20 units of Novolog insulin to be administered and the blood glucose to be monitored. The nurse documented at 6:07 AM the blood glucose had been rechecked at 6:00 AM with a "High" result. Nurse #1 documented she administered 20 units of Novolog insulin. Nurse #1 documented "no sign/symptoms of diabetic distress observed." There was no physician contact documented and no physician order documented in the medical record for the documented blood glucose level of "High" at 6:00 AM 8/13/2018. A note written by MD #2 on 8/13/2018 at 3:50 AM documented a one-time order had been given to administer 20 units of Novolog insulin and to monitor the blood glucose for Resident #1. There was no further documentation by MD #2 in the patient progress notes after 8/13/2018. A note dated 8/14/2018 at 6:07 AM written by	F 684	Resident #1 was admitted to the hospital with admitting diagnosis of Diabetic Ketoacidosis. Nurse #1 was suspended on 8/23/18. A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) which included the Administrator (NHA), the Director of Nursing (DON), the Nurse Manager, and the District Director of Clinical Services on 8/23/18 and it was determined that Nurse #1 did not have physician orders for resident #1 to administer Novolog Insulin 20 units on August 18 2018. Nurse #1 failed to notify the attending physician on August 18, 2018 per the physician order. The root cause analysis identified that Nurse #1 failed to review Resident #1 physicians orders prior to administration of Novolog insulin 20 units. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All residents who have physician orders to perform fasting blood sugar and /or insulin administration have a potential to be affected by this alleged deficient practice. On 8/23/18 the Director of Nursing and Nurse Managers conducted an audit of residents identified with orders for insulin and/or obtaining fasting blood sugars for the last 30 days to validate FBS and insulin administration was completed according to the current physicians orders. The twenty-four hour reports and	

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F 684	Continued From page 17 Nurse #1 documented a blood glucose result of "High" and the administration of 20 units of Novolog insulin by sliding scale at that time. Nurse #1 documented "NAD" (no apparent distress) in her note. The medical record contained no information that the physician was notified of Resident #1 ' s blood glucose of "High" or a physician order had been obtained. A nursing note dated 8/15/2018 at 3:19 AM written by Nurse #1 documented a blood glucose reading of "High" at 3:00 AM. Nurse #1 documented the administration of 20 units of Novolog insulin "per sliding scale" and that Resident #1 had NAD noted. The medical record contained no information that the physician had been notified on 8/15/2018 of Resident #1 ' s blood glucose level of "High" or a physician order had been obtained. A nursing note dated 8/15/2018 at 6:36 AM written by Nurse #1 documented a blood glucose of 508 mg/dl at 6:00 AM. The nurse administered 20 units of Novolog insulin "per sliding scale" and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/15/2018 of Resident #1 ' s blood glucose level of 508 mg/dl or a physician order had been obtained. A nursing note dated 8/16/2018 at 6:36 AM written by Nurse #1 documented a blood sugar result of 485 mg/dl at 6:30 AM, the administration of 20 units of Novolog insulin and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/16/2018 of Resident #1 ' s blood glucose level of 485 mg/dl	F 684	physician orders were reviewed by the Director of Nursing and Nurse Managers to ensure residents that have a change in condition during the last 30 days had been identified and appropriate action had been taken. The resident's medical records were then reviewed by the Director of Nursing and Nurse Managers to validate there is nursing documentation present supporting the completion of a nursing assessment following of a significant change in condition and notification to the Physician following the significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review. On August 13, 2018 at approximately 3:00 am Nurse 1 obtained fasting blood sugar (FBS) reading of HIGH for Resident #1. Nurse #1 contacted Tele Health physician services and order was received to administrated Novolog 20 units insulin (subq). At approximately 6:00 am on August 13, 2018 Nurse #1 rechecked the resident fasting blood sugar (FBS) with reading of High. Nurse #1 administrated 20 units of Novolog insulin (subq). On August 15, 2018 at approximately 3:00 am Nurse #1 obtained fasting blood sugar reading of HIGH on Resident #1. August 15, 2018 at approximately 6:00 am Nurse #1 obtained fasting blood sugar of 508. Nurse #1 administrated 20 units of Novolog (subq). On 8/23/18 The Director of Nursing and	

