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	345569	A. BUILDING _____ B. WING _____	C 08/30/2024

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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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F 000	INITIAL COMMENTS A complaint survey was conducted from 8/27/24 through 8/30/24. Event ID#Z8QU11 . The following intake was investigated NC00221049. One (1) of 1 allegation resulted in a deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive 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 interviews of the staff, physician, and family member, the facility failed to follow the resident's hospital physican order from the discharge summary for sliding scale insulin which included blood glucose checks (normal range 70 to 120) before meals and at bedtime and to check a resident with diabetes blood glucose as indicated in the standing orders when staff was unable to wake him for 1 of 9 residents reviewed for diabetic care (Resident #1). Findings included: Resident #1's hospital discharge summary dated 8/1/24 documented diagnoses of diabetes, diabetic right foot ulcer, and amputation of the right fifth toe. The resident had blood glucose checks before every meal (3) and at bedtime.	F 684	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 09/24/2024

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The discharge summary included Resident #1's insulin medication orders as follows:

- Lispro 100 units/milliliter solution pen-injector. Inject subcutaneous (below the skin) 15 units before meals, sliding scale (fast acting insulin that requires blood glucose check before meals and at bedtime to determine the amount of insulin in addition or less according to the blood glucose level).
- Lantus 100 units/milliliter solution pen-injector. Inject subcutaneous 20 units at bedtime, sliding scale (long-acting insulin that required a blood glucose check before administration).

Resident #1 was admitted to the facility on 8/1/24 for orthopedic after care of right fifth toe amputation from diabetic ulcer and had the diagnosis of diabetes.

Resident #1's physician orders for insulin dated 8/1/24 were as follows (entered by Nurse #4):
- Lispro 100 units/milliliter solution pen-injector. Inject subcutaneous (below the skin) 15 units before meals for diabetes. (This order was not the same as the hospital discharge summary, the sliding scale and accompanying blood glucose check before meals and at bedtime was missing).
- Lantus 100 units/milliliter solution pen-injector. Inject subcutaneous 20 units at bedtime for diabetes. (This order was not the same as the hospital discharge summary, the blood glucose check was missing).

Resident #1 had standing orders dated 8/1/24 as follows:
- Accu-checks (fingerstick blood glucose) before meals and at bedtime for all diabetics, diet controlled, or on oral agents, or insulin for 7 days.

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Notify the physician of results on day 8. Call the physician for blood sugar less than 60 or greater than 500.
- For blood sugars less than 60 give orange juice with two packs of sugar. Recheck in 15 minutes. If still less than 60 contact the physician. For blood sugars greater than 500 contact the physician.

Resident #1 had a baseline care plan dated 8/1/24 that addressed his aftercare orthopedic needs and diabetic care.

On 8/28/24 at 12:50 pm Nurse #4 was interviewed. Nurse #4 stated that she was the admitting nurse for Resident #1 on 8/1/24 at 5:00 pm. Nurse #4 stated she entered the resident's orders into the electronic medical record including medication from the resident's hospital discharge summary. The summary had the insulin type and dosage and documented sliding scale next to it. Nurse #4 stated she called the physician on 8/1/24 to discuss the Lantus insulin which was long acting because the hospital order had sliding scale. She explained long-acting insulin doses were prescribed with the same dosage and were not given on a sliding scale. Nurse #4 further explained the physician directed her to give the Lantus, as ordered with no sliding scale. She indicated there was no directive received from the physician related to checking blood glucose levels (as indicated in the standing orders). Nurse #4 stated she did not recall if there was short acting insulin because the resident was admitted after mealtime. The nurse further stated she had not checked the resident's blood glucose. She indicated her shift ended at 8:00 pm and she had not administered insulin. Nurse #4 stated Resident #1's admission was her first admission

