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	345442	A. BUILDING ______ B. WING ______	C 03/05/2021

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FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 000	INITIAL COMMENTS A complaint survey was conducted on 2/25/21 through 3/5/21. Event ID# 7WHT11. 3 of 3 complaint allegations were not substantiated. Past-noncompliance was was identified at: CFR 483.45 at tag F760 at a scope and severity (J) The tag F760 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 760 SS=J	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 reviews and staff interviews, the facility failed to obtain and administer an intermediate acting insulin (NPH) and a rapid-acting insulin (Lispro) for 1 of 3 newly admitted insulin dependent residents (Resident #2) resulting in hospitalization for six days with the diagnosis of diabetic ketoacidosis (a condition when the body is unable to produce enough insulin). Findings included: Resident #2 was admitted to the facility on 11/7/20 with diagnoses which included: diabetes mellitus, pancreatic insufficiency, disorder of thyroid, and pneumonitis. Review of the hospital's discharge medication list	F 760	Past noncompliance: no plan of correction required.	3/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/23/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 included orders which read: 1. NPH 20 units subcutaneous daily before breakfast. 2. NPH 8 units subcutaneous each night at bedtime. 3. Lispro subcutaneous 3 times a day before meals (number of units not specified). Review of admission orders dated 11/7/20 revealed an order for NPH 8 units subcutaneous each night at bedtime. There were no orders for NPH 20 units subcutaneous daily before breakfast or Lispro subcutaneous 3 times a day before meals. A review of the facility's "Admission Medication Reconciliation" form dated 11/7/20 indicated there were no medication issues identified and no medications listed as needing clarification. The form was not signed or dated. Review of an undated Baseline Care Plan revealed under section titled "Metabolic\Diabetic" a check mark beside the resident's goal stating, "will have no complications related to diabetes". None of the interventions were checked. Review of the nurse's note dated 11/7/20 at 8:20 p.m., written by Nurse #1 indicated Resident #2's medications were ordered but had not arrived. There was no documentation indicating the pharmacy, the physician, the DON (Director of Nursing) or the Executive Director were notified. The nurse's note dated 11/8/20 at 9:17 p.m., written by Nurse #1 indicated the facility continued to await the resident's medications to arrive from the pharmacy. There was no documentation indicating the pharmacy, the physician, the DON (Director of Nursing) or the Executive Director were notified.	F 760		

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The November 2020 medication administration record (MAR) indicated Resident #2 was not administered the NPH on 11/7/20 at 9:00 p.m. and 11/8/20 at 9:00 p.m. The November 2020 MAR also revealed the 6:00 a.m. dose of NPH was initialed as administered on 11/8/20 and 11/9/20.

Review of the Weights and Vitals Summary Record for the month of November 2020 revealed the first blood sugar value for Resident #2 was documented by Nurse #3 on 11/9/20 at 12:30 p.m. which was 379. There was no documentation of any blood sugar monitoring for the resident on 11/7/20 and 11/8/20.

The nurse's note dated 11/11/20 as a late entry for 11/9/20 at 9:30 a.m. and written by Nurse #3 revealed the pharmacy was telephoned regarding Resident #2's medications not received at by the facility. The request was made for the pharmacy to immediately deliver all of the resident's medications along with the resident's other admission medications from the weekend. The pharmacy agreed to send the medications on the first run that would be delivered early that evening.

The progress noted by Nurse #3 dated 11/10/20 documented that at approximately 9:15 a.m. Resident #2 became listless and was having trouble breathing during therapy exercises in his room. During the nurse's assessment, the resident's blood sugar read "HI". The Nurse Practitioner was notified and ordered STAT (immediate) laboratory tests, IV (intravenous) fluids and STAT insulin (12 units Lispro) was ordered and administered. The resident's family

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F 760	Continued From page 3 was notified. On 11/10/20 at 1:05 p.m., the laboratory notified the facility of the resident's critical blood glucose of 1452. The nurse practitioner was notified and ordered the resident sent to the emergency room. The resident's family was notified. Emergency Medical Services (EMS) arrived at the facility at 1:00 p.m. and transported Resident #2 to the hospital. During a telephone interview on 3/5/20 at 12:57 p.m., Nurse #3 stated she did not work during the weekend Resident #2 was admitted to the facility; but worked with the resident beginning the following Monday, 11/9/20 during first shift. She stated during the morning medication administrations to the residents on the F-hall she observed no medications in the medication cart for Resident #2. She revealed that during report, the third shift nurse did not inform her the resident's medications had not been delivered to the facility. Also, the resident was to receive NPH insulin, but there was no NPH in the facility. Nurse #3 stated she immediately notified the interim DON concerning the unavailable medications. She stated she also telephoned the pharmacy at approximately 9:30 a.m. and requested a STAT delivery of the ordered medications; the pharmacy agreed to the request. She revealed she was informed the next day the medications arrived during second shift on 11/9/20. Nurse #3 stated on the morning of 11/10/20 she observed the resident while administering his medications with no complaints or problems. But later that morning during room therapy, the therapist noticed resident was off balance while standing. Nurse #3 stated when she checked the resident's blood sugar level, it read "HI" (glucometer's maximum was 600). The NP was in the building and was notified and	F 760		

