STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT CLAYTON	204 DAIRY ROAD CLAYTON, NC 27520

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 7/11/21 through 7/15/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #T7WX11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 7/11/21 to conduct a recert and complaint survey and exited on 7/15/21. Additional information was obtained on 7/21/21. Therefore, the exit date was changed to 7/21/21. Event ID# T7WX11. Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity (J). The tag F684 constituted Substandard Quality of Care. An extended survey was conducted. 4 of the 10 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		8/2/21

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

Electronically Signed | 08/02/2021

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to keep the urine collection bag of an indwelling catheter covered for 1 of 4 residents (Resident #56) reviewed for indwelling urinary catheter. The findings included: Resident # 56 was admitted to the facility on 6/16/21. Her diagnosis included stroke, diabetes, and neurogenic bladder.	F 550	F550 Resident Rights/Exercise of Rights On 07/11/21, the Assistant Director of Nursing placed a privacy cover on the collection bag. On 07/11/21, a 100% audit of all residents with a urinary catheter was completed by the Assistant Director of Nursing. The audit was to ensure all urinary catheter bags were emptied and had a privacy cover on the collection bag. The Director	

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F 550	Continued From page 2 The admission Minimum Data Set dated 6/23/21 revealed she was severely cognitively impaired and had an indwelling catheter. She required extensive assistance with activities of daily living. The care plan updated 7/9/21 revealed Resident #56 had an indwelling catheter. The interventions included position catheter bag and tubing below the level of the bladder, check tubing for kinks frequently each shift, observe/document pain/discomfort due to catheter and observe/record/report to physician for signs or symptoms of a urinary tract infection. During an observation from the doorway of Resident #56's room on 7/11/21 at 4:07 PM with Nursing Assistant (NA) #1, the urinary catheter collection bag was visible hanging from the side of the bed. There was no privacy bag to cover the collection bag and urine was observed in the bag. During the observation NA #1 stated the bag needed to be emptied because she could see the amount of urine in the bag. She then stated the bag should be covered with a privacy cover. She was unable to say why the privacy cover was not on the collection bag. On 7/11/21 at 4:13 PM Nurse #4 stated she observed Resident #56's catheter bag from the doorway. She said the collection bag was uncovered and needed to be emptied. Nurse #4 further stated the urine collection bag should have a privacy cover. On 7/11/21 at 4:20 PM the Assistant Director of Nursing stated he had not noticed the uncovered collection bag during his previous visit to Resident #56's room. He reported the urinary collection bag should have a privacy cover. He stated the	F 550	of Nursing corrected all concerns identified during the audit to include ensuring all urinary catheter bags have a privacy cover. An in-service was initiated by the Staff Development Coordinator on 07/12/21 with all staff in regarding dignity and respect including resident privacy to include ensuring a privacy cover is on any urinary catheter collection bag. All newly hired staff and contracted staff will be in-serviced regarding dignity and respect including resident privacy to include ensuring a privacy cover is on any urinary catheter collection bag by the Staff Development Coordinator. 100% of all residents with a urinary catheter will be monitored by the Nurse Supervisors weekly x 4 weeks then monthly x 1 month utilizing the Urinary Catheter Audit Tool. This audit is to ensure all urinary catheter bags were emptied and had a privacy cover on the collection bag. The nurse will be immediately re-trained by the Nurse Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Urinary Catheter Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Urinary Catheter Audit Tool to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee will meet	

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F 550	Continued From page 3 privacy covers are packaged with the urine collection bags, so he did not know why the privacy cover was not present. He indicated any of the nursing staff should ensure the privacy cover was in place.	F 550	monthly for 2 months and review the Urinary Catheter Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		8/2/21