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she completed by herself as she usually worked the night shift. She reported there was a feature in the medication record to initiate for nurses to check the blood glucose before giving the Lantus. Nurse #4 stated she was not aware of this feature and was informed during education when she returned to work 8/5/24. She further stated that feature was normally initiated for all new admits receiving Lantus and she had not initiated this feature with the Lantus order for Resident #1. Nurse #4 commented 20 Units of Lantus was a lot of insulin, and a nurse would check the blood glucose before administering. The Lispro short acting insulin had a sliding scale automatically appear in the medication record parameter to choose. But it didn't automatically appear as expected when the order was put in the record. Nurse #4 stated she was not aware the sliding scale with blood glucose check for Lispro insulin before meals and at bedtime had not been initiated with the order to appear in the MAR (Medication Administration Record). Nurse #4 observed the resident's August MAR during interview and could see there was no parameter for sliding scale for the Lispro insulin or blood glucose check before the Lantus administration. Nurse #4 stated she discussed Resident #1 with the Director of Nursing (DON) and Admission Nurse on Monday 8/5/24 when she returned to work that the sliding scale was missed. The DON provided education on how to initiate the blood glucose check with Lantus insulin and how to initiate sliding scale and blood glucose checks with Lispro insulin in the record to appear in the MAR for nurses to check.

A review of Resident #1's MAR for 8/1/24 - 8/3/24 revealed he was administered Lispro 100 units/milliliter solution pen-injector 15 units before

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meals and Lantus 100 units/milliliter solution pen-injector 20 units at bedtime for diabetes. There was no documentation of sliding scale along with the Lispro (short acting insulin) and no blood glucose fingerstick checks before meals and at bedtime prior to the Lantus (long-acting insulin) being administered.

A review of Resident #1's nurses' notes for his admission (8/1/24 - 8/3/24) revealed no documentation of fingerstick blood glucose being completed.

Resident #1's lab glucose blood draw on 8/2/24 and result on 8/3/24 was 69 (range 70 - 99 normal) for admission.

A review of the nurses' documented shift-change report revealed Resident #1 had a fingerstick blood glucose check on 8/3/24 at 4:30 pm with a value of 167 entered by Nurse #1.

On 8/27/24 at 1:40 pm an interview was conducted Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 8/3/24 day shift, 7:00 am to 7:00 pm. Nurse #1 stated that the resident was ordered 15 units of Lispro, which was fast acting, before meals. Nurse #1 stated that the resident had no have sliding scale orders in his record and the hospital discharge summary was not available. She stated that 15 units of Lispro was a lot of insulin to administer without checking the blood glucose. Nurse #1 stated she checked the resident's blood glucose without an order before administering the insulin twice on her shift as a nursing judgement. Nurse #1 stated she had never seen a resident with fast acting insulin not have an order to check the blood glucose before meals and at bedtime and had not asked

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the physician for an order. Nurse #4 stated she reported the blood glucose level taken to nursing staff at shift change and documented one result in the 24-hour shift report. Nurse #1 had not seen any documentation of other blood glucose checks in the 24-hour report, had not received verbal report, or documented in the resident's record. Nurse #1 stated that nurses documented blood glucose in the progress notes if there was no place on the MAR. Nurse #1 stated she had not documented the resident's blood glucose she took in the nursing progress notes.

A Nurse's' note dated 8/4/24 by Nurse #2 was created at 1:08 am revealed Resident #1 was sent out to the hospital on 8/3/24 at 11:40 pm. The staff went into the resident's room to change him around 11:00 pm and he was unresponsive and had foam at his mouth. The resident's vital signs were blood pressure 151/109, pulse 63, temperature 98.1 Fahrenheit, respirations 20, and oxygen saturation 94% (normal range 90 to 100%) on room air. When Emergency Medical Services arrived, the resident's blood glucose was 24. The resident was taken to the hospital for further evaluation.

On 8/29/24 at 12:15 pm an interview was conducted with Nurse #2. Nurse #2 stated she was assigned to Resident #1 on 8/3/24 7:00 pm to 7:00 am. Nurse #2 received in nursing shift report that the resident was a deep sleeper and difficult to arouse at night. Nurse #2 stated she administered Lantus insulin and Oxycodone at 9:30 pm and the resident was alert and awake. At approximately 11:00 pm or so, Nursing Assistant (NA) #1 reported to Nurse #2 that she could not arouse the resident, and he had some foam around his mouth. The resident was not in

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any apparent distress and was breathing on his own. His color was unchanged. Nurse #2 stated she tried to wake the resident, and he would not wake. She tried sternal rub and the resident moaned. Nurse #2 stated she took the resident's vital signs, and they were normal for him except the blood pressure was higher. Nurse #2 stated she had NA #1 remain with the resident and she called the physician. The physician provided an order to send the resident out. She indicated she called 911 and Emergency Medical Services (EMS) arrived in about 7 minutes. She reported the whole process took about 15 to 20 minutes Nurse #2 indicated the resident was observed and remained stable breathing on his own until EMS arrived. Nurse #2 stated she had not believed the resident had a blood glucose issue because he had the foam around his mouth and could have had a seizure. The physician had not ordered a blood glucose check and ordered for the resident to be sent out.

