

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345570	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/17/2019
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 13835 BOREN STREET HUNTERSVILLE, NC 28078		
(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	E 000			
F 000	An unannounced recertification and complaint survey was conducted on 04/29/19 - 05/17/19. The facility is in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID: 4M1U11.	F 000			
F 578 SS=D	INITIAL COMMENTS The survey team entered the facility on 04/29/19 to conduct a recertification survey with complaint investigations and exited on 05/03/19. Additional information was obtained on 05/10/19. Immediate Jeopardy was identified on 5/14/19 at: CFR 483.25 at tag F 684 at a scope and severity (J). The tag F 684 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/19/18 and was removed on 05/17/19. An extended survey was conducted. Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		6/21/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/07/2019

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

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F 578	<p>Continued From page 1</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.</p> <p>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on family, physician, nurse practitioner and staff interviews and medical record review, the facility failed to honor a resident's right to refuse cardio-pulmonary resuscitation (CPR) for 1 of 6 sampled residents reviewed for advanced directives (AD) (Resident #71).</p> <p>The findings included:</p> <p>Review of the facility policy, Nursing Policies and Procedures, Emergency Care, Cardio-pulmonary Resuscitation (CPR), effective 08/16/17,</p>	F 578	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged</p>		

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F 578	<p>Continued From page 2</p> <p>recorded, in part, CPR will be initiated as a resuscitation procedure to restore breathing and or heart beat if any patient is found to be in cardio-pulmonary arrest. EXCEPT when the patient's physician has specifically and appropriately documented a DNR (Do Not Resuscitate) order in the patient's permanent medical record.</p> <p>Resident #71 was admitted to the facility from the hospital on 2/9/19. Diagnoses included end stage renal disease, dependence on renal dialysis, Parkinson's disease, hypertensive heart disease, paroxysmal atrial fibrillation, shortness of breath, diabetes mellitus 2, and pleural effusion, among others.</p> <p>Review of his electronic medical record (e-record) revealed he was his own responsible party. His e-record included a physician's order dated 2/9/19 for the code status of DNR.</p> <p>Review of the hospital discharge summary dated 2/8/19 revealed it was scanned into the facility's e-record for Resident #71 on 2/11/19. It documented his code status as DNAR (Do Not Attempt Resuscitation).</p> <p>A Medical History and Physical Note, by the medical doctor (MD) with a text date of 2/11/19, and an effective date of 2/13/19, recorded Resident #71 admitted from the hospital for post-acute care and rehabilitation, his code status was documented as DNR.</p> <p>An admission Minimum Data Set (MDS) dated 2/16/19, recorded Resident #71 entered the facility from the hospital expecting to discharge to the community. The MDS assessed him with</p>	F 578	<p>deficiencies cited have been or will be completed by the dates indicated.</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #71 is deceased. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: All resident's medical records were checked to ensure that the Code Status matched the MOST (Medical Orders for Scope of Treatment) Form. In the absence of the MOST form if the resident is alert and oriented the Nurse will initiate the conversation with the resident as to their wishes in regards to Code Status. If the residents' cognitive level is compromised then the POA (Power of Attorney) will be identified and asked of the wishes of the resident and a MOST form initiated and physician notified of the resident/POA wishes. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All Nurses were educated on the requirement of Policy 901, 1) A DNR order may be issued at any time during the course of the resident's stay in the Center by the attending physician with the consent of the resident, or if otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the consent of the person authorized by state law to consent on the resident's behalf. 2) If upon admission the resident provides advanced medical</p>		

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F 578	<p>Continued From page 3</p> <p>adequate hearing/vision, clear speech, able to be understood/understand, and intact cognition.</p> <p>A nursing progress note for Resident #71, written by Nurse #1, with an effective date of 3/7/19 at 12:57 AM recorded, in part, that Resident #71 was found unresponsive by Nurse #1 during one of the staff's every 15 minute rounds. Nurse #1 documented that she called a registered nurse (RN) for help and that Nurse #1 started CPR immediately. Nurse #1 documented that she called the family of Resident #71 and they confirmed his code status as DNR. Nurse #1 documented that CPR was stopped. Nurse #1 documented that she later found the golden rod form for Resident #71 in his room closet while helping the family pack his clothes.</p> <p>Review of the facility's Record of Death and the Certificate of Death recorded Resident #71 expired in the facility on 3/6/19 at 9:30 PM due to renal carcinoma and end stage renal disease.</p> <p>An interview occurred in person on 04/30/19 at 5:03 PM with Nurse #1. During the interview, Nurse #1 stated she was the assigned Nurse for Resident #71 on 3/6/19 for the 2nd shift. Nurse #1 stated she was not familiar with Resident #71 as she had not been his nurse before. Nurse #1 stated she received report from the 1st shift nurse that Resident #71 was unstable, making frequent attempts to get up unassisted. Nurse #1 stated that due to the Resident's history of falls and the report she received from the 1st shift nurse, Nurse #1 asked his nurse aide (NA) to help her monitor Resident #71 every 15 minutes. Nurse #1 stated that she had received prior training regarding AD and how to respond in an emergency. She further stated that forms to</p>	F 578	<p>directive documents, such as a Durable Health Care Power of Attorney, or a Living Will that specifies the withholding of CPR (Cardio Pulmonary Resuscitation) a licensed nurse must immediately notify the attending physician and secure a valid written DNR (Do Not Resuscitate) order for the medical record. All new nurses will be educated on the requirement of Policy 901, 1) A DNR order may be issued at any time during the course of the resident's stay in the Center by the attending physician with the consent of the resident, or if otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the consent of the person authorized by state law to consent on the resident's behalf. 2) If upon admission the resident provides advanced medical directive documents, such as a Durable Health Care Power of Attorney, or a Living Will that specifies the withholding of CPR a licensed nurse must immediately notify the attending physician and secure a valid written DNR order for the medical record during their orientation process and if not will not be allowed to work until education is completed by the Staff Development Coordinator or Director of Nursing. This education will be completed by June 17, 2019. This process will be monitored Daily (Monday through Friday) for a period of 4 weeks then bi-weekly x2 and monthly x11, a list will be run of new admissions, the Monday list to include residents admitted on Friday through Sunday ensure that a MOST Form has been initiated with each new admission.</p>		

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F 578	Continued From page 4 represent the resident's AD was completed upon admission for each resident and scanned into their e-record. A hard copy of these forms was also kept at the nursing station for reference. Nurse #1 stated sometime after 8:00 PM on 3/6/19, she checked on Resident #71, no distress noted, left his room and entered another resident's room. After about 20 minutes, she returned to Resident #71's room, found him lying on his bed, pale in color, with no response when she called his name, touched him or commanded him to squeeze her hand. She stated his eyes were closed and he did not open them upon her request. Nurse #1 stated she checked his radial (inside of the wrist) and apical (left side of the chest) pulse using her stethoscope but could not find a pulse. She then checked his carotid (neck) artery and noted a "faint" pulse. Nurse #1 stated "I can't speak to his breathing because I did not fully assess that." Nurse #1 then stated she went to the hallway, yelled to a NA to go get the RN (Nurse #2) on an adjacent unit to help and returned to Resident #71's room. His legs were slightly off the bed, so she repositioned him back on the bed and started CPR. She stated she did not know or verify his code status at that time, she stated "I just did not want him to die." After less than 10 minutes, Nurse #1 stated Nurse #2 arrived and took over CPR while Nurse #1 went to verify code status and call for emergency medical services (EMS). Nurse #1 stated she checked the folder at the nurse's station and found the pink form (Medical Orders for Scope of Treatment) which documented Resident #71's code status as Full Code. Nurse #1 noted, at the time of the interview, that Resident #71's MOST form was lost and was not available for review. Nurse #1 stated she also checked his e-record and saw the MD order for a code status of DNR	F 578	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will compile the findings from the audits and submit this information to the QAPI (Quality Assurance Performance Improvement) Committee monthly for 12 months or until compliance is achieved and sustained or revisions to the Monitoring is needed and additional monitoring as directed by the QAPI Committee.		