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F 583	Continued From page 4 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations staff and resident interviews the facility failed to lock the electronic medical record screen to provide privacy and confidentiality of medical records for 1 of 1 resident reviewed for privacy (Resident #25). Findings included: Resident #25 was admitted to the facility on 10/26/20. Resident #25's active diagnoses included coronary artery disease, heart failure, diabetes mellitus, hyperlipidemia, and thyroid disorder. Resident #25's minimum data set assessment dated 5/19/21 revealed she was assessed as cognitively intact. During an observation on 7/13/21 at 2:11 PM the 200 hall medication cart was observed against the 200 hall wall with a computer mounted on the medication cart which was positioned to face the 200 hall hallway and entrance. The medication cart was unattended by staff and the screen was observed to have the photo, name, 4 medications, allergies, room number, date of birth, age, attending physician, gender, most recent vitals of blood pressure, respirations, temperature, blood sugar, pulse, oxygen saturation, weight, and code status of Resident #25 displayed on the screen and was able to be observed from the 200 hall hallway and entrance. At 2:13 PM Nurse #3 returned to the medication	F 583	F583 Personal Privacy/Confidentiality of Records On 07/13/21, Nurse #3 locked the 200 medication cart□s computer screen. The Director of Nursing educated Nurse #3 on ensuring the medication cart□s computer screen remained locked with not in use. On 07/13/21, a 100% audit of all medication cart□s and nurse stations with computer screens was conducted by the Assistant Director of Nursing and Director of Nursing. The audit was to ensure all computer screens were locked and did not display resident information. The Director of Nursing and Assistant Director of Nursing corrected all concerns identified during the audit to ensure all computer screens were locked and did not display resident information. An in-service was initiated by the Staff Development Coordinator on 07/14/21 with all staff related to ensuring all computer screens were locked and did not display resident information. All newly hired staff and contracted staff will be in-serviced regarding ensuring all computer screens were locked and did not display resident information by the Staff Development Coordinator.	

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F 583	Continued From page 5 cart from a resident's room. During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 hall medication cart's computer screen was supposed to be locked to not display resident information when the nurse left the medication cart unattended. This was to provide privacy and confidentiality to residents. During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the computer screens were to be locked when unattended by staff to ensure privacy and confidentiality of records for residents. She concluded Nurse #3 should have locked the screen prior to leaving the medication cart. During an interview on 7/14/21 at 9:08 AM Resident #25 stated she absolutely did not want her medical information left where anyone could see it. She concluded this was because her medical history and status was not anyone's business but her own.	F 583	100% of all medication cart□s and nurse stations with computer screens will be monitored by the Nurse Supervisors weekly x 4 weeks then monthly x 1 month utilizing the Privacy and Confidentiality Audit Tool. This audit is to ensure all medication cart□s and nurse stations with computer screens remain locked when not in use. The employee will be immediately re-trained by the Nurse Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Privacy and Confidentiality Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Privacy and Confidentiality Audit Tool to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Privacy and Confidentiality Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		8/2/21

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F 655	Continued From page 6 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a baseline care plan	F 655	F655 Baseline Care Plan	