On 8/29/24 at 12:35 pm an interview was conducted with NA #1. NA #1 stated she was assigned to Resident #1 on 8/3/24 7:00 pm to 7:00 am shift. NA #1 stated that during her usual rounds at approximately 11:00 pm she observed the resident lying in his bed supine. The resident appeared comfortable as if he was sleeping. She indicated when she went to arouse the resident for nighttime care she noticed some foam around his mouth. She indicated she tried to wake the resident by shaking him and he did not arouse. NA #1 stated the resident's color was normal and could see he was breathing on his own. NA #1 indicated she went and got Nurse #2. The nurse tried to arouse the resident and received very little response, and he would not wake up. NA #2 stated that the nurse took the resident's vital

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signs, and they were normal except the blood pressure was high. The resident was breathing on his own. She reported the time from finding the resident and calling the physician and then EMS was about 15 to 20 minutes.

Resident #1's EMS record documented first set of vital signs at 11:39 pm on 8/3/24 were blood pressure 216/99, pulse 116, respirations 20, and oxygen saturation 93% on room air. The resident was unresponsive. The blood glucose was 24 and intravenous therapy was started for hypoglycemia.

Resident #1's hospital record documented he was seen in the Emergency Department on 8/4/24 and was diagnosed with sepsis from his right foot ulcer/recent toe amputation which caused renal failure and profound hypoglycemia. The hypoglycemia was resistant to treatment until the sepsis was treated.

On 8/27/24 at 4:55 pm an interview was conducted with the physician. The physician stated that the resident had just been admitted (8/1/24) and he had not seen the resident yet. The physician stated he looked at the resident's orders and agreed/signed upon admission. The physician was aware that the hospital discharge summary order for insulin included sliding scale which would mean before meals and at bedtime blood glucose check. He stated his impression was that the nursing staff was checking the resident's blood glucose. He revealed this appeared to have been missed. The physician stated that he was not aware of the admitting blood glucose lab reported on 8/3/24 of 69, he would be looking at the finger stick blood glucose

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checks 4 times a day by staff to determine the significance. There were 3 finger stick blood glucose checks (one was documented) and one blood glucose lab over the 2 days the resident was at the facility. The physician also commented that he was scheduled to see the resident on 8/4/24 and would have seen the lab drawn blood glucose of 69 resulted on 8/3/24.

On 8/29/24 at 2:14 pm a follow up interview was conducted with the physician. The physician stated that he was on call on 8/3/24, all weekend. The physician had not remembered the particulars of Resident #1. He stated if the staff used the airway, breathing, and circulation check for an emergency and the vital signs were stable, it was acceptable to call him and not 911 immediately. The physician reported the staff call 911 for emergencies and not the physician when residents were not stable, or the cause of change was known. A fingerstick glucose check could be part of the emergency assessment. The physician indicated if the nurse was unsure of the cause of the change, as was in this case a seizure was suspected, it was acceptable to contact him first and received direction since the resident had been assessed and vital signs were stable. EMS was close by, arrived quickly, and addressed the issue. "The point was the resident needed a higher level of care and the nurse had sought this. The outcome was unchanged. The resident had sepsis from his recent foot surgical site that needed treatment to control the hypoglycemia."

On 8/28/24 at 1:30 pm the Director of Nursing (DON) was interviewed. The DON stated when Resident #1 was admitted on 8/1/24, the physician had not provided orders for blood

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glucose check by fingerstick before meals and at bedtime, which is part of sliding scale. (The standing orders said check blood glucose before meals and at bedtime for 7 days.) The DON stated all residents in the facility that had short acting insulin ordered had a blood glucose check before meals and at bedtime. She indicated she could see how there was confusion due to the Lantus order from the hospital discharge summary noted "sliding scale", however, you would check the blood glucose before administration. The DON stated the physician would have added the sliding scale before meals and at bedtime for the Lispro insulin on Sunday 8/4/24 when the physician would have come in to see the resident. She reported if the resident had signs and symptoms of a change, we would have called the physician and informed him of the assessment.