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F 578	<p>Continued From page 5</p> <p>and the scanned copy of his hospital discharge summary which also documented a code status of DNR, but at the time, she could not locate a gold form (an indication of DNR) for the Resident. Due to the conflicting documents, Nurse #1 stated she called for EMS. Nurse #1 further stated that when she initiated CPR, she did not verify the code status of Resident #71. Nurse #1 stated she returned to Resident #71's room and saw Nurse #2 performing CPR on Resident #71. Nurse #1 advised Nurse #2 that she found a MOST form for the code status, Full Code as well as a MD order and hospital discharge summary for code status, DNR. Nurse #1 stated Nurse #2 continued CPR. Nurse #1 then stated that when EMS arrived, they asked the Resident's code status and Nurse #1 advised them the same. EMS responded that without a gold form to indicate DNR code status, they would have to continue CPR. Nurse #1 stated EMS then continued CPR on Resident #71. Nurse #1 stated she then contacted the family of Resident #71, EMS spoke to the family and received verification of a DNR code status and it was at that time CPR was stopped and Resident #71 was pronounced dead.</p> <p>During an interview on 04/30/19 at 6:48 PM, the Corporate Nurse Consultant (CNC) stated that the MD order in the e-record was an order that superseded the MOST form. He stated that Nurse #1 should have verified the code status of Resident #71 prior to initiating CPR and that she should have followed the MD order in the Resident's medical record for a code status of DNR.</p> <p>An interview on 05/01/19 at 9:00 AM with the Administrator revealed that it was the facility's</p>	F 578			

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F 578	<p>Continued From page 6</p> <p>policy that each nurse verify the code status of a resident prior to initiating CPR.</p> <p>An interview occurred on 05/01/19 at 9:32 AM with the Nurse Practitioner (NP). She stated that she reviewed the hospital discharge summary for Resident #71 upon admission and signed his admission orders. The NP stated she noted his code status was DNR. The NP stated that Nurse #1 informed her on 3/7/19 that she did not verify the code status of Resident #71 before she initiated CPR and then when she attempted to verify the Resident's code status she could not locate the MOST form or the gold form. The NP stated Nurse #1 initiated CPR on a resident with a code status of DNR which was reflected in the medical record. The NP also stated that this was an ethical issue for the facility to learn from and that the MD order for DNR is what should have been followed.</p> <p>During an interview with Nurse #2 on 05/01/19 at 11:06 AM, Nurse #2 stated on 3/6/19 she worked on the 100 hall for the 2nd shift. Nurse #2 stated she had previously worked as a paramedic for 15 years, so when she entered the room for Resident #71, she immediately recognized that Resident #71 was unresponsive and stated "I thought he was dead." Nurse #2 stated she did not witness anyone performing CPR when she entered his room. Nurse #2 asked the Resident's code status and Nurse #1 stated she did not know and would have to go check. Nurse #1 left the room. Nurse #2 stated she assessed Resident #71 as cyanotic (blue in color), there was no movement in his diaphragm, he was without a radial, apical or carotid pulse. Nurse #2 stated she initiated CPR because when she asked his code status his Nurse did not know.</p>	F 578			

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F 578	<p>Continued From page 7</p> <p>Nurse #2 further stated "Had I known his code status was DNR I would not have started CPR." Nurse #2 then stated that when EMS arrived they took over CPR so she stopped CPR and left the room.</p> <p>A telephone interview occurred on 05/01/19 at 11:41 AM with the family of Resident #71. The family stated that Resident #71 was his own responsible party and he signed his own MOST form. The family stated they never saw the MOST form, but that Resident #71 was adamant he did not want CPR. The family also stated they were told that the facility could not locate the MOST form so they initiated CPR until they verified with the family that his code status was DNR and then CPR was stopped. The interview also revealed the family was not bothered that CPR was initiated until code status could be verified.</p> <p>An interview occurred on 05/01/19 at 12:03 PM with Nurse #3 who stated he worked on 3/6/19 on the 2nd shift when Resident #71 expired. Nurse #3 stated he was the Nurse who admitted Resident #71 to the facility and entered his MD orders into the e-record. Nurse #3 stated he could not recall completing the MOST form for Resident #71, but that the Resident did have an MD order for the code status of DNR. Nurse #3 stated he entered the code status of DNR into the medical record for Resident #71 on admission.</p> <p>During a telephone interview on 05/01/19 at 02:20 PM, the MD stated that CPR should not be initiated until the staff know the code status and if the code status on documents were conflicting, then the dates of the documents should be referenced and followed based on the document that is the most current; all documents should</p>	F 578			

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F 578	Continued From page 8 then be updated so that we honor the residents AD. The Director of Nursing (DON) was interviewed on 5/01/19 at 7:00 PM. During the interview the DON stated she expected the nurses to verify code status before initiating CPR, but in the absence of code status, initiate CPR. The DON stated that AD documents should be completed on admission or within a few days of admission by the admitting nurse, the resident and their family and scanned into the e-record so that the nurse could reference them in an emergency.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that	F 580		6/21/19	

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F 580	<p>Continued From page 9</p> <p>all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Nurse Practitioner (NP) interviews, the facility failed to notify the medical provider after a resident, who did not have a diagnosis of diabetes or an order to receive insulin, was mistakenly administered long acting insulin for 1 of 2 residents (Resident #221) reviewed for change in condition.</p> <p>Findings included:</p> <p>Resident #221 was readmitted to the facility on 10/4/2018.</p>	F 580	<p>F580</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #221 is no longer in the facility.</p> <p>How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: 24 hour daily shift report is run and highlighted for Change of Conditions that require notification of</p>		

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F 580	<p>Continued From page 10</p> <p>The Significant Change Minimum Data Set (MDS) dated 11/1/2018 revealed that Resident #221 was cognitively intact and did not have a diagnosis of diabetes and did not receive any insulin injections.</p> <p>The Medication Error Report completed by Nurse #4 dated 11/19/2018 revealed Resident #221 received 20 units of Levemir Insulin, in error, during the 9:00 PM medication administration by Nurse #4.</p> <p>Review of Resident #221's nursing notes revealed the following blood sugar readings and information:</p> <p>11/19/2018 9:00 PM blood sugar reading- 93 mg/dl (blood sugar reading prior to the administration of insulin). Normal blood sugar ranges are between 70 to 130 mg/dl. 11/19/2018 9:20 PM blood sugar reading- 193 mg/dl (blood sugar reading after the administration of insulin) 11/20/2018 12:16 AM blood sugar reading- 71 mg/dl Review of nursing note dated 11/20/2018 at 1:06 AM read in part: Resident #221 lying supine in bed, eyes closed and responsive. Respiration even and unlabored. On 11/20/2018 at 5:30 AM, the blood sugar reading was 40mg/dl.</p> <p>Review of the call log dated 11/20/2018 for the on-call/ after-hours provider service revealed Nurse #4 placed one initial call at 12:11 AM. The on-call/after-hours provider service returned that call at 12:13 AM. No further calls were placed from the facility to the on-call/after-hours provider.</p>	F 580	<p>physician and checked to ensure that the physician was notified which started on June 11, 2019 by the Director of Nursing. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: To ensure the physician is notified if a change in condition occurs. All nurses were re-educated on Policy 2002 Significant Change of Condition which includes, 1. The resident's change of condition shall be reported immediately to a licensed nurse. 2. A licensed nurse shall assess the resident for signs and symptoms of physical or mental change of condition. 3. This assessment shall be reported to primary physician or designated alternate. 4. Responsible party will also be notified of a change of condition and will be completed by June 13, 2019, by the Corporate QI Monitor and Staff Development Coordinator. Any nurse not receiving the education will be removed from the schedule until the education is completed. All new hires will be educated during orientation will be educated starting June 5, 2019. Starting June 11, 2019 a 24 hour report which includes progress notes and any change of condition will be run Monday through Thursday by the Director of Nursing and Unit Coordinators or Administrator and highlighted for Change of Conditions that require notification of physician and checked to ensure that the physician was notified. Starting June 11, 2019 a 72 hour report will run on Mondays to include Friday-Sunday and will be audited by the Director of Nursing and Unit Coordinators</p>		