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F 684	Continued From page 18 or a physician order had been obtained. Nurse #1 wrote a note dated 8/18/2018 at 3:16 AM that documented a blood glucose result of 454 mg/dl at 3:00 AM, the administration of 20 units of Novolog insulin and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/18/2018 at 3:16 AM of Resident #1 ' s blood glucose level of 454 mg/dl or a physician order had been obtained. A nursing note dated 8/18/2018 at 6:52 AM written by Nurse #1 revealed a blood glucose result of 531 mg/dl at 6:30 AM. Nurse #1 documented the administration of 20 units of Novolog insulin and Resident #1 had "no signs/symptoms of diabetic distress". The medical record contained no information that the physician had been notified on 8/18/2018 at 6:52 AM of Resident #1 ' s blood glucose level of 531 mg/dl or a physician order had been obtained. A nursing note written by Nurse #2 dated 8/18/2018 at 3:00 PM documented the blood glucose result of 450 mg/dl at 10:30 AM. Nurse #2 documented administration of 20 units of Novolog insulin via sliding scale orders dated 8/9/2018 and communication of the blood glucose results to the dialysis treatment center. The medical record contained no information that the physician had been notified on 8/18/2018 by Nurse #2 for Resident #1 ' s blood glucose result of 450 mg/dl. The MD sliding scale for insulin coverage specified the resident was to have 10 units of Novolog insulin with a blood glucose level of 450 mg/dl. A review of the hospital records revealed	F 684	Nurse Managers re-educated current Licensed Nurses regarding the facility policy for Changes in Resident Condition, with a focus on assessment following HIGH blood sugar or blood sugar that is outside physician order parameter. The re- education of current Licensed Nurses also included the 5 steps regarding medication administration, to include validation of resident physician orders prior to administration of insulin, or performing of fasting blood sugars. twenty-two of the facility's licensed nurses received the in-service as of 8/23/18. No staff shall work after 8/23/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 8/23/18. 3. 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: On 8/24/18 a new process will be initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of Nursing and Nurse Managers, of residents identified with physician orders for fasting blood sugars and/or insulin to validate the following process was completed as implemented. -The attending physician was notified of	

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F 684	Continued From page 19 Resident #1 was admitted to the hospital for recurrent diabetic ketoacidosis (DKA) on 8/18/2018 and received intravenous fluids and intravenous insulin to reduce her blood glucose level. The admission note for the hospitalization dated 8/18/2018 revealed the resident was admitted with abdominal pain, chest discomfort and shortness of breath. Blood glucose level at 5:12 PM was 520 and at 6:58 PM was 581 mg/dl. She was admitted to the Intensive Care Unit for continual monitoring and treatment of DKA with intravenous insulin. Resident #1 was discharged back to the facility on 8/21/2018. The resident ' s primary physician (MD #1) was interviewed on 8/21/2018 at 8:57 AM. MD #1 reported Resident #1 was non-compliant and had unstable blood glucose control. An interview was conducted with NP #1 on 8/21/2018 at 2:26 PM. She reviewed the order for sliding scale insulin dated 8/9/2018 and stated that the physician or nurse practitioner should have been notified of the blood glucose results that were over 450 on 8/14/2018, 8/15/2018, 8/16/2018. She further reported it was her expectation that orders were followed for diabetics due to the potential for complications related to elevated blood glucose levels. Resident #1 was interviewed on 8/22/2018 at 9:09 AM. She reported she was not certain why she had a recent hospitalization. Nurse #1 was interviewed on 8/22/2018 at 9:19 AM via phone call. Nurse #1 reported she had been assigned to Resident #1 on 8/13/2018, 8/14/2018, 8/15/2018, 8/16/2018 and 8/18/2018 on the third shift (11:00 PM to 7:00 AM). Nurse #1 reported she checked Resident #1 ' s blood glucose at 3:00 AM every night she worked	F 684	fasting blood sugar outside physician order parameters and/or change condition -The physician orders for fasting blood sugars and/or insulin are being followed. -Residents receiving insulin and/or fasting blood sugars had current physician orders. -The Director of Nursing will report the results of this monitoring during the monthly QAPI meeting and the committee will make recommendations as needed. 4. Facility Administrator is responsible for implementing this acceptable plan of correction.	

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because Residents #1 ' s blood glucose was unstable and sometimes she would have very low blood glucose levels or very high blood glucose levels. Nurse #1 reported that a "High" reading usually indicated a blood glucose over 500 mg/dl. Nurse #1 reported she had called the on-call physician service on 8/13/2018 at 3:25 AM and was asked by the on-call physician (MD #2) about Resident #1 ' s sliding scale. Nurse #1 reported she conveyed the amount of insulin to be administered to Resident #1 for blood glucose over 400 mg/dl and MD #2 instructed her to give 20 units of insulin. Nurse #1 went on to explain she thought that because MD #2 had ordered insulin according to the sliding scale, she had not written a physician order. Nurse #2 went on explain that she felt MD #2 had told her to use the sliding scale insulin protocol for blood glucose results in the future. Nurse #1 concluded by reporting she had not written a physician order to use the sliding scale insulin protocol for the 3:00 AM blood glucose checks and she had used the facility sliding scale insulin protocol to administer 20 units of insulin when Resident #1 ' s blood glucose was above 450 mg/dl during her shift because she did not want to bother the on-call physician.