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F 655	Continued From page 7 within 48 hours of admission for 3 of 5 residents reviewed for baseline care plans (Resident #166, Resident #168, and Resident #316). Findings included: 1. Resident #166 was admitted to the facility on 7/9/21. Resident #166's active diagnoses included transient cerebral ischemic attack, nontoxic single thyroid nodule, gastro-esophageal reflux disease, hypertension, hyperlipidemia, and anemia. Upon review of Resident #166's chart on 7/12/21 at 11:31 AM, the resident's chart did not have a care plan. During an interview on 7/12/21 at 11:37 AM the Director of Nursing stated the unit manager or, if the unit manager worked the cart, nursing management would complete baseline care plans within 48 hours of admission. The Director of Nursing stated the unit manager was working the cart the day Resident #166 was admitted and therefore, nurse management should have completed the baseline care plan. Upon checking the resident's chart, she concluded a baseline care plan had not been completed within the 48 hours. 2. Resident #168 was readmitted to the facility on 07/02/2019 with diagnoses including failed pancreas (a gland which secretes insulin) transplantation and uncontrolled type 1 diabetes mellitus (a chronic condition where the pancreas produces little or no insulin). The discharge minimum data set (MDS) assessment for Resident #168 dated 07/06/2019 indicated he was moderately impaired for daily	F 655	On 07/12/21, a baseline care plan was created and entered into the electronic health record for Resident #166. On 07/13/21, a baseline care plan was created and entered into the electronic health record for Resident #316. On 07/13/21, a 100% audit of all resident care plans was completed by the MDS Coordinator. This audit was to ensure that all residents have a baseline care plan entered into the electronic health record within 48 hours or admission. The MDS Coordinator corrected all concerns identified during the audit to include ensuring that all residents have a baseline care plan entered into the electronic health record within 48 hours or admission. An in-service was initiated by the MDS Nurse and Staff Development Coordinator on 07/13/21 with all licensed nurses in regards to ensuring that all residents have a baseline care plan entered into the electronic health record within 48 hours or admission. This in-service emphasized checking completing the initial baseline care plan in the electronic health record within 48 hours for all admissions. All newly hired nurses and contracted nurses will be in-serviced regarding completing the initial baseline care plan in the electronic health record within 48 hours for all admissions by the Staff Facilitator or MDS Nurse. 100% of all residents will be monitored by	

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F 655	Continued From page 8 decision making. It further indicated he received insulin injections 2 out of 7 look back period days. A review of Resident #168's medical record indicated a physician's order dated 07/02/2019 for insulin glargine (a long acting injectable medication for diabetes) 12 units subcutaneously (under the skin) each evening. A review of Resident #168's base line care plan initiated 07/02/2019 indicated no focus area for diabetes mellitus or insulin administration was present. On 07/12/2021 at 2:31 PM an interview with Nurse #3 indicated she completed the admission paperwork for Resident #168 on 07/02/2019. She stated this included Resident #168's physical assessment and other nursing assessments but did not include his baseline care plan. She stated she thought the MDS nurse did those. On 07/13/2021 at 9:16 AM an interview with MDS Nurse #1 indicated she did not complete residents' baseline care plans. She stated back in July 2019 she was not sure who was doing them but currently the facility's process was that the unit manager completed them. On 07/13/2021 at 8:17 AM an interview with the Director of Nursing (DON) indicated she was not aware of what the facility process was for completing baseline care plans in July 2019. She stated the current facility process was that the unit manager completed the baseline care plan within 48 hours of a resident's admission to the facility. She went on to say if the unit manager was not available then she did them. The DON further indicated Resident #168's baseline care	F 655	the Nurse Supervisors weekly x 4 weeks then monthly x 1 month utilizing the Baseline Care Plan Audit Tool. This audit is to ensure that all residents have a baseline care plan entered into the electronic health record within 48 hours or admission. The nurse will be immediately re-trained by the Nurse Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Baseline Care Plan Audit Tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Baseline Care Plan Audit Tools to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Baseline Care Plan Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 655	Continued From page 9	F 655		

plan should have included diabetes and insulin administration. She stated this would have triggered nursing staff to be monitoring for signs and symptoms of high and low glucose levels which would be important for a resident with diabetes.

On 07/15/2021 at 11:20 AM an interview with the Administrator indicated Resident #168 should have had a baseline care plan completed within 48 hours of his admission to the facility which included diabetes management and insulin administration.

3. Resident #316 was re-admitted to the facility on 07/09/2021 with diagnoses including diabetes mellitus and glioblastoma (a brain cancer).

The discharge minimum data set (MDS) assessment for Resident #316 dated 06/28/2021 indicated he was moderately impaired for daily decision making. It further indicated he required the extensive to total assistance of staff for dressing, personal hygiene, toileting, and bathing. He was occasionally incontinent of bowel and bladder.

A review of the medical record for Resident #316 indicated a physician's order dated 07/09/2021 for a controlled carbohydrate diet (a therapeutic diet for diabetes mellitus which limits the amount of carbohydrates consumed).