The facility provided the following corrective action plan with a completion date of 8/8/24:

1. Corrective action for resident(s) affected by the alleged deficient practice:
Resident #1 was sent to the hospital on 8/3/24 for hypoglycemia and altered mental status. The resident was treated at the hospital for hypoglycemia and sepsis that caused the hypoglycemia. The resident had not returned to the facility.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
On 8/6/24, the DON/Unit Manager initiated an audit of all diabetic residents to ensure orders are in place for fingerstick as ordered by the

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physician. The Unit Managers contacted the physician for any residents on diabetic medications identified without a fingerstick order to validate need for monitoring. A justification note was documented in the clinical record by the Unit Managers for any diabetic resident that the physician does not want blood sugar obtained. Orders were written for all other diabetic residents that require blood sugar monitoring. The audit was completed on 8/8/24.

On 8/6/24, the DON/Unit Manager initiated an audit of all residents receiving insulin to ensure sliding scare was initiated per physician orders when indicated or the physician was notified if the order did not specify amount/type of insulin to be administered based on fasting blood glucose level, frequency to be administered, and/or parameters for notification of the physician. The DON/Unit Manager addressed all concerns identified during the audit to include verifying with the physician the need for sliding scale insulin, updating the Medication Administration Record when indicated and education of all nursing staff. The audit was completed on 8/8/24.

On 8/6/24, the DON/Unit Manager initiated an audit of all newly written standing orders for glucose monitoring for residents on diabetic medications from 8/1/24-8/6/24. This audit was to ensure that standing orders were activated and completed per physician orders. The DON/Unit Managers addressed all concerns identified during the audit to include but not limited to activating orders when indicated and/or education of staff. The audit was completed on 8/8/24.

3. Measures/Systemic changes to prevent

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reoccurrence of alleged deficient practice:
All nursing staff participated in in-services entitled hypoglycemia, observations of and reporting changes in resident's condition, acute changes, when to notify the physician by telephone, and emergency management by the Director of Nursing completed on 8/8/24

4. Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Beginning 8/5/24, the Admissions Nurse/Unit Managers/ADON will review discharge summary for all new admissions/readmissions 5 times a week for discharge summary, for 4 weeks, then monthly for 1 month utilizing the Diabetic Audit Tool. This audit is to ensure all residents admitted with diagnosis of diabetes have blood glucose monitoring orders in place and/or validate with the physician the need for blood glucose monitoring and to ensure the nurse verified with the physician any sliding scale insulin order that does not specify amount/type of insulin to be administered based on fasting blood sugar level, frequency to be administered, and/or parameters for notification of the physician before transcribing to the Medication Administration Record. The Director of Nursing will review the Diabetic Audit Tool 5 times a week for 4 weeks, then monthly for 1 month to ensure all concerns are addressed.

The Admissions Nurse/Unit Manager will audit all newly written standing orders to include orders for glucose monitoring utilizing the Standing Orders Audit Tool 5 times a week for 4 weeks, then monthly for 1 moth. This audit is to ensure

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standing orders were activated and medication and/or glucose monitoring completed per physicians' orders. The Admissions Nurse/Unit Managers will address all concerns identified during the audit to include activating orders when indicated and/or retraining of staff. The DON will review the audit 5 times a week for 4 weeks, then monthly for 1 month to ensure all concerns are addressed.

The Director of Nursing will present the findings of the Diabetic Audit Tool and the Standing Orders Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into placed and to determine the need for further frequency monitoring. Ad hoc QAPI meeting held on 8/8/24.

Compliance Date: 8/9/24

Validation of the corrective action plan was completed on 8/30/24:

There was a signed roster of clinical staff who received in-service for sliding scale insulin blood glucose monitoring, how to input admission orders and activate standing orders, and to verify any unclear admission orders with the hospital and physician. The nursing staff also participated in acute changes, hypoglycemia, when to notify the physician, and emergency management for the in-services. The medication record was reviewed for eight diabetic residents with insulin. All residents had orders for blood glucose monitoring and sliding scale for short acting insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE 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
F 684	Continued From page 13 There was documentation of initial audit as well as on-going monitoring audits as part of the quality assurance plan. Nurses #1, #2, #3, and #4, NA #1, the Admitting Nursing, the Director of Nursing, and the physician were all interviewed and were able to state nursing received education for diabetic residents admitted with insulin orders and the need for blood glucose checks and sliding scale for fast-acting insulin and to evaluate blood glucose when a diabetic resident had received insulin or oral anti-glycemic medication and there was a change in status. The completion date of 8/9/24 was validated.	F 684		