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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 11/18/20 to 11/20/20. One of one complaint allegation was substantiated resulting in deficiencies. Survey ID: 443V11.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews, pharmacy interview, nurse practitioner interview and physician interview, the facility failed to administer insulin as ordered by the physician and perform and document glucose monitoring for 2 of 4 residents (Residents #1 and #2) reviewed for insulin administration. The omission of administering the prescribed insulin for two doses and the omission of performing and documenting blood glucose monitoring contributed in the hospital admission for Resident #1 for diabetic ketoacidosis (Diabetic Ketoacidosis is a severe and life-threatening complication of diabetes). Resident ' s #1 other hospital admitting diagnoses included sepsis (life threatening body ' s response to an infection), metabolic acidosis and gastrointestinal bleeding. Finding Included: 1. Resident #1 was admitted to the facility on 10/15/20 at 3:00pm from the hospital post a right hip fracture surgery. Resident #1 medical diagnoses included Type 2 Diabetes Mellitus and Hypertension.	F 760	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 2. F 760 G Facility failed to administer insulin as ordered by the physician and perform and document glucose monitoring for 2 to 4 residents. 3. Corrective action for affected resident. Resident #1 no longer resides in the facility. Resident #2 discharged from facility, and had no negative effects from the late administration of insulin. Medication error report completed with notification to MD. 4. To identify other resident who have the potential to be affected, on 11/19/2020, all orders for current residents who receive blood glucose checks, were reviewed to ensure that orders contained additional documentation to record the glucose result in the electronic health record. Any	12/16/20

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

Electronically Signed | 12/09/2020

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F 760	Continued From page 1 The hospital discharge summary dated 10/15/20 was uploaded to Resident ' s #1 Electronic Medical Record (EMR) and included a discharge medication list. Tresiba insulin (FlexTouch U-200) 30 units subcutaneous at bedtime and Humalog insulin (Kwikpen) 0-16 units subcutaneous three times daily with meals as needed for sliding scale was ordered. No sliding scale or glucose monitoring was ordered on the discharge medication list. The physician orders dated 10/15/20 on Resident ' s #1 EMR listed Finger Stick Blood Sugars (FSBS) at 6:00am and 4:00pm for two weeks and call on-call provider after 48 hours to notify of blood sugar trends for possible Sliding Scale coverage and Tresiba Flex Touch Solution Pen injector 100units/milliliter inject 30 units subcutaneous at bedtime for Diabetes Mellitus. The baseline care plan dated 10/15/20 revealed Resident #1 was a full code, and the physician was to be notified of any changes in the resident. The baseline care plan did not address Resident ' s #1 diagnosis or treatments for Diabetes Mellitus. The October Medication Administration Record (MAR) for Resident #1 revealed Tresiba insulin was scheduled to be administered at 8:00pm. On 10/15/20, Tresiba insulin 30 units subcutaneous at bedtime for DM was coded as "19" (Other, See Nurse ' s Notes). A pharmacy shipment summary dated 10/15/20 revealed three Tresiba Flex Touch U-100 Latex Free, Outer 100 unit/1 milliliter (ml) insulin pen were delivered to the facility at 11:54pm on 10/15/20, and Nurse #1 signed for the shipment.	F 760	order that needed updated was completed at the time of the audit. On 11/19/2020, the Director of Nursing also completed an audit of all current residents who receive insulin to ensure that all ordered insulin was present in the medication carts for administration as ordered. All insulin was present and there were no other negative findings. 5. To prevent this from recurring, on 11/18/2020 the Director of Nursing and Assistant Director of Nursing began education on the facility policy of medication administration, including the need to administer insulin as ordered. The education also included the requirement to document the glucose results in the electronic health record. This education was completed to all current nurses on 11/20/2020. This same education will be provided to new hires and agency staff. 6. To monitor and maintain ongoing compliance beginning on 11/19/2020, the Director of Nursing or designee will observe four medication administrations weekly to ensure insulin was administered as ordered and glucose results were documented in the electronic health record. These observations will be documented for twelve weeks on an audit tool. The Director of Nursing or Designee will review the omissions report 5 days/wk x12 weeks to ensure medications are available for administration as ordered, any discrepancies will be followed up on.	

