STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING _____ B. WING _____	C 03/25/2015

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WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

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F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to obtain and utilize blood sugar results to determine the insulin dose required on 12 of 148 scheduled dates/times for 1 of 1 residents (Resident #3) with physician orders for Sliding Scale Insulin (SSI) coverage; failed to monitor a resident's blood sugar levels as ordered by the physician on 21 of 44 scheduled dates/times for 1 of 1 residents (Resident #2) receiving oral medication for a diagnosis of diabetes; failed to administer two consecutive weekly doses of an osteoporosis medication as prescribed by the physician for 1 of 1 residents (Resident #3) reviewed with a diagnosis of osteoporosis; and the facility failed to initiate administration of a medication/dietary supplement as ordered by the physician for 1 of 2 residents (Resident #2) reviewed with a diagnosis of osteoarthritis. The findings included: 1) Resident #3 was admitted to the facility on 3/30/12 from a hospital. Her cumulative diagnoses included diabetes and osteoporosis. Resident #3 ' s most recent quarterly Minimum	F 309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1) Resident #2 blood sugar level was monitored and dietary supplement was administered. The physician was notified by the Director of Clinical Services regarding resident #2 on 03/25/2015. There were no adverse outcomes to Resident #2. Resident #3 blood sugar level was monitored, sliding scale order followed and Fosamax administered as ordered. The physician was notified by the Director of Clinical Services regarding resident #3 on 03/25/2015. There were no adverse outcomes to Resident #3. 2) Residents currently residing in the facility have a potential to be affected. Current residents receiving sliding scale insulin were reviewed by the Director of	4/17/15

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

Electronically Signed | 04/16/2015

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F 309	Continued From page 1 Data Set (MDS) assessment dated 1/16/15 indicated the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance for walking, supervision for locomotion on/off the unit, and supervision with eating. A review of the Resident #3's Care Plan dated 1/16/15 included the following area of focus: The resident is at risk for developing hypoglycemia (low blood sugar) / hyperglycemia (high blood sugar) related to a diagnosis of diabetes. The care plan included a notation (dated 10/25/14) which indicated the resident was changed to an insulin regimen in accordance with her physician's orders. A review of the resident's medical record included current physician's orders for the following medications: (Order dated 1/7/13) 5 milligrams (mg) glipizide (an oral medication used to lower blood sugar in patients with Type 2 diabetes) given as one tablet by mouth every morning; (Order dated 10/22/14) 1000 mg metformin (an oral antidiabetic medication) given as one tablet by mouth twice daily; (Order dated 10/27/14) 5 units of Lantus insulin (a long-acting insulin) injected subcutaneously (under the skin) once daily; (Order dated 10/31/14) Novolin R (a short-acting insulin) injected subcutaneously two times a day as sliding scale insulin (SSI) at 6:30 AM and 9:00 PM. SSI coverage indicated that the dose of insulin administered was dependent on the resident's blood sugar (BS) result at that designated time (6:30 AM and 9:00 PM). The	F 309	Clinical Services/Administrative Nurse to ensure blood sugars results were obtained, transcribed on the medication administration record to determine the insulin dose for 3/25/15 thru 4/20/15 . Current residents receiving oral medication for diagnosis of diabetes were reviewed by the Director of Clinical Services and/or Nursing Supervisor to ensure blood glucose monitoring for scheduled dates and times as ordered by the physician 03/25/2015 thru 04/20/2015. The Director of Clinical Services and Nursing Supervisor reviewed all residents medication administration records to ensure transcribing of medications and administration of medications 03/25/2015 thru 04/20/2015. During the clinical meeting on 04/13/2015 and 04/14/2015 the Director of Clinical Services and/or Nursing Supervisor discussed all residents including resident #2 and resident #3 and in serviced the nurses on medication administration including but not limited to insulin and oral medications for current residents, using right dose, right time, right route and time, following physician orders, administering medications, and documenting on medication administration record along with site of injection. Furthermore, the nursing staff was in-serviced on 04/13/2015 and 04/14/2015 by the Director of Clinical Services and/or Nursing Supervisor the process of month end Medication Administration Record change for all residents as well as transcribing new orders and change of orders on the Medication Administration	