An interview via phone call was conducted with MD #2 and MD #3 on 8/22/2018 at 11:28 AM. MD #2 reported she was the physician on-call the night of 8/13/2018 and she had given the order to cover the blood glucose result of 533 with 20 units of Novolog insulin. MD #2 went on to explain she had asked Nurse #1 to read the sliding scale to determine the amount of insulin to administer to Resident #1. MD #2 went on to explain she had not given an order to use the sliding scale insulin orders for future 3:00 AM blood glucose checks

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and her expectation was staff would call for orders for blood glucose results obtained at 3:00 AM. MD #3 added the on-call service was contracted by the facility was to be used for off-hour physician contact for any issues, and he reported it was his expectation that nursing staff would call the on-call agency to provide care for residents during physician off-hours.

Nurse #2 was interviewed on 8/22/2018 at 12:00 PM. Nurse #2 reported she worked day shift (7:00 AM to 3:00 PM) on 8/18/2018 and had received report from Nurse #1 at the beginning of her shift. Nurse #2 reported she had checked the blood glucose two hours after the 6:30 AM blood glucose at 8:30 AM and it was 450. Nurse #2 administered insulin as ordered on the sliding scale orders dated 8/9/2018. Nurse #2 went on to explain the orders on for sliding scale insulin on 8/9/2018 ordered for a physician to be called if the blood glucose was more than 450, so she had administered the ordered insulin and had not called a physician. Nurse #2 concluded by reporting Resident #1 had complained of back pain, and she administered Tylenol prior to Resident #1 leaving for dialysis treatment.

The dialysis center nurse (Dialysis Nurse #1) was interviewed via phone call on 8/22/2018 at 12:54 PM. She reported she was very familiar with Resident #1 and had been assigned to her to provide dialysis treatment on 8/18/2018. Dialysis Nurse #1 reported that Resident #1 told her she did not feel well and wanted to go to the hospital upon her arrival at the dialysis center on 8/18/2018. The nurse went to describe the edema (swelling) Resident #1 had in her face, her low blood pressure, pain in her abdomen and blood glucose of 464. Dialysis Nurse #1 contacted the

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dialysis center NP and reported Resident #1 ' s symptoms. The dialysis center NP ordered for Dialysis Nurse #1 to attempt to provide the dialysis treatment to Resident #1 and to send to the emergency room for evaluation after treatment.

The Director of Nursing (DON) was interviewed on 8/21/2018 at 3:39 PM and she reported it was her expectation that nursing would contact a physician for all patient issues, including abnormal blood glucose results.
The DON was interviewed again on 8/23/2018 at 12:15 PM and she further stated she did not know why Nurse #1 would have administered insulin without an order or why Nurse #1 had not contacted the on-call physician service for the elevated blood glucose levels of Resident #1. The DON reported Nurse #1 had been suspended until a medication retraining could be completed with her.

The Administrator, Director of Nursing, and Area Staff Development Manager were notified of Immediate Jeopardy on 8/22/2018 at 3:10 PM and they provided the following credible allegation of Immediate Jeopardy removal:

Brian Center Health and Retirement Cabarrus respectfully submits this allegation of compliance to lift the allegation of immediate jeopardy identified on August 14, 2018 for F684

Resident #1 has had physician orders related to diabetic management as follows:
On 8/3/18 reads as follow:
Check fasting blood sugar one-time a day at 3 am.
Novolog 10 unit before meals, and per sliding

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scale: if 0 - 200 = 0 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 15 units; 401 - 450 = 18 units; 451+ = 20 units, after meals and at bedtime
A new order dated 8/9/18 read as follows: Novolog 6 unit subcutaneously before each meals AND Inject as per sliding scale: if 0 - 60 Notify NP/MD; 61 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units & recheck FSBS in 2 hours; if FSBS still > 400, notify NP/MD; 451+ Notify NP/MD, subcutaneously before meals and at bedtime.

August 18, 2018 at approximately 3:13 am Nurse #1 obtained FBS of 454 and administered 20 units of Novolog insulin based on previous instruction from physician, however she did not notify the physician of the results or receive any new orders. Nurse # 1 rechecked FBs at 6:45 am of 531 and administered 20 units of Novolog. Nurse # 4 obtained FBS at 9:30 am of 450 and administered 10 units of Novolog sliding scale and 6 units of scheduled 70/30 per order (8-9-18). Nurse #4 reported to Dialysis the fasting blood sugar of 450 at 9:30 am and insulin coverage per dialysis communication form.