On 07/12/2021 a review of Resident #316's medical record indicated no baseline or comprehensive care plan was present.

On 07/13/2021 at 11:57 AM an interview with MDS Nurse #1 indicated she did not know where

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F 655	Continued From page 10 the baseline care plan for Resident #316 was. She stated Resident #316 should have had a baseline care plan completed within 48 hours of his admission to the facility. She further indicated the unit manager would be the one assigned to complete the baseline care plan for Resident #316. On 07/13/2021 at 12:31 PM an interview with Nurse #6 indicated she was the unit manager. She stated it was her responsibility to complete baseline care plans for residents within 48 hours of their admission. She went on to say Resident #316 was re-admitted to the facility on Friday 07/09/2021 and his baseline care plan would have been due by 07/11/2021. Nurse #6 stated 07/11/2021 was a Sunday and she had not worked that weekend. On 07/13/2021 at 12:05 PM an interview with the Director of Nursing (DON) indicated there was no staff member present in the facility on 07/11/2021 assigned to complete Resident #316's baseline care plan. She stated his baseline care plan should have been completed within 48 hours of Resident #316's admission to the facility and it had not been. On 07/15/2021 at 11:20 AM an interview with the Administrator indicated Resident #316's baseline care plan should have been completed within 48 hours of his admission to the facility and it had not been.	F 655		
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		7/27/21

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F 684	Continued From page 11 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 and staff and physician interviews the facility failed to reconcile and transcribe the hospital physician discharge orders on readmission to the facility and failed to provide glucose monitoring and sliding scale insulin coverage as recommended by the hospital discharging physician for 1 of 3 resident (Resident #168) reviewed for diabetic management. This resulted in Resident #168 being admitted to the hospital on 07/06/2019 for diabetic ketoacidosis (DKA) which required the administration of intravenous insulin. DKA is the formation of a toxic chemical in the blood caused by prolonged high blood glucose which can be life threatening. Findings included: A review of the hospital discharge summary for Resident #168 dated 07/02/2019 indicated discharge to outside facility physician orders included glucose monitoring before meals (AC) and at bedtime (HS), insulin lispro (a fast acting insulin given per a sliding scale) 0-10 units (U) subcutaneously (SQ) three times daily with meals, insulin glargine (a long acting insulin) 12 U SQ each evening, and prednisone (an immunosuppressant medication that can cause elevated glucose levels) 5 milligrams (mg) by mouth (po) once daily (QD).	F 684	Past noncompliance: no plan of correction required.	

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Resident #168 was readmitted to the facility on 07/02/2019 with diagnoses including failed pancreas (a gland which secretes insulin) transplantation, uncontrolled type 1 diabetes mellitus (a chronic condition where the pancreas produces little or no insulin), kidney transplant and long term use of immunosuppressant medication.

The facility physician orders for Resident #168 dated 07/02/2019 indicated insulin glargine 12 U SQ each evening and prednisone 5 mg po QD. No facility physician orders for glucose monitoring AC and HS or insulin lispro sliding scale (a dosing method based on the glucose result) were found.

No focus area for diabetes mellitus or insulin administration was present on the baseline care plan initiated 07/02/2019 for Resident #168.

On 07/13/2021 at 8:17 AM an interview with the facility director of nursing (DON) indicated she was not in her current position as the DON in July 2019. She stated she used the hospital discharge summary dated 07/02/2019 to enter the facility physician admission orders for Resident #168 on 07/02/2019. She stated this discharge summary included glucose monitoring AC and HS and insulin lispro sliding scale orders which she should have entered but had not. She stated she must have missed those orders, and this was an error. On 07/13/2021 at 12:12 PM a follow up interview with the DON indicated she could not remember if she called Physician #1 on 07/02/2019 to verify Resident #168's facility admission orders when she entered them or to get any clarification. On 07/21/2021 at 11:15 AM a follow up interview with the DON indicated she

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was serving as the unit manager for the facility on 07/02/2019.