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F 309	Continued From page 2 SSI ordered utilized the following parameters: If BS 200-249, give 4 units insulin; If BS 250-299, give 6 units insulin; If BS 300-349, give 8 units insulin; If BS 350-399, give 10 units insulin; If BS 400 or greater, call MD (Medical Doctor) A review of Resident #3's January 2015 Medication Administration Record (MAR), beginning on 1/10/15, revealed the resident's blood sugar results were documented and SSI coverage provided appropriately, with the following exceptions: 1/22/15 at 9:00 PM: BS result and SSI coverage were not recorded 1/26/15 at 9:00 PM: BS result and SSI coverage were not recorded 1/31/15 at 9:00 PM: BS result and SSI coverage were not recorded A review of Resident #3's February 2015 Medication Administration Record (MAR) revealed the resident's blood sugar results were documented and SSI coverage provided appropriately, with the following exceptions: 2/1/15 at 6:30 AM: BS result and SSI coverage were not recorded 2/4/15 at 6:30 AM: BS result and SSI coverage were not recorded 2/7/15 at 6:30 AM: BS result and SSI coverage were not recorded 2/14/15 at 9:00 PM: BS result and SSI coverage were not recorded 2/21/15 at 9:00 PM: BS result and SSI coverage were not recorded 2/27/15 at 9:00 PM: BS result and SSI coverage were not recorded 2/28/15 at 9:00 PM: BS result and SSI coverage were not recorded	F 309	Record. In addition, the process of signing off on physician orders, transcribing orders and faxing new orders to the pharmacy was discussed. 3) Current nursing staff have been in-serviced by the Director of Clinical Services/Administrative Nurse on 4/13/15 and 4/14/15 on all residents including resident #2 and resident #3 regarding medication administration including but not limited to insulin and oral medications for residents using right dose, right time, right route and time, following physician orders, administering medications, and documenting on medication administration record along with site of injection. Furthermore, the nursing staff was in-serviced on the process of month end Medication Administration Record change. The process of signing off on physician orders, transcribing orders and faxing new orders to the pharmacy was reviewed. The Director of Clinical Services /Administrative Nurse will audit and document on a QAPI data gathering tool reviewing of the medication administration record to ensure transcribing and administration of medications and residents blood sugar levels are obtained as ordered by the physician for scheduled dates and times, blood sugar results are obtained and utilized to determine insulin dose for sliding scale insulin, residents receiving a medication/dietary supplements are administered as ordered by the physician on five residents throughout the day three times a week for four weeks, two times a	

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F 309	Continued From page 3 A review of Resident #3's March 2015 Medication Administration Record (MAR) revealed the resident's blood sugar results were documented and SSI coverage provided appropriately, with the following exceptions: 3/1/15 at 6:30 AM: BS result and SSI coverage were not recorded 3/5/15 at 6:30 AM: BS result = 207; no notation of SSI coverage was recorded (According to the SSI regimen ordered by the physician, 4 units of Novolog insulin was the dose of insulin ordered to cover a blood sugar result of 207). An interview was conducted on 3/25/15 at 2:15 PM with Nurse #1. Upon inquiry as to where a resident's blood sugar results were documented, the nurse indicated she documented the BS results on both the MAR (part of the resident ' s medical record) and a 24-hour report sheet (which was not part of the permanent medical record). The nurse emphasized she would always record the results in both places. The nurse also stated that if a resident had an order for SSI, the dose of insulin given and site of the injection would be documented on the MAR. An interview was conducted on 3/25/15 at 2:22 PM with Nurse #2. Upon inquiry as to where a resident's blood sugar results were documented, the nurse stated the results were written on the MAR. The nurse also reported that if a resident had an order for SSI, the dose of the insulin and site of the injection would be documented on the MAR. An interview was conducted on 3/25/15 at 4:20 PM with Nurse #3. Upon inquiry as to where a	F 309	week for four weeks, one times a week for four weeks. 4)Results of the Quality Improvement Monitoring will be discussed at the Quality Assurance Performance Improvement Committee by the Director of Clinical Services/Unit Manager each month for 3 months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance.	

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resident's blood sugar results were documented, the nurse indicated the primary place she recorded these results was on the MAR. However, the nurse also noted she would make another notation of the results on her own sheet to include on the 24-hour report. The nurse stated that if a resident had an order for SSI, the units of insulin given would be documented on the MAR, along with the site of the injection.

An interview was conducted on 3/25/15 at 12:10 PM with the facility's Director of Nursing (DON). During the interview, the missing blood glucose results noted for Resident #3 over the past 2 1/2 months were discussed. The DON indicated that the topic of incomplete monitoring/documentation on the residents' MARs had been identified as an area of concern and discussed with the nursing staff during a mandatory in-service conducted last week. The DON stated her expectation was for the nurses to check blood sugars as prescribed and document the blood sugar results (and SSI coverage) on the resident's MAR.