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F 580	<p>Continued From page 11</p> <p>An interview was completed on 4/30/2019 at 5:49 PM with Nurse #4. Nurse #4 revealed she had worked a double shift (7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM) and administered insulin to Resident #221 in error during the 9:00 PM medication pass on 11/19/2018. She realized the error occurred once she left Resident #221's room and read the names located outside the room doors and looked at the picture on the electronic medication administration record (eMAR). Nurse #4 verbalized that Resident #221 did not question the administration of the insulin. Nurse #4 stated she immediately notified the on-call/ after-hours provider service and received orders from the NP to monitor Resident #221 and recheck her blood sugar at 6:00 AM on 11/20/2018. Nurse #4 verbalized that she reported the incident and reviewed the orders with the oncoming shift.</p> <p>Five (5) additional attempts were made to contact Nurse #4 for clarification with no success.</p> <p>An interview was completed with Nurse #5 on 4/30/2019 at 5:31 PM. Nurse #5 stated she and Nurse #4 assessed Resident #221 at the start of 3rd shift (11:00 PM to 7:00 AM). She recalled obtaining a blood sugar reading around midnight but did not recall notifying the on-call/after-hours provider service of the blood sugar reading. She stated Resident #221 was responsive (alert and talking) and doing well at that time.</p> <p>An additional telephone interview with Nurse #5 was completed on 5/10/2019 at 11:15 AM. Nurse #5 stated Nurse #4 was panicking when she arrived on the unit on 11/19/2018 and informed her that she administered long acting insulin to</p>	F 580	<p>or Administrator and highlighted for Change of Conditions that require notification of physician and checked to ensure that the physician was notified. Re-education will be provided by the Staff Development Coordinator for first instance of not notifying the physician and disciplinary action for any other infractions. These audits will continue for a period of 12 months.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will be responsible for the implementation and ensuring that the audits are completed as directed monthly x12. The results of the audits will be brought to the monthly QAPI Committee meeting which lead by the Administrator and discussed and assessed for the need for revision and follow through with any disciplinary actions if needed.</p> <p>Alleged Date of Compliance: June 21, 2019</p>		

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F 580	Continued From page 12 Resident #221, who did not have a diagnosis of diabetes. Nurse #5 verbalized she and Nurse #4 went to immediately check Resident #221 and assess her condition. Nurse #5 directed Nurse #4 to obtain a blood sugar reading and notify the on-call/after-hours provider service. The blood sugar reading obtained by Nurse #4 was 71 mg/dl. She was not present when Nurse #4 made notification to the on-call/ after-hour provider to inform them of the medication error and blood sugar reading. Nurse #4 did not tell her why she had waited to notify the on-call/after-hours provider of the medication error. A telephone interview was completed on 5/1/2019 at 9:23 AM with the NP. The NP was notified by the on-call/ after-hours provider service around midnight on 11/20/2018 of an incident that occurred at the facility. The NP returned the call to the facility shortly after midnight on 11/20/2018. She spoke with Nurse #4 and was informed that the wrong medication was given to Resident #221 during the 9:00 PM medication administration. The resident had no diagnosis of diabetes and there was no reversal of the medication once administered. An interview was completed with the DON on 5/3/2019 at 5:54 PM. The DON stated her expectation of staff would have been to notify the physician or nurse practitioner immediately, and responsible party/emergency contact regarding any change in a resident's condition.	F 580			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		6/21/19	

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F 641	<p>Continued From page 13</p> <p>The assessment must accurately reflect the resident's status.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and medical record review, the facility failed to record the weight in section K on an annual Minimum Data Set (MDS) assessment for 1 of 3 MDS reviewed for nutrition (Resident #26). Additionally, the facility failed to accurately code the discharge location in section A for 2 Residents (Residents #222 and #371) for 2 of 6 MDS reviewed for discharge location.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #26 was admitted to the facility on 2/20/17. Diagnoses included severe Alzheimer's dementia with behavior, cerebral infarction, atrial fibrillation, and edema, among others. <p>Medical record review of nursing progress notes September 17 - 27, 2018 revealed there was no documentation that Resident #26 refused to have her weight assessed.</p> <p>An annual MDS assessment dated, 9/27/18 assessed Resident #26 with no speech, sometimes understood/understands, severely impaired cognition, and dependent on staff for eating assistance. Her weight was recorded with a dash.</p> <p>Review of her weight history from August - October 2018 revealed the following weights:</p> <ul style="list-style-type: none"> · August 4, 2018, 120.8 pounds · August 13, 2018, 121.5 pounds · October 3, 2018, 128.7 pounds <p>Review of her September 2018 care plan and</p>	F 641	<p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: F641: The facility failed to record the weight in section K on an annual Minimum Data Set MDS assessment for 1 of 3 MDS reviewed for nutrition (Resident #26). Resident #26's weight in K0200B was dashed on Annual MDS 9/27/18 as the weight was not obtained within 30 days of the ARD. Her weight was obtained on 10/3/18.</p> <p>F641: The facility failed to accurately code the discharge location in section A for 2 Residents (Residents #222 and #371) for 2 of 6 MDS reviewed for discharge location. The MDSC inadvertently coded Question A2100 Discharge Status incorrectly on resident #371 4/1/19 DC RNA MDS as discharge to the community. The resident was discharged to another skilled nursing facility. The MDSC inadvertently coded Question A2100 Discharge Status incorrectly on resident #222 2/1/19 DC RNA MDS as discharge to the community. The resident was discharged to hospital. On 05/2/19, the MDSC modified resident #222's 2/1/19 Discharge (DCRNA) MDS to hospital and #371's 4/19/18 Discharge (DCRNA) MDS to Another Skilled Nursing to code Question A2100 Discharge Status correctly.</p>		

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F 641	<p>Continued From page 14</p> <p>April 2019 Palliative Care Consult revealed Resident #26 was at risk for nutritional decline due to her comorbidities, impaired fluid balance, mechanically altered diet (pureed consistency) and history of weight loss.</p> <p>An interview with the facility's consultant registered dietitian (RD) occurred on 5/03/19 at 12:43 PM and revealed that she completed the nutrition section (section K) of the annual MDS assessment dated 9/27/18 for Resident #26. The RD reviewed the Resident Assessment Instrument manual which instructed staff completing section K of the MDS assessment to obtain a weight within 30 days of the Assessment Reference Date (ARD) for the MDS assessment. The RD then stated "I put the dash for her weight because I did not have a weight for her in the last 30 days." The RD further stated that when she reviewed the Resident's weight history, the August 2018 weights were too old and the Resident did not have a September 2018 weight recorded. She then stated "I did not attempt to reweigh her and I typically complete my assessments the day after the ARD."</p> <p>An interview was completed with the Administrator on 5/3/2019 at 5:28 PM. The Administrator stated her expectation of staff completing the MDS assessment, in conjunction with the IDT (Interdisciplinary) team, would be to accurately code the nutrition section of the MDS assessment.</p> <p>2. Resident #222 admitted to the facility on 11/14/2018 and discharged to the hospital on 1/31/2019. Resident #222 had diagnoses that included displaced fracture of posterior wall of right acetabulum, infection/ inflammatory reaction</p>	F 641	<p>The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: F641: All current residents as of June 21, 2019 will have a weight coded in question K0200B on their most recent MDS.</p> <p>F641: MDS Coordinator and/or MDSC Consultant will conduct an audit of all discharged residents discharged within the last 30 days to ensure Question A2100 Discharge Status was correctly coded. The audit will be completed by date of compliance date June 21, 2019.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected/and or in compliance with the regulatory requirements: On 6/7/19, the MDSC Consultant provided education to the MDSC, Dietitian, and Diet Tech regarding the RAI Rules for coding weight in question K0200B on the MDS. MDSC will now provide DON weekly a list of MDS scheduled within the next 14 days to obtain a weight timely.</p> <p>The MDS Coordinator or designee will audit 5s MDS to ensure Question K0200B, weight, is coded correctly. This will be accomplished one time a week for 1 month, twice a month for 1 month and monthly for one month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution</p>		

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F 641	<p>Continued From page 15</p> <p>due to other internal joint prosthesis, and muscle weakness.</p> <p>Review of the Discharge Minimum Data Set (MDS) assessment dated 2/1/2019 revealed Resident #222 was cognitively intact for decision making with no memory problems. Resident #222 required assistance with activities of daily living (ADL). Review of Section A2100 (Discharge Status) revealed a discharge location of community.</p> <p>An interview was completed with the Discharge Planner #1 on 5/2/2019 at 5:19 PM. The Discharge Planner #1 stated Resident #222 was originally scheduled to discharge home but transferred to the hospital prior to discharge. The Discharge Planner #1 stated she did not code Section A2100 on the MDS assessment.</p> <p>An interview was completed with the MDS Coordinator #1 on 5/3/2019 at 9:29 AM. The MDS Coordinator #1 stated that she has worked in the facility since September of 2018. The MDS Coordinator #1 verbalized the process of discussing a resident's discharge status in the daily morning meetings. The MDS Coordinator #1 indicated A2100 was coded in error for Resident #222 to discharge to the community. The MDS Coordinator #1 communicated Resident #222 discharged to the hospital and the assessment would be modified.</p> <p>An interview was completed with the Administrator on 5/3/2019 at 5:28 PM. The Administrator stated her expectation of the MDS Coordinator, in conjunction with the IDT (Interdisciplinary) team, would be to accurately code the discharge location of the resident.</p>	F 641	<p>if needed.</p> <p>On 5/8/19, the MDSC Consultant provided education to the MDSC regarding the RAI Rules for coding Question A2100 Discharge Status. The MDS Consultant or designee will audit 5 discharged residents <input type="checkbox"/> Discharge Return Not Anticipated MDS to ensure Question A2100 Discharge Status was coded correctly. This will be accomplished one time a week for 1 month, twice a month for 1 month and monthly for one month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution if needed.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will compile the findings from the audits and submit this information to the QAPI Committee monthly for 12 months or until compliance is achieved and sustained or revisions to the Monitoring is needed and additional monitoring as directed by the QAPI Committee.</p>		