A review of the medication administration record (MAR) for Resident #168 dated 07/01/2019-07/31/2019 indicated he received insulin glargine 12 U SQ each evening at 9:00 PM from 07/03/2019 through 07/05/2019 and prednisone 5 mg po daily at 9:00 AM from 07/03/2019 through 07/06/2019. No glucose monitoring results or sliding scale insulin administration was indicated on this MAR.

On 07/13/2021 at 10:16 AM, during a telephone interview, Nurse #5 indicated she administered insulin glargine 12 U SQ to Resident #168 at 9:00 PM on 07/03/2019. She stated she also provided care to Resident #168 on 07/06/2019 from 7AM-3PM. She stated she did not check Resident #168's glucose or administer any sliding scale insulin because Resident #168 did not have physician's orders for that. She stated she did not observe anything unusual with Resident #168 on her shift from 3PM-11PM on 07/03/2019 or 7AM-3PM on 07/06/2019 and Resident #168 had no complaints.

On 07/13/2021 at 10:35 AM an interview with Nurse #6 indicated she administered insulin glargine 12 U SQ to Resident #168 at 9:00 PM on 07/04/2019. She stated she did not check Resident #168's glucose or administer any sliding scale insulin because Resident #168 did not have physician's orders for that. She stated she did not observe anything unusual with Resident #168 on her shift from 3PM-11PM that day and Resident #168 had no complaints.

On 07/13/2021 at 9:48 AM a telephone interview

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with Nurse #7 indicated she administered insulin glargine 12 U SQ to Resident #168 at 9:00 PM on 07/05/2019. She stated she did not check Resident #168's glucose or administer any sliding scale insulin on 07/05/2019 because Resident #168 did not have physician's orders for that. She further indicated she did not observe anything unusual with Resident #168 on her shift from 3PM-11PM that day and Resident #168 had no complaints. Nurse #7 went on to say she also provided care to Resident #168 from 3PM-11PM on 07/06/2019. She indicated Resident #168 had not complained of any symptoms to her, she had not noticed anything unusual, and nothing had been reported to her by the nursing assistant. She stated on 07/06/2019 Resident #168's family member asked her to check his glucose level because he wasn't feeling right. Nurse #7 went on to say she did this and the result had been a reading of "HI". She stated Resident #168's family member requested he be sent out to the hospital.

On 07/21/2021 at 11:16 AM a telephone interview with nursing assistant (NA) #2 who provided care to Resident #168 on 07/06/2019 on the 3PM-11PM shift indicated she did not recall Resident #168. NA #2 stated if she noticed anything unusual with a resident or if a resident had any complaints, she would immediately notify the nurse.

On 07/13/2019 at 8:26 AM a review of the manufacturer's guidelines dated 1/2018 for the glucose monitor provided by the facility indicated a reading of "HI" meant the glucose result was greater than 600 mg per deciliter (dl). A glucose reading of less than 140 mg/dl was considered normal.

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A nursing progress note dated 07/06/2019 at 6:07 PM written by Nurse #7 revealed Resident #168's family member reported Resident #168 was not feeling right. It further revealed Resident #168 was assessed but did not have any mental status, functional status, or respiratory status change. His glucose level was checked, and the result had been a reading of "HI". Resident #168's family member requested Resident #168 be sent out to the hospital. Resident #168 left the facility at 5:20 PM.

Multiple attempts to contact Resident #168's family member were unsuccessful.

A review of the discharge minimum data set assessment for Resident #168 dated 07/06/2019 indicated he was moderately impaired for daily decision making. It further indicated he received insulin injections 2 out of 7 look back period days.