2) Resident #2 was admitted to the facility on 6/11/13. Her cumulative diagnoses included diabetes and osteoarthritis. Resident #2's annual Minimum Data Set (MDS) assessment dated 2/24/15 indicated the resident had intact cognitive skills for daily decision making. The resident required limited assistance from staff for dressing and personal hygiene, and supervision for all of her other Activities of Daily Living (ADLs).

A review of the resident's Care Plan dated 2/24/15 included the following area of focus: The resident is at risk for metabolic complications (related to the diagnosis of diabetes). Interventions included on the care plan for this

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area of focus included: "Blood Glucose levels as ordered."

A review of the resident's medical record revealed a current physician's order (dated 6/28/14) instructed Resident #2's blood sugar to be checked twice daily at 6:30 AM and 4:00 PM every Monday and Saturday. On 12/26/14, a physician's order was received to initiate 500 milligrams (mg) metformin ER (an antidiabetic medication in an extended release formulation) to be given every evening to Resident #2.

A review of Resident #2's January 2015 Medication Administration Record (MAR) revealed blood sugar results were not obtained/documented as ordered on 8 of the 14 scheduled dates/times (beginning with 1/10/15):
1/10/15 at 4:00 PM: BS result = not available
1/12/15 at 4:00 PM: BS result = not available
1/17/15 at 4:00 PM: BS result = not available
1/19/15 at 6:30 AM: BS result = not available
1/24/15 at 4:00 PM: BS result = not available
1/26/15 at 4:00 PM: BS result = not available
1/31/15 at 6:30 AM: BS result = not available
1/31/15 at 4:00 PM: BS result = not available

A review of Resident #2's February 2015 Medication Administration Record (MAR) revealed blood sugar results were not obtained/documented as ordered on 9 of the 16 scheduled dates/times
2/7/15 at 6:30 AM: BS result = not available
2/7/15 at 4:00 PM: BS result = not available
2/9/15 at 6:30 AM: BS result = not available
2/9/15 at 4:00 PM: BS result = not available
2/14/15 at 4:00 PM: BS result = not available
2/16/15 at 4:00 PM: BS result = not available
2/21/15 at 4:00 PM: BS result = not available

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F 309	Continued From page 6 2/23/15 at 4:00 PM: BS result = not available 2/28/15 at 4:00 PM: BS result = not available A review of Resident #2's March 2015 Medication Administration Record (MAR) revealed blood sugar results were not obtained/documented as ordered on 4 of the 14 scheduled dates/times (through the date of the review): 3/2/15 at 4:00 PM: BS result = not available 3/14/15 at 4:00 PM: BS result = not available 3/16/15 at 4:00 PM: BS result = not available 3/21/15 at 6:30 AM: BS result = not available An interview was conducted on 3/25/15 at 2:15 PM with Nurse #1. Upon inquiry as to where a resident's blood sugar results were documented, the nurse indicated she documented the BS results on both the MAR (part of the resident's medical record) and a 24-hour report sheet (which was not part of the permanent medical record). The nurse emphasized she would always record the results in both places. An interview was conducted on 3/25/15 at 2:22 PM with Nurse #2. Upon inquiry as to where a resident's blood sugar results were documented, the nurse stated the results were written on the MAR. An interview was conducted on 3/25/15 at 4:20 PM with Nurse #3. Upon inquiry as to where a resident's blood sugar results were documented, the nurse indicated the primary place she recorded these results was on the MAR. However, the nurse also noted she would make another notation of the results on her own sheet to include on the 24-hour report. An interview was conducted on 3/25/15 at 12:10	F 309		

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PM with the facility's Director of Nursing (DON). During the interview, the missing blood glucose results noted for Resident #2 over the past 2 1/2 months were discussed. The DON indicated that the topic of incomplete monitoring/documentation on the residents' MARs had been identified as an area of concern and discussed with the nursing staff during a mandatory in-service conducted last week. The DON stated her expectation was for the nurses to check blood sugars as prescribed and document the blood sugar results on the resident's MAR.

3) Resident #3 was admitted to the facility on 3/30/12 from a hospital. Her cumulative diagnoses included diabetes and osteoporosis. Resident #3's most recent quarterly Minimum Data Set (MDS) assessment dated 1/16/15 indicated the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance for walking, supervision for locomotion on/off the unit, and supervision with eating.