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F 641	<p>Continued From page 16</p> <p>3. Resident #371 was admitted to the facility on 02/19/19 with diagnoses of Hemiplegia and Hemiparesis following Cerebral infarction affecting left non-dominant side, Hypertension and Vascular dementia.</p> <p>Review of Resident #371's Minimum Data sheet (MDS) assessment dated 2/19/19 revealed that resident #371 was cognitively intact, extensive assistance with Activities of Daily Living (ADL). Review of the discharge entry dated 4/1/19, revealed discharge not anticipated, Discharge - return not anticipated, Type of discharge - planned, Discharge status - community.</p> <p>Review of resident #371's Nurse Practitioner's order dated 3/28/19 revealed orders to discharge resident to Long term care (LTC).</p> <p>An interview was conducted with the Discharge planner on 05/02/19 at 04:30 PM, She confirmed that the resident was discharged to another LTC facility on 04/01/19.</p> <p>An interview was conducted with the MDS Coordinator on 05/02/19 at 04:43 PM, She stated that the discharge status of resident #371 was coded in error and that she would do the correction immediately. She stated that she failed to check the discharge planner's notes regarding resident moving to another LTC facility.</p> <p>An interview was conducted with the Director of Nursing on 05/02/19 at 05:43 PM, she stated that the MDS assessment was coded incorrectly regarding resident discharge status due to oversight and human error and that her expectation is for the MDS Coordinator to code</p>	F 641			

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F 641	Continued From page 17	F 641			
F 684 SS=J	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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, staff, Physician, and Nurse Practitioner (NP) interviews, the facility failed to monitor a resident's condition to prevent a hypoglycemic reaction after the resident, who did not have a diagnosis of diabetes or an order to receive insulin, was mistakenly administered long acting insulin for 1 of 2 residents (Resident #221) reviewed for change in condition. This resulted in an abnormal drop in blood sugar with a blood sugar reading of 40 milligram per deciliter (mg/dl) and unresponsiveness that required Emergency Department (ED) evaluation and treatment for hypoglycemia (a condition caused by low blood sugar).</p> <p>Immediate jeopardy began on 11/19/2018 when staff failed to monitor Resident #221's condition after she was administered insulin in error which resulted in an abnormal drop in blood sugar with a blood sugar reading of 40 mg/dl, unresponsiveness and the resident being transferred to the hospital for treatment of hypoglycemia. Immediate jeopardy was removed</p>	F 684	<p>F684</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Patient #221 was given insulin, administered Glucagon and sent to the hospital for evaluation.</p> <p>How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: An emergency Quality Assurance Performance Improvement Committee meeting held by the Administrator and a new hypoglycemia protocols were voted in to include the Medical Director on May 15, 2019 and nurses on staff were educated on the new protocols and notification of changes.</p> <p>What measures will be put into place or systemic changes made to ensure that</p>	6/21/19	

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F 684	<p>Continued From page 18</p> <p>on 5/17/2019 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity Level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective.</p> <p>Findings included:</p> <p>The facility's Hypoglycemic Protocol (no date) read in part:</p> <p>For a FSBS (finger stick blood sugar) below 70 and is conscious: give 3 glucose tablets or snack and re-check</p> <p>FSBS in 15 minutes.</p> <p>For a FSBS below 70 and unconscious/ unable to chew tablets: give glucagon 1 ampule Intramuscular or</p> <p>Subcutaneous times one (1) and recheck FSBS in 15 minutes.</p> <p>Resident #221 was readmitted to the facility on 10/4/2018.</p> <p>The significant change Minimum Data Set (MDS) dated 11/1/2018 revealed that Resident #221 was cognitively intact and did not have a diagnosis of diabetes and did not receive any insulin injections.</p> <p>The resident's care plan dated 10/4/2018 revealed no care plan for diabetes.</p>	F 684	<p>the deficient practice will not recur: Began and completed on May 15, 2019 all nurses were educated on Hypoglycemia Protocol and monitoring based on practitioner orders and the 6 rights of medication administration and removal of syringes. Education continues to be performed with new nursing staff. Nurses during medication pass observations were educated by the Staff Development Coordinator and Pharmacy Nurse Consultant are educated on noted errors during the Medication Pass Observations and documented on the Medication Pass Observation Sheet. Medication Pass Observations were conducted on May 14, 2019 Nurses that were on staff and completed by May 14, 2019. Medication Pass Observations will be conducted on 3 Nurses on various shifts starting May 2, 2019, bi-weekly x4 and monthly x8. Starting on June 17, 2019 the Director of Nursing and Staff Development Coordinator, all new hires will have a Medication Pass Observation completed prior to coming off orientation. The observations will be completed by the Staff Development Coordinator or Director of Nursing. All medication pass observations will be given, to the Director of Nursing, and reviewed for errors and if the medication error rate is greater than 5% then the nurse will be removed from the schedule until remedial education, is provided by the Staff Development Coordinator. If the nurse that receives remedial education has another instance of a medication error rate of >5% will result in disciplinary action by verbal</p>		