A review of the hospital record dated 07/10/2019 indicated Resident #168 was admitted on 07/06/2019 for DKA that was likely the result of a lack of insulin therapy. His family member reported he had not been managed at the nursing home with glucose monitoring and sliding scale insulin. He was complaining of increased weakness, shortness of breath and he was not as alert and interactive as his baseline. The hospital record revealed Resident #168's glucose level was 627 mg/dl on admission to the hospital. He required treatment with insulin intravenously to manage his glucose levels until these were less than 250 mg/dl on 2 occurrences. He could then be transitioned to SQ insulin. He was transitioned to SQ insulin on 07/07/2019, with the recommendation to continue long acting and

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short acting insulin SQ and frequent glucose checks.
Resident #168 was discharged from the hospital on 07/10/2019. He did not return to the facility.

On 07/14/2021 at 9:09 AM a telephone interview with Physician #1 indicated he had been Resident #168's facility physician. He stated he expected the nurse to use the hospital discharge summary dated 07/02/2019 to determine Resident #168's facility admission orders and call him to verify these orders when they were entered and to get any clarification needed. Physician #1 stated he could not recall if the nurse called him to verify Resident #168's orders on 07/02/2019. He further indicated if Resident #168's hospital discharge orders included glucose monitoring AC and HS and lispro sliding scale insulin these orders should have been entered by the nurse on 07/02/2019. He stated if Resident #168 had his facility admission orders entered correctly, he would have been receiving glucose monitoring AC and HS along with a sliding scale insulin based on those results to treat any high readings. He stated this was the standard of care for someone who was fragile, like Resident #168, and insulin dependent. He went on to say simply observing a resident for signs and symptoms of diabetic complications without monitoring their glucose levels would not be the standard of care. He stated glucose monitoring and sliding scale insulin could have very likely prevented Resident #168's hospitalization on 07/06/2019 for DKA with a blood sugar of over 600 mg/dl. Physician #1 stated DKA was a serious complication of uncontrolled type 1 diabetes that put Resident #168 at risk for coma (a state of deep unconsciousness that lasts for a prolonged or indefinite period), organ damage, and death.

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On 07/15/2021 at 11:09 AM the facility provided the corrective actions taken by the facility for tag F684 as follows:

All residents with a diagnosis of diabetes are at risk.

A diagnosis report for all residents that are diabetic was reviewed by the Director of Nursing or Designee on 6/25/21 to ensure there was a blood sugar monitoring frequency in place and orders were accurate. This diagnosis report was used to audit the current residents with a diagnosis to ensure blood sugar monitoring was in place and the physician's orders were accurate.

The current licensed nursing staff were educated on the system for reviewing new admit and readmit orders, including reviewing the discharge summaries from the hospitals to ensure all orders are reconciled onto the resident MAR. Education included clarifying and verifying physician orders with the physician and about monitoring residents with diabetes and medications that can negatively impact diabetes.

This education was completed by the Director of Nursing or Designee by 6/25/21. No current licensed staff will work without this education. The facility will ensure all newly hired licensed staff or agency licensed staff are educated on the system for reviewing new admit and readmit orders, including reviewing the discharge summaries from the hospitals to ensure all orders are reconciled onto the resident MAR and will have education including clarifying and verifying physician orders with the physician and

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monitoring residents with diabetes and medications that can negatively impact diabetes.

The new admit /readmit checklist is being utilized as the monitoring tool effective 6/25/21 to ensure medication reconciliation has been completed by comparing the physician discharge summary orders to the electronic medical record order entries. This checklist continues to be completed by the Director of Nursing or Designee and is discussed with the interdisciplinary team.

The facility conducted a QAPI meeting on 6/25/21 and reviewed the monitoring tool and audit results. The results of these audits will be reported by the Director of Nursing or Designee at the QAPI meeting monthly for 3 months. The QAPI team will review and approve all audits for 3 months.

Our date of compliance is 6/26/21.

The plan of correction was verified through review of the in-service records dated 6/25/2021 which covered glucose monitoring, medication administration and the admission process, the competency checklists for all licensed staff, the 24 hour admission checklist auditing tool which was initiated in April 2021 and the random checklist audits. The checklist audits included admission physician orders transcribed from hospital orders accurately.