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F 760	Continued From page 2 The nurse ' s notes for Resident #1 revealed on 10/15/20 at 11:58pm Nurse #1 recorded a medication administration note stating he was awaiting the arrival of the Tresiba Insulin Flex Touch Solution Pen- Injector. The nurse ' s notes further revealed no documentation of the administration of insulin. The MAR noted the start date for the FSBS was for 10/16/20 at 6:00am. The FSBS were marked on the MAR as completed at 6:00am on 10/16/20, but there was no reading of the FSBS recorded on the MAR. The Blood Sugar Summary on the EMR revealed the FSBS level of 351.0 milligram(mg)/deciliter(dl) was recorded on 10/16/20 at 6:00am The physician ' s admission progress note dated 10/16/20 revealed Resident #1 had Type 2 Diabetes Mellitus (DM), and the medication record was reviewed. The physician noted Resident #1 was not experiencing headaches, dizziness, double vision, or difficulty breathing and the blood sugar was noted as 351. The physician noted Resident #1 complained of heartburn, and three plus edema was noted to both lower extremities and the scrotum. The physician noted the plan of treatment for DM was Tresiba 30 units at bedtime and increased Furosemide 40mg and Omeprazole 20mg from daily to twice a day for the heartburn and edema (edema means swelling). On 10/16/20, FSBS were marked completed as scheduled for 4:00pm, but there was no documentation of the blood glucose reading on the MAR, nurse ' s notes or the blood glucose	F 760	7. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Director of Nursing is responsible for compliance. The Date of compliance is 12/16/2020.	

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summary.

The MAR for Resident #1 revealed on 10/16/20, Tresiba insulin 30 units subcutaneous at bedtime for DM was coded as "18". A chart code was listed on the MAR to note reasons why a medication was omitted. Code "18" meant nauseated/vomiting.

On 10/16/20, Nurse #2 entered a medication administration note that stated Tresiba Flex Touch Solution Pen Injector 100unit/ml: inject 30 units subcutaneous at bedtime for DM. There was no explanation or indication if insulin was administered included in the medication administration note. The nurse ' s notes further revealed no record of the administration of insulin to Resident #1 or reason the medication was omitted.

The Admission 5-day Minimum Data Set (MDS) assessment dated 10/17/20 coded Resident #1 as cognitively intact and diabetes mellitus as an active diagnosis. Resident ' s #1 MDS assessment was also coded receiving no injections or insulin for the assessment period.

The nurse ' s notes written by Nurse #2 on 10/17/20 at 5:00am revealed the resident began to vomit minimal amounts of brown liquid, and the nurse notified the on-coming nurse and attempted to notify the on-call physician.

On 10/17/20, FSBS were marked completed as scheduled for 6:00am on the MAR, but there was no documentation of the blood glucose reading on the MAR, nurse ' s notes or the blood glucose summary.

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On 10/17/20, the nurse ' s notes revealed no documentation of any FSBS readings randomly performed.

On 10/17/20 at 12:59pm, the nurse ' s notes, written by Nurse #3, revealed Resident #1 was restless and having trouble breathing but refused to go the hospital.

On 10/17/20 at 3:45pm, the physician ordered to send Resident #1 to the hospital.

The Blood Sugar Summary on the EMR revealed the FSBS level of 555.0 mg/dl was recorded on 10/17/20 at 3:52pm.

A nurse ' s note written by Nurse #3 on 10/17/20 at 4:22pm, specified Resident #1 was transported by the Emergency Medical Services (EMS) from the facility to the hospital for an evaluation. The nurse ' s notes further revealed the physician was notified of the blood sugar trends for the last two days as ordered at 4:29pm on 10/17/20.

The Harnett County Emergency Medical Services (EMS) report dated 10/17/20 recorded Resident ' s #1 blood glucose reading as 592. The EMS recorded Resident #1 was confused but responsive to voice and possible Diabetic Ketoacidosis on the report.

On 11/17/20, the hospital ' s emergency record revealed Resident #1 blood sugars were elevated today, and according to the EMS, Resident #1 had been refusing treatment and arrived with altered mental status. The wife reported Resident #1 had called her stating he had not been getting his insulin at the facility. The ER record noted Resident #1 began experiencing symptoms on

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11/17/20. The laboratory results revealed an elevated blood glucose reading of 730, an elevated white cell count of 23,000, a low hemoglobin level of 8.8, a high platelet count of 975, a high potassium level of 6.1, a low calcium level of 8.9, a low chloride level of 88 and an elevated lactic acid level of 2.1. An urinalysis on 11/17/20 revealed no bacteria, glucose was greater than 500 and moderate amount of ketones. The arterial blood gas revealed a low oxygen level of 75.0 and a low carbon dioxide level of 29. Resident #1 began hypotensive in the emergency room and required mechanical ventilation. Resident #1 was admitted to the intensive care unit with acute diabetic ketoacidosis, leukocytosis, thrombocytosis, and metabolic acidosis listed as problems.