A review of the resident's March 2015 Physician's Orders included a current medication order (dated 3/30/12) for the following: 70 milligrams (mg) alendronate (a medication used for the treatment of osteoporosis) given as one tablet by mouth once weekly. The Physician's Orders indicated the alendronate was scheduled for administration every Monday at 6:30 AM.

A review of Resident #3's February 2015 Medication Administration Record (MAR) revealed the resident received a dose of alendronate on Monday, 2/2/15. No notation was

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made to indicate the resident received alendronate on Monday, 2/9/15. However, the MAR indicated a dose of alendronate was administered to Resident #3 on Tuesday, 2/10/15. No additional doses of alendronate were noted as having been administered to Resident #3 during the remainder of February 2015.

An interview was conducted on 3/25/15 at 12:10 PM with the facility's Director of Nursing (DON). During the interview, Resident #3's February 2015 MAR was reviewed. The MAR indicated alendronate was given to the resident on two dates only (2/2/15 and 2/10/15) during the month of February. Upon review of the MAR, the DON acknowledged that two Mondays (2/16/15 and 2/23/15) had not been flagged on the MAR as scheduled dates for the administration of alendronate. The DON indicated the administration of alendronate was likely overlooked on 2/16/15 and 2/23/15 because these dates had not been flagged. Upon inquiry, the DON stated her expectation was for Resident #3 to receive her prescribed alendronate every Monday as ordered by the physician.

4) Resident #2 was admitted to the facility on 6/11/13. Her cumulative diagnoses included osteoarthritis. Resident #2's annual Minimum Data Set (MDS) assessment dated 2/24/15 indicated the resident had intact cognitive skills for daily decision making. The resident required limited assistance from staff for dressing and personal hygiene, and supervision for all of her other Activities of Daily Living (ADLs). She received medication as needed for occasional mild pain.

A review of the resident's medical record included

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a Physician's Nursing Home Note dated 2/28/15. The note indicated Resident #2's only complaint was of back and left knee pain. The physician's plan stated, "Review her med list and see if we can modify her regimen to provide a little bit better osteoarthritic pain control."

On 2/28/15, a Physician's Order was received to give the resident 1000 milligrams (mg) of glucosamine/chondroitin with each meal. Glucosamine/chondroitin is a dietary supplement frequently used for the treatment of osteoarthritis.

A review of Resident #2's February 2015 Medication Administration Record (MAR) included a hand-written notation which read, "glucosamine/chondroitin 1000 mg po (by mouth) with each meal." The MAR indicated the dietary supplement was to be given at 8:00 AM, 1:00 PM, and 5:00 PM. The MAR did not include a notation to indicate the glucosamine/chondroitin had been given on 2/28/15.

A review of Resident #2's March 2015 monthly Physician's Orders revealed glucosamine/chondroitin was not listed among the current orders.

A review of Resident #2's March 2015 Medication Administration Record (MAR) revealed the glucosamine/chondroitin ordered on 2/28/15 was not included on the list of medications to be administered to the resident.

An interview was conducted on 3/25/15 at 3:03 PM with the facility's Director of Nursing (DON). During the interview, the 2/28/15 order written for glucosamine/chondroitin by Resident #2's physician was discussed. Upon review of both

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F 309	Continued From page 10 Resident #2's March 2015 Physician Orders and March 2015 MAR, the DON acknowledged there were no notations made in the medical record to indicate the resident received the dietary supplement as ordered. A follow-up interview was conducted on 3/25/15 at 4:00 PM with the DON. During the interview, the DON reported the glucosamine/chondroitin was missed on Resident #2's March monthly orders and MAR because of an error made during the month end change-over. The DON reported it was the responsibility of 3rd shift nurse working the night of 2/28/15 to 3/1/15 to be sure any orders written on the 28th were transcribed onto the March 2015 Physician ' s Orders and March 2015 MAR. The DON outlined the facility's process of checking the orders and MARs during month end change-over to ensure they were accurate and complete. She stated the staff did three checks on the MARs. The third and final check was completed by the 3rd shift nurse the night before the month end change-over. During this check, a comparison of the new month's MAR (March 2015) was made to the previous month's MAR (February 2015). The DON indicated the new order written for the glucosamine/chondroitin on 2/28/15 should have been caught during this final check, but it was not. The DON indicated an attempt to contact the 3rd shift nurse who worked the night of 2/28/15 to 3/1/15 was unsuccessful; she was not available at this time. Upon inquiry, the DON stated her expectation was that the medication (dietary supplement) would have been transcribed to the resident's MAR, faxed to the pharmacy, and the order carried out for administration as prescribed by the physician.	F 309		