On August 18, 2018 approximately 10:30 am resident transported to dialysis Center by wheelchair. Nurse # 4 reports per progress note dated 8-18-18 resident alert and oriented but complained of lower back pain. Tylenol was administrated per resident request. Nurse # 4 received call from resident #1 husband at approximately 2 pm to inform the facility that dialysis was transferring resident to the hospital. Nurse # 4 called Dialysis to determine if resident

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was transferred to the hospital. The Dialysis center informed facility resident was transferred to the hospital due to pain on left side and resident request to be transferred to the hospital.

Resident #1 was admitted to the hospital with admitting diagnosis of Diabetic Ketoacidosis.

Nurse # 1 was suspended on 8/23/18.

A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) which included the Administrator NHA), the Director of Nursing (DON), the Nurse Manager, and the District Director of Clinical Services on 8/23/18 and it was determined that Nurse #1 did not have physician orders for resident #1 to administrator Novolog Insulin 20 units on August 18, 2018. Nurse #1 failed to notify the attending physician on 18, 2018 per the physician order. The root cause analysis identified that Nurse #1 failed to review Resident #1 physician ' s orders prior to administration of Novolog insulin 20 units.

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

1. All residents who have physician orders to perform fasting blood sugar and /or insulin administration have a potential to be affected by this alleged deficient practice. On 8/23/18 the Director of Nursing and Nurse Managers conducted an audit of residents identified with orders for insulin and/or obtaining fasting blood sugars for the last 30 days to validate FBS and insulin administration was completed according to the current physician ' s orders. The twenty-four-hour reports and physician orders were reviewed by the Director of Nursing and

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Nurse Managers to ensure residents that have a change in condition during the last 30 days had been identified and appropriate action had been taken. The resident ' s medical records were then reviewed by the Director of Nursing and Nurse Managers to validate there is Nursing documentation present supporting the completion of a nursing assessment following of a significant change in condition and notification to the Physician following the significant change. The Nurse Managers
completed notification to the Physician for any opportunities identified a result of this review.

On August 13, 2018 at approximately 3:00 am Nurse 1 obtained fasting blood sugar (FBS) reading of HIGH for Resident #1. Nurse #1 contacted on-call physician services and order was received to administrated Novolog 20 units insulin (subcutaneously). At approximately 6:00 am on August 13, 2018 Nurse #1 rechecked the resident fasting blood sugar (FBS)with reading of High. Nurse #1 administrated 20 units of Novolog insulin (subcutaneously). On August 15, 2018 at approximately 3:00 am Nurse #1 obtained fasting blood sugar reading of HIGH on Resident #1. August 15, 2018 at approximately 6:00 am Nurse #1 obtained fasting blood sugar of 508. Nurse #1 administrated 20 units of Novolog (subcutaneously).

On 8/23/18 The Director of Nursing and Nurse Managers re-educated current Licensed Nurses regarding the facility policy for "Changes in Resident Condition", with a focus on assessment following HIGH blood sugar or blood sugar that is outside physician order parameter. The re-education of current Licensed Nurses also

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included the 5 steps regarding medication administration, to include validation of resident physician orders prior to administration of insulin or performing of fasting blood sugars. Twenty-two of facilities licensed nurses received the in-service as of 8/23/18.

No staff shall work after 8/23/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 8/23/18.

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;

On 8/24/18 a new process will be initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of Nursing and Nurse Managers, of residents identified with physician orders for fasting blood sugars and/or insulin to validate the following process was completed as implemented.

The attending physician was notified of fasting blood sugar outside physician order parameters and/or change condition.

The physician orders for fasting blood sugars and/or insulin are being followed.

Residents receiving insulin and/or fasting blood sugars had current physician orders.

The Director of Nursing will report the results of this monitoring during the monthly QAPI (Quality

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Improvement Performance Improvement) meeting and the committee will make recommendations as needed.

2. Facility Administrator is responsible for implementing this acceptable plan of correction

The facility ' s credible allegation was verified on 8/23/2018 at 7:15 PM. The in-service records were reviewed, and 22 nurses received in-service on fingerstick blood glucose, notifying the physician and the 5 rights of medication administration.
The charts of 7 residents with the diagnosis of diabetes were reviewed and found to have current orders for insulin, fingerstick blood glucose monitoring and orders for notifying the physician.
Ten out of 22 nurses were interviewed, and all could state the 5 rights of medication administration (right drug, right dose, right time, right route, right documentation) and all could verbalize the steps to notifying a physician for a blood sugar out of parameters or for a change of status. All nurses could state the correct form to complete when notifying a physician of an elevated blood glucose or change in status (Situation Background, Assessment Response - SBAR form).