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F 684	<p>Continued From page 19</p> <p>Resident #221's physician orders dated November 2018 indicated no orders for the resident to receive insulin.</p> <p>The Medication Error Report dated 11/19/2018 revealed Resident #221 received 20 units of Levemir Insulin, in error, during the 9:00 PM medication administration by Nurse #4.</p> <p>A nursing note written by Nurse #4 on 11/19/2018 at 9:00 PM, specified Resident #221's the blood sugar reading was 93 mg/dl. A second entry written by Nurse #4 was made on 11/19/2018 at 9:20 PM which specified the blood sugar reading was 193 mg/dl.</p> <p>According to the nursing home's lab service, normal blood sugar ranges are between 70 to 130 mg/dl (for a person who does not have a diagnosis of diabetes).</p> <p>An interview was completed on 4/30/2019 at 5:49 PM with Nurse #4. Nurse #4 revealed she had worked a double shift on 11/19/2018 (7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM) and administered insulin to Resident #221 in error during the 9:00 PM medication pass. She realized the error occurred once she left Resident #221's room and read the names located outside the room doors and looked at the picture on the electronic medication administration record (eMAR). Nurse #4 verbalized that Resident #221 did not question the administration of the insulin. Nurse #4 notified the on-call/after-hours provider service at 12:11 AM on 11/20/2018 and received orders from the NP to monitor Resident #221 and recheck her blood sugar at 6:00 AM on 11/20/2018. Nurse #4 verbalized that she reported the incident and reviewed the orders</p>	F 684	<p>warning up to and including termination if non-compliance continues. Pharmacy Nurse Consultant will provide Random Medication Pass Observations monthly for a period of 6 months on random shifts. Current schedule will be the first observation on May 8, 2019 and then the first Wednesday every month for the months of June, July, August, September, October.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will be responsible for the implementation and ensuring that the audits are completed as directed monthly x12. The results of the audits will be brought to the monthly QAPI Committee meeting which lead by the Administrator and discussed and assessed for the need for revision and follow through with any disciplinary actions if needed.</p> <p>Alleged date of compliance: June 21, 2019</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345570	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/17/2019
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 13835 BOREN STREET HUNTERSVILLE, NC 28078		
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F 684	<p>Continued From page 20 with the oncoming shift.</p> <p>Additional attempts were made to contact Nurse #4 during the survey for clarification and further interview with no success.</p> <p>According to manufacturer's instructions, Levemir insulin has an onset of insulin effect in 1 1/2-2 hours and reaches its peak concentration in blood six to eight hours after it is taken but can remain close to peak levels for up to 24 hours.</p> <p>A telephone interview with Nurse #5 was completed on 5/10/2019 at 11:15 AM. Nurse #5 stated that Nurse #4 was panicking when she arrived on the unit on 11/19/2018 and informed her that she administered the wrong medication to Resident #221. Nurse #5 verbalized she and Nurse #4 went to immediately check Resident #221 and assess her condition. Nurse #5 directed Nurse #4 to obtain a blood sugar reading and notify the on-call/ after-hours provider service. The blood sugar reading obtained by Nurse #4 was 71 mg/dl. She was not present when Nurse #4 made notification and received orders back from the NP.</p> <p>An interview was completed with Nurse #5 on 4/30/2019 at 5:31 PM. Nurse #5 stated she and Nurse #4 assessed Resident #221 on 11/19/18 at the start of 3rd shift (11:00 PM to 7:00 AM). She recalled obtaining a blood sugar reading around midnight but did not recall notifying the on-call/ after-hours provider service of the blood sugar reading. She stated Resident #221 was responsive (alert, verbal) and doing well at that time.</p> <p>The call log dated 11/20/2018 for the</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345570	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/17/2019
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F 684	<p>Continued From page 21</p> <p>on-call/after-hours provider service revealed Nurse #4 placed one initial call at 12:11 AM on 11/20/2018. The call log noted the on-call/ after-hours provider service returned that call at 12:13 AM on 11/20/2018. During the same call at 12:13 AM on 11/20/2018, the Registered Nurse (RN) with the on-call/after-hours provider service advised Nurse #4 to feed the resident a meal of carbohydrates, proteins, and fats after she had spoken to the on-call provider. The RN on-call also gave direction to check the resident's blood sugar more closely (every two hours), and again at 6:00 AM per the original order given by the on-call provider. Additional advisement by the RN on-call was to send the resident to the ED if she became unstable and call the on-call/ after-hours provider service back to let us know she was sent out. No further calls were recorded on the call log between the facility and the on-call/ after-hour provider.</p> <p>A telephone interview with Nurse #5 was completed on 5/10/2019 at 11:15 AM. She recalled Nurse #4 saying, "the orders given by the NP were to monitor Resident #221 throughout the night and recheck her blood sugar at 6:00 AM on 11/20/2018". Nurse #5 stated that a blood sugar reading of 71 mg/dl was not bad. She stated she gave Resident #221 some orange juice and peanut butter crackers for a snack after the blood sugar reading of 71 mg/dl was obtained.</p> <p>The Medication Error Report dated 11/19/2018 reiterated Nurse #4 contacted the on-call/ after-hours provider service to provide notification of the medication error and receive further orders/ direction. Orders were given by the NP to monitor Resident #221 and recheck blood sugar at 6:00 AM on 11/20/2018.</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 684	<p>Continued From page 22</p> <p>The NP order dated 11/20/2018 at 12:11 AM read: Check blood sugar at 6:00 AM.</p> <p>A telephone interview was completed on 5/1/2019 at 9:23 AM with the NP. The NP was notified by the on-call/ after-hour provider service at 12:11 AM on 11/20/2018 of an incident that occurred at the facility. The NP returned the call to the facility at 12:13 AM on 11/20/2018. She spoke with Nurse #4 and was informed that the wrong medication was given to Resident #221 who had no diagnosis of diabetes and there was no reversal of the medication once administered. She gave instruction to monitor Resident #221. The NP explained the medication administered was Levemir (a long acting insulin medication used to lower blood sugar in people with diabetes) and its primary effect would be hypoglycemia (symptoms that could be exhibited were altered mental status, low blood sugars and sweating). She could not recall if she was contacted regarding the continued monitoring of Resident #221 throughout the night or when Resident #221 was sent to the local ED. The NP stated she did not indicate to Nurse #4 what was to be monitored or provide a specified monitoring schedule for Resident #221. The NP explained Levemir had a peak time of 12 hours, and she felt that 6:00 AM would be a good time frame to recheck the blood sugar.</p> <p>The nursing note written by Nurse #5 dated 11/20/2018 at 1:06 AM read: Resident #221 lying supine in bed, eyes closed and responsive. Respiration even and unlabored.</p> <p>An interview with Nurse #5 on 4/30/2019 at 5:31 PM. Nurse #5 verbalized that she checked on</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
OMB NO. 0938-0391

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F 684	<p>Continued From page 23</p> <p>Resident #221 on 11/20/18 around 1:00 AM and Resident #221 was lying in bed, eyes closed and responsive (verbal).</p> <p>During an interview with Nurse #5 on 5/10/2019 at 11:15 AM, she stated she checked on Resident #221 on 11/20/2018 at 2:00 AM. The resident was sleeping. Nurse #5 verbalized that she did not document this observation. Nurse #5 stated the next time she observed Resident #221 was at 5:30 AM.</p> <p>Continued review of Resident #221's nursing notes revealed no further blood sugar readings or monitoring of Resident #221 on 11/20/2018 from 2:00 AM until Nurse #5 observed the resident at 5:30 AM. Nurse #5 recorded a blood sugar reading of 40 mg/dl. The Situation, Background, Assessment, Recommendation note dated 11/20/2018 read: Around 5:30 AM Nurse #5 went in to check Resident #221's blood sugar and noted Resident #221 unresponsive (unable to arouse, non-verbal) with shallow breathing, blood drooling from the left side of her mouth and eyes closed. Blood sugar reading was 40 mg/dl. Oxygen was applied via nasal cannula at 5 liters per minute. Vital Signs were: pulse (87), respirations (16), oxygen saturation (91%), and blood pressure reading did not register. Resident #221's mouth locked up, tongue was sticking out. Resident #221's skin was cold to touch. Standing orders were implemented with the administration of Glucagon (a hormone used to treat severe low blood sugar) 1 ampule (amp) Intramuscular (IM) times one (1) dose. Per the standing orders, the blood sugar was rechecked, and the blood sugar reading increased to 95 mg/dl. Resident #221 began to respond. 911 was notified. DON (Director of Nursing) was notified. Family was</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
OMB NO. 0938-0391

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F 684	<p>Continued From page 24</p> <p>contacted. Resident was transferred to the ED. Resident #221 verbally was responsive.</p> <p>An interview was completed with Nurse #5 on 4/30/2019 at 5:31 PM. Nurse #5 explained she went in to check on Resident #221 on 11/20/2018 at 5:30 AM to obtain the ordered 6:00 AM blood sugar reading. She expressed Resident #221 was unresponsive (non-verbal, hard to wake) with shallow breathing, and blood drooling from the left side of her mouth. Resident #221's eyes were closed, and she was cold and sweaty. Nurse #5 stated Resident #221's blood sugar reading was 40 mg/dl. Nurse #5 explained she implemented the facility's standing orders and administered Glucagon 1amp IM times one (1) dose, applied 5 L (liters) of oxygen via nasal cannula, contacted 911, notified the Director of Nursing (DON) and left a note in the physician communication book of the incident.</p> <p>A follow up telephone interview was completed on 5/2/2019 at 4:21 PM with Nurse #5. She stated she did not recall communicating with the on-call/after-hours provider service regarding Resident #221's 71 mg/ dl blood sugar reading. Nurse #5 recalled Resident #221 being symptomatic when she went to obtain the ordered blood sugar at 5:30 AM. Nurse #5 could not explain why she did not notify the on-call/ after-hour provider knowing Resident #221 had been administered the wrong medication.</p> <p>A telephone interview with Nurse #5 was completed on 5/10/2019 at 11:15 AM. Nurse #5 stated at around 5:30 AM on 11/20/2018, she went to obtain the ordered blood sugar check and Resident #221 was unresponsive. She called for help from facility staff. Nurse #5 gave direction to</p>	F 684			