The QAPI meeting minutes dated 6/25/2021 were reviewed. These included an ongoing review of the 24 hour admission checklist which includes the reconciliation of the physician's orders from discharge/transfer and admission to the facility to ensure accuracy and completeness of this

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F 684	Continued From page 19 information. The blood sugar check and parameters audit tool dated 6/25/21 was reviewed. The facility's date of compliance of 6/26/2021 was verified.	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		8/2/21

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F 758	Continued From page 20 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, pharmacist, and physician interviews the facility failed to have a stop date for an as needed antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #167). Findings included: Resident #167 was admitted to the facility on 7/9/21. Her active diagnoses included diabetes mellitus, hypertension, and anemia. Resident #167's care plan dated 7/9/21 revealed she was care planned for behavior problems. The interventions included to administer medications as ordered. Resident #167's order dated 7/9/21 revealed she was ordered Zyprexa tablet 5 milligrams give 1	F 758	F758 Free from Unnec Psychotrophic Meds/PRN Use On 07/13/21, Nurse #1 updated the order for Zyprexa 5 milligrams on 07/12/21 for Resident #167 to include discontinuation date for 14 days post admission. On 07/13/21, a 100% audit of all psychotropic medications was completed by the Assistant Director of Nursing. This audit was to ensure that all PRN psychotropic medications included a discontinuation date. The Director of Nursing corrected all concerns identified during the audit to include ensuring that all PRN psychotropic medications included a discontinuation date.	

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F 758	Continued From page 21 tablet by mouth every 6 hours as needed for care-interfering behavior or hallucinations. The order had a start date of 7/9/21 with no end date and was documented as indefinite. Resident #167's medication administration record for July 2021 revealed she received Zyprexa 5 milligrams once on 7/11/21. During an interview on 7/12/21 at 3:04 PM Nurse #1 stated she did perform the admission orders for Resident #167. She stated the physician verified the orders over the phone and were entered into the e-chart. She further stated this resident did come to the facility from the hospital with a new order for Zyprexa 5 milligrams as needed every 6 hours and she read the orders to the doctor and put them in the system per the hospital discharge summary and the facility physician approved them. She concluded she was not aware as needed antipsychotic medications were required to have a stop date. During an interview on 7/12/21 at 3:16 PM the Director of Nursing stated as needed antipsychotic medications were required to have a stop date of 14 days. She further stated Resident #167's order for as needed Zyprexa 5 milligram every 6 hours did not have an end date and it should have an end date. During an interview on 7/12/21 at 3:32 PM Pharmacist #1 stated at this time, as needed antipsychotic medications would need to be revisited by the provider within 14 days of the start date and should not be ordered with no end date or as indefinite per current regulations. During an interview on 7/13/21 at 8:03 AM	F 758	An in-service was initiated by the Staff Development Coordinator on 07/13/21 with all licensed nurses in regards to ensuring that all PRN psychotropic medications included a discontinuation date. This in-service emphasized checking psychotropic medications for newly admitted residents to ensure that all PRN psychotropic medications included a discontinuation date. All newly hired nurses and contracted nurses will be in-serviced regarding checking psychotropic medications for newly admitted residents to ensure that all PRN psychotropic medications included a discontinuation date by the Staff Facilitator. 100% of all residents who receive psychotropic medications will be monitored by the Nurse Supervisors weekly x 4 weeks then monthly x 1 month utilizing the Psychotropic PRN Medication Audit Tool. This audit is to ensure that all PRN psychotropic medications include a discontinuation date. The nurse will be immediately re-trained by the Nurse Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Psychotropic PRN Medication Tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Psychotropic PRN Medication Tools to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee	

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F 758	Continued From page 22 Physician #1 stated as needed antipsychotic medications such as Zyprexa should have a 14 day stop date. He further stated Resident #167's order for as needed Zyprexa 5 milligrams every 6 hours should have a stop date and he was unaware it did not have an end date.	F 758	will meet monthly for 2 months and review the Psychotropic PRN Medication Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to document the open	F 761	F761 Label/Store Drugs and Biologicals	8/2/21