On 11/18/20 at 3:10pm, Physician #1 was interviewed. She stated she visited the resident on 10/16/20 and noted Resident #1 didn ' t want to answer her questions. She stated Resident ' s #1 edema to both legs and scrotum was a concern that she treated with medication and felt more was going on with Resident #1 than able to assess. Physician #1 stated blood glucose monitoring was ordered twice a day to determine if medications needed adjusting. She noted the blood glucose reading was 351 on her visit and stated although a blood glucose reading of 351 was a concern, it would not alter the course of treatment for Resident #1 yet and was not high enough to be repeated, and blood glucose monitoring was to be continued. Physician #1 denied the medical staff had set perimeters for staff to call physicians with elevated blood glucose readings, but believed the facility had a protocol when staff were to notify the physician.

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On 11/19/20 at 7:47am, an interview was conducted with Nurse #1. He stated medications arrived after the scheduled time from pharmacy if admission orders were not entered into the system before 4:00pm. He stated some medications were available in the facility stock but noted Tresiba was an insulin that was not available in the facility and could not substitute with another insulin. He noted when insulin was not available the physician was called for another order but usually waited until the pharmacy delivered the medications around midnight. Nurse #1 recalled Resident #1 not being on a fasting acting insulin or sliding scale insulin. He stated medications given after the scheduled time were recorded in the nurse ' s notes. When Nurse #1 was informed there was no nurse ' s note regarding insulin administration on 11/15/20, he stated he was unable to recall if the insulin was given or not and cited the reason for medications arriving late to the facility. Nurse #1 further stated he followed physician orders for checking blood glucose levels and also checked blood glucose levels before giving insulin and if the readings were less than 100 or higher than 400, he would call the physician. Nurse #1 was unable to recall calling the physician due to elevated blood glucose levels.

On 11/19/20 at 9:25am, an interview with Nurse #4 was conducted. She briefly remembered admitting Resident #1 and noted seeing Resident #1 was receiving Insulin coverage within hours on the medication orders and electronically put the orders in the system before 5:00pm to pharmacy so pharmacy would send the medications. She stated if medications do not arrive from the pharmacy, the nurse was to call the pharmacy, check the stock medication in the facility and

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notify the physician. She stated unless the physician ordered parameters to call for a blood glucose reading usually do not call the physician until the blood glucose level is greater than 400. Nurse #4 denied the facility having any diabetic standard protocol for blood glucose levels.

On 11/19/20 at 4:28pm, a phone interview was conducted with Nurse #3. She recalled taking care of Resident #1 on 11/16/20 and 11/17/20 and noticing there was something a little different about the resident on 11/17/20. She recalled Nurse #2 reporting Resident #1 vomiting a dark material and trying to reach the physician that morning at the change of shift. Nurse #3 stated she went to Resident ' s #1 room first to assess the situation and noted his vital signs were stable. She stated Resident #1 told her he was fine, and although he seems to be different from the day before and thought Resident #1 needed to go to the hospital for an evaluation, Resident #1 refused to go to the hospital. Nurse #3 stated the on-call physician was informed and ordered Ativan for Resident #1 after reporting Resident #1 was having labored breathing. Nurse #3 stated she was aware Resident #1 was a diabetic and denied Resident #1 showing signs and symptoms of hyperglycemia. Nurse #3 was unable to recall any blood glucose readings performed on Resident #1 but noted the blood glucose was elevated when a blood glucose was checked prior to EMS arrival. When Nurse #3 was informed the EMR and the MAR did not have a blood glucose level for 11/16/20 at 4:00pm recorded, she stated she would not sign the task off and not record a glucose level and denied recalling Resident #1 refusing. She noted the blood glucose reading would be in the chart and was unsure why a note was not in the chart. Nurse #3 further stated the

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physician was notified of blood glucose levels over 400.

On 11/20/20 at 11:42am, a phone interview was conducted with Nurse #2. She stated Resident #1 refused his evening medications on 11/16/20 due to nausea and vomiting. She recalled he slept through most of the night and vomited like spitting up twice the morning of 11/17/20. Nurse #2 stated she checked his blood glucose twice that shift but was unable to recall the blood glucose readings. She stated if the blood glucose level had been less than 60 or more than 400, she would notify the physician and documented in the nurse ' s notes.