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F 684	<p>Continued From page 25</p> <p>staff to notify EMS (Emergency Management Services) and she implemented the facility's standing orders for hypoglycemia. She administered Glucagon 1 amp IM times one (1) dose, applied oxygen via nasal cannula at 5 L, notified the Director of Nursing (DON), and placed a note in the physician communication book. Nurse #5 stated Resident #221 was responding prior to EMS arriving to the facility. She rechecked her blood sugar. The blood sugar reading was 95 mg/dl. EMS arrived and transported Resident #221 to the ED. Nurse #5 took responsibility for monitoring Resident #221 throughout the evening due to her receiving a medication not prescribed to her in error. Nurse #5 could not explain why Nurse #4 waited to provide notification to the on-call/after-hours provider service.</p> <p>The resident's blood sugar reading of 71 mg/dl on 11/20/2018 at 12:16 AM that was obtained by Nurse #4 was at the lowest of the normal blood sugar range and the Levemir insulin had not reached its peak concentration in the blood. According to manufacturer's instructions, the peak concentration would occur 6-8 hours after the administration at 9:00 PM. Therefore, the peak concentration was expected between 3:00 AM - 5:00 AM. According to Nurse #5's interview, she last checked on Resident #221 at 2:00 AM. Nurse #5 did not monitor the resident during the medication's peak concentration in the blood.</p> <p>An attempt was made to interview the Nurse Aides assigned to Resident #221 during the night of 11/19/2018 and 11/20/2018. They did not respond to the voicemail messages.</p> <p>A telephone interview was completed on 5/1/2019</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
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F 684	<p>Continued From page 26</p> <p>at 1:58 PM with the resident's Physician, in which he recalled Resident #221 and her receiving the wrong medication. He stated he would have given an order for more frequent monitoring of Resident #221 for every one to two hours for a 24-hour period based on the fact Resident #221 did not have a diagnosis of diabetes. He explained the symptoms (sweating, being cold, unresponsive) Resident #221 experienced were typical of hypoglycemia. He said the staff responded appropriately by rechecking the blood sugar, taking emergency action (administering glucagon), and sending her to the emergency department for further evaluation. The Physician stated there was a direct correlation between Resident #221 having received the wrong medication and being sent out to the hospital. The Physician reviewed the hospital records and stated Resident #221's emergency department treatment was for hypoglycemia and mild feeling of general weakness.</p> <p>A follow up interview with the resident's Physician was completed at the facility on 5/1/2019 at 3:57 PM in which he revealed he could not make a definitive correlation that the wrong medication being administered would be the cause of Resident #221 being transferred to the emergency department. The Physician stated he re-reviewed the medical record and Resident #221 responded to the glucagon appropriately. Resident #221 was verbal, responding prior to transfer and her blood sugar was at 95 mg/dl prior to leaving the facility with EMS (Emergency Management Services).</p> <p>An additional interview with the resident's Physician was completed at the facility on 5/1/2019 at 6:10 PM. The Physician explained he</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
OMB NO. 0938-0391

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F 684	<p>Continued From page 27</p> <p>reviewed the hospital documentation and there were two separate issues that he wanted to identify- sepsis and wrong medication being administered. He stated that Resident #221 responded to the treatment that was administered prior to being sent to the emergency department and her hypoglycemia was resolved prior to leaving the facility. The Physician further explained once in the emergency department, Resident #221 received some IV (intravenous) support for her blood sugars (Dextrose IV). Once Resident #221 was admitted to the hospital, her hospital admission was related to the sepsis and not her blood sugar.</p> <p>The EMS Run report dated 11/20/2018 read in part: the resident "had a Glasgow Coma Scale (GCS; assessment used to determine level of consciousness) of 3 when they arrived and her blood sugar was 52 mg/dL at 5:58 AM. Started dextrose infusion and GCS improved to 15 (scale is 3-15). At 6:18 AM her blood sugar was 113 mg/dL".</p> <p>Hospital records dated 11/20/2018 read in part: the resident "presented to ED today due to hypoglycemia. She was brought to the ED today after the facility noted persistent hypoglycemia, despite patient denying any discomfort. Upon arrival she was noted to have hypoglycemia, though relatively alert and responsive. She was provided with dextrose infusions".</p> <p>An interview was completed with the DON on 5/3/2019 at 5:54 PM. She explained Resident #221 should have received continued monitoring via accuchecks (pricking the finger to get a blood sugar reading), the nurses should have offered snacks due to the medication that was</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 13835 BOREN STREET HUNTERSVILLE, NC 28078		
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F 684	<p>Continued From page 28</p> <p>administered in error and notified the on-call/after-hours provider service if the blood sugar continued to drop.</p> <p>The Administrator was notified of immediate jeopardy on 5/14/19 at 1:15 PM via telephone call.</p> <p>On 5/15/2019 the facility provided the following credible allegation for immediate jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:</p> <p>For Resident #221 the nurse administered insulin to her when the medication was intended for another resident.</p> <p>The nurse failed to document in the patient chart assessing or monitoring of patient during the shift.</p> <p>On, November 19, 2018, Resident #221 received 20 units of Levemir at approximately 9:00 p.m., intended, for another resident. Resident #221's blood sugar at 9:20 p.m. was 193.</p> <p>The on-call Nurse Practitioner (NP) was notified by the On-call RN of the error at 12:18 a.m. when the resident #</p> <p>221's blood sugar was 71 mg/dl. Based on nurse #5 statement the patient was given a snack of orange juice and peanut butter crackers. The Nurse Practitioner gave the order to check blood sugar at 6:00 AM to the on-call</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 29</p> <p>Registered Nurse. The Registered Nurse on call, gave order to the Nurse #4 that the resident should be fed a meal of carbohydrates, proteins and fats. The on-call Registered Nurse also ordered to check blood sugar more closely every two hours and again at 6:00 AM during conversation with Nurse #4 at 12:11 a.m. She was also asked to send to the Emergency Department if patient became unstable and call after hours back to let them know she was sending resident #221 to the Emergency Department. Based on documentation there is no indication that this was done.</p> <p>Nurse #5 reassessed the resident at 1:06 a.m. and found the patient was lying in the bed with eyes closed and responsive. Respirations were even and unlabored.</p> <p>At approximately 5:30 a.m. nurse entered the resident #221's room to check the blood sugar and noted resident #221 was unresponsive with shallow breathing, mouth "locked-up", her blood sugar indicated (40). Oxygen 5 liters administered via nasal cannula. Vitals signs were a pulse of (87), respirations (16), and oxygen saturation of 91%. The nurse was unable to obtain a blood pressure.</p> <p>Based on the blood sugar reading of 40 at around 5:30 a.m., standing orders were implemented, and Glucagon 1mg administered. Between the hours of</p>	F 684			

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F 684	<p>Continued From page 30</p> <p>5:30 a.m. and 6:10 a.m. resident #221's blood sugar increased to 95.</p> <p>On November 20, 2018 at approximately 6:10 a.m. resident #221 was transferred to the Emergency Department via Emergency Services and treated for hypoglycemia, hypotension and hypothermia. The resident #221 was admitted subsequently for sepsis.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:</p> <p>On May 14, 2019 a 72-hour shift summary (a list of all documentation in the progress notes) was obtained and reviewed by the Director of Nursing to identify changes in resident conditions and evaluated if the physician was notified.</p> <p>May 14, 2019 current nurses on staff were re-educated on "How to respond to a change in condition", with a focus on medication errors and notifying the physician immediately and then the responsible party. The following information was relayed to the nursing staff, 1) Notification of the physician of changes in resident conditions immediately or as soon as practicable. 2) Following physician orders. 3) Orders are to be carried out and placed into the system (all monitoring should be documented in the progress notes.</p>	F 684			

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F 684	<p>Continued From page 31</p> <p>Example given, blood sugars should be documented each and every time they are obtained). 4) Notification of the family or responsible party after the physician is notified. Let the family member know of the orders that have been received from the physician. (If you do not get the family member, document in the progress notes each of your attempts and results of each.) 5) In the case of a medication error for a blood sugars the appropriate blood pressure, pulse and blood sugar should monitored and physician notified for further orders if indicated.</p> <p>Additional education provided was information from the National Institute of Health as follows. Hypoglycemia can have severe, life-threatening consequences. When the blood glucose (BG) level falls to 60 mg/dL (normal >70 mg/dL), most patients begin to exhibit signs and symptoms of hypoglycemia, both sympathetic (tachycardia, palpitations, diaphoresis, tremulousness) and parasympathetic (nausea and hunger). The most severe and feared complications of hypoglycemia include seizure, coma, and death, which can occur at BG levels <40 mg/dL.</p> <p>Protocol for Hypoglycemic episode approved by Medical Director: If a resident has a low or near low blood sugar, the following protocol to be performed by licensed nursing staff:</p>	F 684			