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ordered BMP, IV fluids and a chest x-ray. She stated the NP also instructed her to give the resident a fast-acting insulin. She revealed when she informed the NP there was no order for the resident to receive a fast-acting insulin. the NP gave the order. Nurse #3 stated she obtained a spare fast-acting insulin pen from the refrigerator in the medication room and administered the insulin to the resident. The resident's blood sugar was rechecked but still read "HI". The results of the BMP were called in from the laboratory showing the resident's blood sugar was at a critical level. Nurse #3 stated the NP ordered Resident #2 sent immediately to the emergency room.

The review of the hospital discharge summary dated 11/16/20 revealed Resident #2 was admitted to the hospital on 11/10/20 due to blood glucose levels in the 1400s as the result of not receiving insulin since the weekend (11/7/20). The resident was quite lethargic but able to answer yes/no questions and did not refuse insulin. The resident was discharged from the hospital with the primary diagnosis of DKA (diabetic ketoacidosis) and re-admitted to the facility on 11/16/20.

During an interview on 2/25/20 at 4:35 p.m., the Executive Director stated while receiving in-room therapy on the morning of 11/10/20, the therapist noticed a change in Resident #2's interactions and called for the nurse who took his vital signs. The resident's blood sugars read "HI" (glucometer maximum was 600). The nurse informed the nurse practitioner who ordered STAT laboratory work up. The laboratory notified the facility of the resident's blood sugars were at the critical high value of 1452. The physician was

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notified and the resident was sent to the hospital. She stated because the resident's blood sugars were at such a critical high value, she and the acting Director of Nursing (DON) made the decision to investigate what caused the resident's blood sugars to rise so high and if the facility could have prevented the occurrence. Their findings included: the resident was admitted to the facility on 11/7/20 (Saturday); unless notified, the pharmacy did not make weekend deliveries; and the facility did not have the resident's type of insulin in-house. She stated there were two nurses on duty on 11/7/20 and 11/8/20. Nurse #1 worked first and second shifts and Nurse #2 worked third shift both days. The Executive Director stated the nurses on duty failed to follow facility policy and call the back-up pharmacy to obtain the needed insulin. The nurses also failed to make the supervising nurse on duty, the DON, or the Executive Director aware the resident did not have any of his insulin. Both nurses were aware of the facility's policy/protocol. She stated both nurses were terminated and reported to the Board of Nursing. The Executive Director also revealed the current DON was not employed at the facility at the time of the incident.

During a telephone interview on 3/2/21 at 4:31 p.m., the Executive Director revealed Resident #2 did not receive four doses of NPH insulin as a result of the unavailability of the medication. She stated the resident's medications were delivered to the facility by the pharmacy on 11/9/20 between 8:00 p.m. and 9:00 p.m.

During a telephone interview on 3/3/21 at 11:02 a.m., Nurse #1 revealed she admitted Resident #2 to the facility on Saturday, 11/7/20 and faxed his medication list to the pharmacy. The

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pharmacy did not delivery the resident's medications anytime throughout the weekend of 11/7/20 through 11/8/20 and the facility did not have any NPH insulin in stock. Nurse #1 stated she did not notify the physician, the Director of Nursing, or the Executive Director about the pharmacy not delivering the medication and the resident not receiving his medications. She revealed she was aware the resident had brittle diabetes and closely monitored his blood sugars.

During a telephone interview on 3/3/21 at 11:42 a.m., Nurse #2 stated that on 11/8/20 and 11/9/20 she marked on the MAR that she administered the NPH at 6:00 a.m. to the resident, but "I didn't give it". She stated she forgot to erase/delete those markings

During a telephone interview on 3/3/21 at 2:30 p.m., the Nurse Practitioner (NP) stated she was notified early morning of 11/10/20 via telephone that Resident #2's blood sugar reading was "HI". She ordered STAT laboratory tests. The NP stated upon her arrival to the facility, she conducted an admission visit with the resident. The resident was awake, alert, calm, able to answer questions, skin temperature was normal, and blood pressure was 91/55. She stated during the exam the resident became lethargic but answered questions appropriately. She stated when the results of the basic metabolic panel with the reading greater than 1500 blood sugar level, she ordered the resident sent to the emergency room. The NP stated that in her professional opinion not receiving four doses of insulin would contribute to Resident #2's blood sugar reaching a high critical level. She revealed the facility was aware if there was ever a question about any physician's order or hospital discharge orders, the

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Personal Care Provider (PCP) had 24-hour call coverage available.