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F 761	Continued From page 23 date of Xalatan eye drops and failed to keep an unattended medication locked for 2 of 4 medication carts reviewed (400 Hall Medication Cart and 200 Hall Medication Cart). Findings included: 1. Resident #45 was admitted to the facility on 3/15/21. His active diagnoses included anemia, hypertension, diabetes mellitus, dementia, and glaucoma. Resident #45's minimum data set assessment dated 6/14/21 revealed he was assessed as moderately cognitively impaired. He required extensive assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. His vision was adequate with corrective lenses. Resident #45's care plan dated 3/15/21 revealed he was care planned for impaired visual function due to glaucoma. The interventions included arrange eye care practitioner consults as needed, monitor for signs and symptoms of acute eye problems, and tell resident where items are placed and be consistent. Resident #45's order dated 3/15/21 revealed he was ordered Xalatan 0.005% instill one drop in both eyes at bedtime for glaucoma. During observation on 7/13/21 at 1:35 PM Resident #45's Xalatan 0.005% eye drops were observed in the 400 Hall Medication Cart with no open date documented on medication. The medication was documented as dispensed to the facility on 5/17/21. The medication had a yellow label which indicated the medication was to be refrigerated until opened and discarded after 6	F 761	On 07/13/21, the Director of Nursing removed the expired medications from the 400 hall medication cart. On 07/13/21, Nurse #3 locked the 200 hall medication cart. On 07/28/21, an audit of 100% of all medication carts to include the medication cart on the 400 hall was completed by the Assistant Director of Nursing and Staff Development Coordinator. The audit was to ensure no expired medications were stored in the medication carts and that all medication carts were locked. The Director of Nursing corrected all concerns identified during the audit to include removal of expired medications and ensuring all medication carts were locked. An in-service was initiated by the Staff Development Coordinator on 07/14/21 with all licensed nurses in regards to medication labeling and storage and ensuring all medication carts are locked at all times. This in-service emphasized (1) checking medications before administration for expiration dates and ensuring that all medication carts are locked when not being used to deliver medication. All newly hired nurses and contracted nurses will be in-serviced regarding medication labeling and storage and ensuring all medication carts are locked at all times by the Staff Facilitator. 100% of all medication carts will be monitored by the Nurse Supervisors weekly x 4 weeks then monthly x 1 month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 24 weeks of being open. During an interview on 7/13/21 at 1:35 PM Nurse #2 stated Xalatan should have an open date written on the medication when opened as it must be discarded after 6 weeks of being open. She further stated the medication was dispensed on 5/17/21 which was eight weeks ago. She concluded she was unable to tell if the medication was or was not passed the expiration date now due to not knowing when it was opened. During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated the Xalatan should be dated upon being opened and discarded after six weeks. She concluded if the Xalatan was not dated she could not know when the medication needed to be discarded. 2. During observation on 7/13/21 at 2:11 PM the 200 Hall Medication Cart was observed unlocked and unattended. At 2:12 PM a nurse aide was observed to walk by the unlocked medication cart. At 2:13 PM Nurse #3 returned to the unlocked medication cart from a resident's room. During an interview on 7/13/21 at 2:13 PM Nurse #3 stated the 200 Hall Medication cart should have been locked while she was in the resident's room and she should not have left it unlocked. During an interview on 7/13/21 at 2:21 PM the Director of Nursing stated medication carts should be locked when unattended.	F 761	utilizing the Medication Storage and Labeling Audit Tool. This audit is to ensure no expired medications were stored in the medication carts and that all medication carts are locked. The nurse will be immediately re-trained by the Nurse Supervisor for any identified areas of concern. The Director of Nursing will review and initial the Medication Storage and Labeling Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Medication Storage and Labeling Audit Tools to the Executive Quality Assurance (QAPI) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Medication Storage and Labeling Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	