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F 684	<p>Continued From page 32</p> <p>PO Able Patient: Hypoglycemic Monitoring - Blood Sugars less than 70:</p> <p>1) Immediately give fruit juice, sugar beverage and high carbohydrate snack (ex: crackers and peanut butter)</p> <p>2) At 15 minutes, recheck blood sugar. If BS is less than 70:</p> <p>a) Administer 1 tube glucose gel orally</p> <p>3) At 30 minutes, recheck blood sugar. If BS is less than 70:</p> <p>a) Administer glucagon 1 mg subcutaneously</p> <p>b) Notify provider for further instructions</p> <p>c) Notify RP</p> <p>Non-PO Able Patient: Hypoglycemic Monitoring - Blood Sugars less than 70:</p> <p>1) If unable to take PO, unable to use G Tube, OR unconscious/unresponsive, administer glucagon 1 mg subcutaneously</p> <p>2) Notify provider for further instructions</p> <p>3) Notify RP</p> <p>If at any time a patient has a blood sugar less than 50 OR unresponsive/unconscious due to low blood sugar:</p> <p>1) Administer glucagon 1 mg. subcutaneously</p>	F 684			

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F 684	<p>Continued From page 33</p> <p>2) Initiate EMS</p> <p>3) Notify provider for further instructions</p> <p>4) Notify RP</p> <p>Any nurse not able to be contacted to be educated a message was left on voicemail of education if available but will not be allowed to work until they have either received the education face to face or verbally. Education started on May 14, 2019 and completed on May 14, 2019.</p> <p>All new nurses hired will receive education "How to respond to a change in condition", with a focus on medication errors and notifying the physician immediately and then the responsible party. Emphasizing the following information. 1) Notification of the physician of changes in resident conditions immediately or as soon as practicable. 2) Following physician orders. 3) Orders are to be carried out and placed into the system (all monitoring should be documented in the progress notes. Example given, blood sugars should be documented each and every time they are obtained). 4) Notification of the family or responsible party after the physician is notified. Let the family member know of the orders that have been received from the physician. (If you do not get the family member, document in the progress notes each of your attempts and results of each, example, left</p>	F 684			

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F 684	<p>Continued From page 34</p> <p>voicemail.) 5) In the case of a medication error for a blood sugars the appropriate blood pressure, pulse and blood sugar should monitored and physician notified immediately for further orders if indicated and any changes afterwards. The Unit Coordinators will run a 24-hour shift summary (a list of all documentation in the progress notes) Tuesday through Friday and a 72-hour shift summary (a list of all documentation in the progress notes) and review for resident changes in condition. Any changes identified will be followed up on to ensure that the physician was notified, if new orders were received, were the orders followed and documentation in progress notes? Was the family notified and documentation in the progress notes?</p> <p>Additional Education for New Hires:</p> <p>From the National Institute of Health as follows- Hypoglycemia can have severe, life-threatening consequences.</p> <p>When the blood glucose (BG) level falls to 60 mg/dL (normal >70 mg/dL), most patients begin to exhibit signs and symptoms of hypoglycemia, both sympathetic (tachycardia, palpitations, diaphoresis, tremulousness) and parasympathetic (nausea and hunger). The most severe and feared complications of hypoglycemia include seizure, coma, and death, which can occur at BG levels <40 mg/dL.</p> <p>Protocol for Hypoglycemic episode approved by</p>	F 684			

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F 684	<p>Continued From page 35</p> <p>Medical Director: If a resident has a low or near low blood sugar, the following protocol to be performed by licensed nursing staff:</p> <p>PO Able Patient: Hypoglycemic Monitoring - Blood Sugars less than 70:</p> <p>1) Immediately give fruit juice, sugar beverage and high carbohydrate snack (ex: crackers and peanut butter)</p> <p>2) At 15 minutes, recheck blood sugar. If BS is less than 70:</p> <p>a) Administer 1 tube glucose gel orally</p> <p>3) At 30 minutes, recheck blood sugar. If BS is less than 70:</p> <p>a) Administer glucagon 1 mg subcutaneously</p> <p>b) Notify provider for further instructions</p> <p>c) Notify RP</p> <p>Non-PO Able Patient: Hypoglycemic Monitoring - Blood Sugars less than 70:</p> <p>1) If unable to take PO, unable to use G Tube, OR unconscious/unresponsive, administer glucagon 1 mg subcutaneously</p> <p>2) Notify provider for further instructions</p> <p>3) Notify RP</p> <p>If at any time a patient has a blood sugar less than 50 OR unresponsive/unconscious due to low</p>	F 684		

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F 684	Continued From page 36 blood sugar: 1) Administer glucagon 1 mg. subcutaneously 2) Initiate EMS 3) Notify provider for further instructions 4) Notify RP Completion date 5/17/2019 Immediate Jeopardy was removed on 5/17/2019 following observations and staff interviews, which included identifying signs and symptoms of hypoglycemia, monitoring of residents and physician notification. Nursing interviews revealed receipt of education regarding the facility's hypoglycemic protocol, monitoring of residents and physician notification. Documentation was reviewed regarding education provided on the signs and symptoms of hypoglycemia, the causes of hypoglycemia and the facility's hypoglycemic protocol.	F 684			
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician, Nurse Practitioner (NP), and Pharmacy Consultant interviews, the facility failed to prevent a significant medication error by administering a long acting insulin to a resident that had no	F 760	F760 How the corrective action will be accomplished for those residents found to have been affected by the deficient	6/21/19	

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F 760	<p>Continued From page 37</p> <p>diagnosis of diabetes and no physician's order for the administration of insulin for 1 of 2 residents (Resident #221). This resulted in Resident #221 experiencing a blood sugar reading of 40 milligrams per deciliter (mg/dl) that required Emergency Department (ED) evaluation and treatment for hypoglycemia (a condition caused by low blood sugar).</p> <p>Findings included:</p> <p>Resident #221 was readmitted to the facility on 10/4/2018.</p> <p>Review of the Significant Change Minimum Data Set (MDS) dated 11/1/2018 revealed that Resident #221 was cognitively intact. Resident #221 had adequate hearing and vision, could make self-understood and understand. Review of Section I (Active Diagnoses) did not indicate Resident #221 had a diagnosis of diabetes. Review of Section N (Medications) revealed that Resident #221 did not receive any insulin injections, nor did Resident #221 have any orders for insulin.</p> <p>Review of the care plan revealed no care plan for diabetes.</p> <p>Review of Resident #221's physician orders indicated no orders for the resident to receive insulin.</p> <p>Review of the Medication Error Report dated 11/19/2018 revealed Resident #221 received 20 units of Levemir Insulin (insulin used to control high blood sugar. Levemir reaches a peak concentration in your blood six to eight hours after you take it but can remain close to peak</p>	F 760	<p>practice: Patient #221 was given insulin, administered Glucagon and sent to the hospital for evaluation.</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: May 2, 2019 current nurses on staff were re-educated on the 6 Rights of Medication Administration with focus being on identifying the resident either by picture on Electronic Medical Record, Identification Bands or asking the resident their name, if they are alert and oriented. Any nurse not able to be contacted to be educated a message was left on voicemail of education if available but will not be allowed to work until they have either received the education face to face or verbally. Education started on May 2, 2019 and completed on May 3, 2019.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurses during medication pass observations were educated by the Staff Development Coordinator and Pharmacy Nurse Consultant are educated on noted errors during the Medication Pass Observations and documented on the Medication Pass Observation Sheet. Medication Pass Observations were completed on Nurses that were on staff and completed on June 4, 2019. Medication Pass Observations will be conducted on 3 Nurses on various shifts starting May 2, 2019, bi-weekly x4 and</p>		