During an interview on 3/4/21 at 1:55 p.m., the facility's Medical Director stated he did not receive any communication from the facility about not having Resident #2's medications available. He revealed he was made aware of the incident on 11/10/20 when the NP was at the facility. He stated the nursing staff should have contacted the pharmacy. He indicated if there was a delay with the pharmacy sending the medication, the expectation was for nursing staff to notify the provider within a 24-hour period. The Medical Director stated that in his opinion, Resident #2 not receiving his insulin over three days contributed to his critical blood sugar value.

The Executive Director presented a completed POC with the date of compliance as 11/12/20.

The POC included:

On 11/11/20 at 4:40 p.m., an Ad Hoc Quality Assurance and Performance Improvement (QAPI) Meeting was held as the result of the resident not receiving medication on the weekend. The QAPI team concluded there was a process failure for medication delivery. Medications were not received for 72 hours due to weekend cutoff being missed. The Root Cause Analysis (RCA) was the nurses were unaware of the need to call the pharmacy after weekend cutoff time. The Plan included: Pharmacy will do delivery on Saturdays and Sundays. Nurses re-educated on pharmacy process. Also re-educated all licensed nurses on 11/11/20 through 11/13/20 to contact physician when medications not available. The Administrator

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(Executive Director) and the DON were responsible for implementing the Plan.

A quality review/observation was completed on 11/11/2020 by the regional Director of Clinical Services and Registered Nurse Manager to ensure currently diabetic residents' medication orders were accurate and up to date as prescribed by the physician to include, but not limited to insulin. An additional quality review/observation was completed on 11/11/2020 by the Director of Nursing to ensure current diabetic residents' medications were being administered by the nurse as ordered. Additionally, current residents with orders for blood glucose level monitoring were being monitored as ordered. All licensed nurses who care for the resident were interviewed on 11/11/20 about the resident not receiving his insulin throughout the weekend of 11/7/20 through 11/8/20.

Education was initiated on 11/11/20 and completed on 11/13/20 by the Regional Director of Clinical Services and the Divisional Director of Clinical Services with all licensed nurses on the facility's policy on medication availability, notification, admission process and pharmacy process which included procuring medications on weekends. The weekend admissions process was evaluated, and the policies and procedures were reviewed with re-education provided to licensed nurses.

Pharmacy delivery procedure changed to include Sunday delivery on 11/11/20. Pharmacy processes reviewed with attention to weekend deliveries as needed. Insulin would be added to the house medication stock in back-up for

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immediate availability on 11/11/20.

As a result of the investigation, it was determined the licensed nurses who were assigned to the resident's care on 11/7/20 and 11/8/20 did not follow the policies and procedures regarding follow-up on medications from the pharmacy. Medication orders were entered upon admission after cut-off time for same-day pharmacy delivery. The nurses were unaware that the medications would not be delivered on 11/7/20 and 11/8/2020 unless pharmacy was called. Therefore, medications were not delivered until the next delivery day. The nurses failed to notify the Executive Director, Director of Nursing, or the physician when the medications were not available.

Going forward, the facility would continue to review 5 different residents at for the next 3 months regarding all medications being available and administered to the residents as the physician ordered, use of the facility's back up (pyxis). Medications being administered on time, physician notification of missing medications, and blood glucose and insulin checks and administration. Any negative findings will be addressed immediately including notifying the physician, Executive Director, DON, and resident's responsible party.
Any negative findings will be brought to the monthly QAPI meetings for review and discussion for 3 months and as long as needed.
The two staff members were suspended on 11/10/20 and were terminated from the facility on 11/16/20 and 11/17/20. Both nurses involved in the incident were also reported to the NC Board of Nursing on 11/25/20.

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F 760	Continued From page 10 On 3/5/21 evidence of the implementation of the corrective action plan was validated through record review and staff interviews. -The quality review/observations (audits) of all medications for each diabetic resident completed by the Regional Director of Clinical Services and the facility Divisional Director of Clinical Services on 11/11/20 were reviewed and no concerns were identified with the initial audit. -The facility's signed attendance records and the agenda of the education in-service presented by the Regional Director of Clinical Services (RDCS) on 11/11/20 through 11/13/20 were reviewed. -All education listed in the corrective active plan was reviewed and there were no concerns. -Pharmacy deliveries days updated to include weekends, when needed -Weekly audit/monitoring tools were reviewed and there were no concerns. -The QAPI minutes were reviewed and diabetic/insulin/pharmacy procedures were included. -The corrective actions were completed by 11/13/20.	F 760		