On 11/20/30 at 12:07pm, a phone interview was conducted with the facility ' s Pharmacist #1. She stated the pharmacy did not had a substitute medication for the insulin, Tresiba, and when the medication was not available for administration, staff needed to call the physician for a one-time medication order. Pharmacist #1 noted the order for insulin, Tresiba, showed it was delivered on 10/15/20 and stated it was best to administer long acting inulin late than skip a dose all together. In a follow up interview with Pharmacist #1 on 11/20/20 at 3:50pm, she stated Tresiba insulin 30 units was a long acting insulin and missing one to two doses would not have an immediate effect on Resident #1 but required monitoring for adverse effects through glucose monitoring. She stated each person with diabetes mellitus was different, but the more consecutive doses on insulin missed, more harm can occur.

On 11/20/20 at 1:19pm, a phone interview was conducted with the on-call nurse practitioner (NP) #1 for 11/17/20. The NP #1 recalled the staff at

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the facility notifying her that Resident #1 was experiencing shortness of breath and refusing to go to the hospital. NP #1 recalled Resident #1 did not respond to the Ativan ordered for anxiety but could not recall specific numbers for blood glucose readings or vital signs reported by the staff. NP #1 noted the medical staff at the facility did not order sliding scale insulin for residents but checked blood glucose levels for two weeks twice a day before meals and adjusted the insulin for the residents based on the blood glucose levels. She noted she generally ordered an intervention for notification of blood glucose levels greater than 450.

On 11/20/20 at 2:51pm, a follow up phone interview was conducted with Physician #1. Physician #1 stated residents refusing medications could not be forced to take the medications, but Resident #1 not receiving insulin as ordered was a concern, and the nursing staff needed to notify the medical staff. She stated Resident #1 not receiving his insulin and monitoring blood glucose levels could lead to hyperglycemia with complications, but not all residents with elevated blood glucose levels go into diabetic ketoacidosis (DKA). She stated metabolic abnormalities and infection could also cause DKA, and Resident #1 not receiving his insulin was one of the many problems that contributed but did not solely cause the problem.

On 11/20/20 at 4:04pm, a phone interview was conducted with the Director of Nursing (DON). She stated the facility had stock medications staff pulled from when medications were not available, and if the medication was not available, staff were to call the physician for a new order. The DON explained that once a nurse documented a

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medication was not given on the MAR, the nurse had to document the administration of the medication in the nurse ' s notes. She stated medications given late or not given required a physician ' s order and was documented in the nurse ' s notes. She further noted refusal of medications were to be documented on the MAR or nurse ' s notes. When referencing Resident #1 not receiving his insulin as ordered by the physician according to the MAR for 2 days, the DON noted the pharmacy report showed the insulin was delivered to the facility the night of 11/15/20 but wasn ' t able to see that the insulin was given and admitted there was nothing in the nurse ' s notes as to why the insulin was not given on 11/16/20 when a documented blood glucose reading would have supported a reason why the insulin was not given. The DON stated the blood glucose levels were recorded on the MAR and explained that if the order for blood glucose monitoring was not entered into the system correctly, the screen on the MAR to record the blood glucose to appear on the MAR will not appear. She further stated the medical staff do not use sliding scale and discharge orders from the hospital were reviewed with the physician upon admission to the facility.

On 11/20/20 at 4:40pm, a phone interview was conducted with the Administrator. She stated insulin administration and blood glucose monitoring should properly be documented on the MAR or nurse ' s notes if the medication was given or a resident complains of nausea. She stated not documenting administering insulin as ordered and recording blood glucose monitoring was not the proper way to move forward with the care of Resident #1.

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2. On 11/17/20, Resident #2 was admitted to the facility and diagnoses included Type 2 Diabetes Mellitus, Hypertension and Enterocolitis due to Clostridium Difficile.

The Entry Minimal Data Set Assessment dated 11/17/20 provided no information on Resident #2.

The physician ' s orders dated 11/17/20 included Humalog Solution 100 units/mL (Insulin Lispro): Inject 5 units subcutaneous three times a day for DM with meals every day.

The care plan dated 11/18/20 revealed Resident #2 was a full code, and the physician was to be notified of any changes. The baseline care plan did not address Resident ' s #2 diagnosis or treatments for Diabetes Mellitus.

The Blood Sugar Summary on the EMR for Resident #2 revealed on 11/18/20 at 6:27am a blood glucose level reading of 193.0 mg/dl and on 11/18/20 at 6:11pm a reading of 205.0mg/dl. There were no other blood glucose reading recorded for 11/18/20.

On 11/18/20 at 10:35am while preparing Resident ' s #2 morning medication pass, Nurse #4 stated, "I feel comfortable giving him his insulin. His blood sugar was 193 this morning at 6:27am."

On 11/18/20 at 10:50am, Nurse #4 was observed administering Resident #2 Humalog Solution 100 unit/ml (Insulin Lispro) 5ml subcutaneous into the left upper arm. Nurse #4 offered Resident #2 a snack when he stated he only ate a few bites of his breakfast, but Resident #2 declined.

On 11/18/20 at 10:55am, an interview was

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EMERALD HEALTH & REHAB CENTER	54 RED MULBERRY WAY LILLINGTON, NC 27546

(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 760	Continued From page 12	F 760		

conducted with Nurse #4. She stated there was a 2-hour window, one hour before and one hour after the scheduled time, to administer medications. She stated she was not familiar with Resident ' s #2 orders and the medications scheduled for 8:00am. She stated this was the first day working with Resident #2 and was not in his room at breakfast time. She stated breakfast was usually on the hall around 8:00am, and now that she knew Resident ' s #2 orders, she would administer his medications earlier.

Resident ' s #2 November 2020 MAR revealed the physician ' s order for Humalog 5 units subcutaneous three times a day with meals every day and was scheduled to be administered at 8:00am, 12:00pm, and 4:30pm.

The "Location of Administration Report" revealed Resident #2 received a Humalog injection 5 units on 11/18/20 at 10:54am in the left arm and on 11/18/20 at 1:31pm in the right arm.

On 11/18/20 at 6:11pm, the Blood Sugar Summary report revealed Resident ' s #2 blood glucose reading was 205.0 mg/dl.

The nurse ' s notes for Resident #2 on 11/18/20 revealed no blood glucose readings recorded or Resident #2 experiencing any signs or symptoms of hyperglycemia.or hypoglysemia.

On 11/18/20 at 3:10pm during an interview with Physician #1, she stated medications should be given as ordered with breakfast because the resident should not receive the insulin ordered if the resident hadn ' t eaten breakfast. Physician #1 stated determining whether the resident ate breakfast was more important than the time the

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insulin was given, and staff should assure the resident has eaten before giving the insulin. When Physician #1 was informed Resident ' s #2 blood glucose reading was 193 that morning and didn ' t receive his scheduled 8:00am insulin until 10:50am, Physician #1 stated she expected Nurse #4 to be thinking about what was going on with the patient, and residents always had something in the room to eat.

On 11/19/20, the facility provided a care plan dated 11/19/20 noting Resident #2 was at risk for unstable blood glucose related to diabetes. Interventions included to assess blood glucose levels as ordered and as needed, administering insulin as directed by the physician and monitoring and educating the resident on signs and symptoms of hyperglycemia and hypoglycemia.

On 11/20/30 at 12:07pm, a phone interview was conducted with the facility ' s Pharmacist #1. She stated the administration of Humalog insulin needed to occur with the meal or within 15 minutes after Resident ' s #2 meal because the blood glucose level can drop too low. She stated the blood glucose reading 193 at 6:00am was an inaccurate reading to use to administer Humalog insulin at 10:50am, and Nurse #4 should have rechecked the blood glucose level prior to administering the Humalog insulin.

On 11/20/20 at 4:04pm, a phone interview was conducted with the DON. She stated medications were administered one hour before and one hour after the scheduled time, and she wanted Humalog insulin given on time as ordered. The DON noted situations on the hall sometimes delayed the medication administration. She noted

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F 760	Continued From page 14 Nurse #4 was not familiar with Resident ' s #2 medications regimen but could have checked the blood glucose for an accurate blood glucose level before administering the Humalog insulin. On 11/2020 at 4:40pm, a phone interview was conducted with the Administrator. She stated morning meetings were held with the clinical team and medication administration issues were reported and discussed with the clinical team. She stated nursing supervisors, assistant Director of Nursing and the DON reviewed 24-hours reports on medication administration records for accuracy of medication administration as ordered. She stated insulin administration was a crucial piece in managing Diabetes Mellitus and needed standing protocols. She stated medication administration was reviewed in the Quality Assurance (QA) meetings monthly and denied any issues with the administration of insulin or conducting blood glucose monitoring reported in the OA meetings.	F 760		