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F 760	<p>Continued From page 38</p> <p>levels for up to 24 hours), in error, during the 9:00 PM medication administration by Nurse #4. Nurse #4 contacted the on-call/after-hours provider service to provide notification of the medication error and receive further orders/ direction. Orders were given by the NP to monitor Resident #221 and recheck blood sugar at 6:00 AM on 11/20/2018.</p> <p>Review of the call log dated 11/19/2018 for the on-call/ after-hours provider service revealed Nurse #4 placed one initial call at 12:11 AM. The on-call/after-hours provider service returned that call at 12:13 AM. No further calls were recorded.</p> <p>Review of Resident #221's nursing notes revealed the following blood sugar readings and information:</p> <p>11/19/2018 9:00 PM blood sugar reading- 93 mg/dl (blood sugar reading prior to the administration of insulin). Normal blood sugar ranges are between 70 to 130 mg/dl.</p> <p>11/19/2018 9:20 PM blood sugar reading- 193 mg/dl (blood sugar reading after the administration of insulin)</p> <p>11/20/2018 12:16 AM blood sugar reading- 71 mg/dl</p> <p>Review of nursing note dated 11/20/2018 at 1:06 AM read in part: Resident #221 lying supine in bed, eyes closed and responsive. Respiration even and unlabored.</p> <p>On 11/20/2018 at 5:30 AM, the blood sugar reading was 40mg/dl.</p> <p>Review of the SBAR (Situation, Background, Assessment, Recommendation) dated 11/20/2018 read in part: Around 5:30 AM Nurse #5 went in to check</p>	F 760	<p>monthly x8. Starting on June 17, 2019, all new hires will have a Medication Pass Observation completed prior to coming off orientation. The observations on all nurses will be completed by the Staff Development Coordinator or Director of Nursing. All medication pass observations will be given, to the Director of Nursing, and reviewed for 6 rights of administration, disposal of syringes and errors and if the medication error rate is greater than 5% then the nurse will be removed from the schedule until remedial education, is provided by the Staff Development Coordinator. If the nurse that receives remedial education has another instance of a medication error rate of >5% will result in disciplinary action by verbal warning up to and including termination if non-compliance continues. Pharmacy Nurse Consultant will provide Random Medication Pass Observations monthly for a period of 6 months on random shifts starting in May. Current schedule will be the first observation on May 8, 2019 and then the first Wednesday every month for the months of June, July, August, September, October.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing will be responsible for the implementation and ensuring that the audits are completed as directed monthly x12. The results of the audits will be brought to the monthly QAPI Committee meeting which lead by the Administrator and discussed and</p>		

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F 760	<p>Continued From page 39</p> <p>Resident #221's blood sugar and noted Resident #221 unresponsive with shallow breathing, blood drooling from the left side of her mouth and her eyes closed. Blood sugar reading was 40 mg/dl. Oxygen was applied via nasal cannula at 5 liters per minute. Vital Signs were: pulse (87), respirations (16), oxygen saturation (91%), and blood pressure reading did not register. Resident #221's mouth locked up, tongue was sticking out. Resident #221's skin was cold to touch. Standing orders were implemented with the administration of Glucagon (a hormone used to treat severe low blood sugar) 1 amp IM/SQ times one (1) dose. Per the standing orders, the blood sugar was rechecked, and the blood sugar increased to 95 mg/dl. Resident #221 began to respond. 911 notified. DON (Director of Nursing) was notified. Family was contacted. Resident was transferred to the ED. Resident #221 verbally was responsive.</p> <p>An interview was completed on 4/30/2019 at 5:49 PM with Nurse #4. Nurse #4 revealed she had worked a double shift (7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM) and administered insulin to Resident #221 in error during the 9:00 PM medication pass. The nurse further explained she confused Resident #221 with the resident located in the adjacent room. She realized the error occurred once she left Resident #221's room and read the names located outside the room doors and looked at the picture on the electronic medication administration record (eMAR). The nurse verbalized Resident #221 did not question the administration of the insulin. Nurse #4 notified on-call/after-hours provider service and received orders from the NP to monitor Resident #221 and recheck her blood sugar at 6:00 AM. Nurse #4 verbalized that she</p>	F 760	<p>assessed for the need for revision and follow through with any disciplinary actions if needed.</p> <p>Date of Alleged Compliance: June 21, 2019</p>		

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F 760	<p>Continued From page 40</p> <p>reported the incident and reviewed the orders with the oncoming shift.</p> <p>An interview was completed with Nurse #5 on 4/30/2019 at 5:31 PM. Nurse #5 stated she and Nurse #4 assessed Resident #221 at the start of 3rd shift (11:00 PM to 7:00 AM). She recalled obtaining a blood sugar reading around midnight but did not recall notifying the on-call/after-hours provider service of the blood sugar reading. She stated Resident #221 was responsive and doing well at that time. Nurse #5 verbalized that she checked on Resident #221 around 1 AM and Resident #221 was lying in bed, eyes closed and responsive. Nurse #5 explained she went in to check on Resident #221 around 5:30 AM and to obtain the ordered blood sugar. She expressed Resident #221 was unresponsive with shallow breathing, and blood drooling from the left side of her mouth. Resident #221's eyes were closed, and she was cold and sweaty. Nurse #5 stated Resident #221's blood sugar reading was 40 mg/dl. Nurse #5 explained she implemented the facility's standing orders and administered 1 amp (ampule) IM (intramuscular)/SQ (subcutaneous) times one (1) dose, placed 5 L (liters) of oxygen via nasal cannula, contacted 911, notified the Director of Nursing (DON) and left a note in the physician communication book of the incident.</p> <p>A telephone interview was completed on 5/1/2019 at 9:23 AM with the NP. The NP stated she received a call from Nurse #4 that she administered the wrong medication to a resident that has no diagnosis of diabetes and there was no reversal for the medication once administered. She further stated the only thing to do would be to monitor Resident #221. The NP explained the medication administered was Levemir (a long</p>	F 760			

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F 760	<p>Continued From page 41</p> <p>acting insulin medication used to lower blood sugar in people with diabetes) which primary effect would be hypoglycemia (symptoms that could be exhibited were altered mental status, low blood sugars and diaphoresis-sweating). She could not recall if she were contacted regarding the continued monitoring of Resident #221 throughout the night nor when Resident #221 was sent to the local ED. The NP did not indicate a specified monitoring schedule for Resident #221. The NP explained Levemir had a peak time of 12 hours, and she felt that 6:00 AM would be a good time frame to recheck the blood sugar.</p> <p>A telephone interview was completed on 5/1/2019 at 9:36 AM with the facility Pharmacy Consultant. The Pharmacy Consultant stated the facility responded appropriately when Resident #221 was observed experiencing hypoglycemic symptoms. She explained Resident #221 received a long acting insulin- Levemir. This means that medication would typically be given once a day and blood sugars would be sustained over a 24-hour period. The Pharmacy Consultant expressed Resident #221's symptoms made sense and Resident #221 would experience a slow decline over a 24-hour period since the medication given was long acting insulin.</p> <p>A telephone interview was completed on 5/1/2019 at 1:58 PM with the Physician, in which he recalled Resident #221 and her receiving the wrong medication. He stated he would have given an order for more frequent monitoring of Resident #221 for every one to two hours for a 24-hour period based on the fact Resident #221 did not have a diagnosis of diabetes. He explained the symptoms Resident #221 experienced. He said the staff responded</p>	F 760			

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NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 13835 BOREN STREET HUNTERSVILLE, NC 28078		
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F 760	<p>Continued From page 42</p> <p>appropriately by rechecking the blood sugar, taking emergency action (administering glucagon), and sending her to the emergency department for further evaluation. The Physician stated there was a direct correlation between Resident #221 having received the wrong medication and being sent out to the hospital. The Physician reviewed the hospital records and stated Resident #221's emergency department treatment was for hypoglycemia and mild feeling of general weakness.</p> <p>A follow up interview with the Physician was completed at the facility on 5/1/2019 at 3:57 PM in which he revealed he could not make a definitive correlation that the wrong medication being administered would be the cause of Resident #221 being transferred to the emergency department. The Physician stated he re-reviewed the medical record and Resident #221 responded to the glucagon appropriately. Resident #221 was verbal, responding prior to transfer and her blood sugar was at 95 mg/dl prior to leaving the facility with EMS (Emergency Management Services).</p> <p>An additional interview with the Physician was completed at the facility on 5/1/2019 at 6:10 PM. The Physician explained he reviewed the hospital documentation and there were two separate issues that he wanted to identify- sepsis and wrong medication being administered. He stated that Resident #221 responded to the treatment that was administered prior to being sent to the emergency department and her hypoglycemia was resolved prior to leaving the facility. The Physician further explained once in the emergency department, Resident #221 received some IV (intravenous) support for her blood</p>	F 760			

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F 760	<p>Continued From page 43</p> <p>sugars (Dextrose IV). Once Resident #221 was admitted to the hospital, her hospital admission was related to the sepsis and not her blood sugar.</p> <p>Review of the hospital records dated 11/20/2018 read in part: the resident "presented to ED today due to hypoglycemia. She was brought to the ED today after facility noted persistent hypoglycemia, despite patient denying any discomfort. Upon arrival she was noted to have hypoglycemia, though relatively alert and responsive. She was provided with dextrose infusions".</p> <p>Review of the hospital records dated 11/20/2018 revealed the following blood sugar readings: 11/20/2018 at 7:49 AM- 60 mg/dl 11/20/2018 at 7:59 AM- 141 mg/dl 11/20/2018 at 8:37 AM- 158 mg/dl 11/20/2018 at 10:07 AM- 29 mg/dl 11/20/2018 at 10:21 AM- 224 mg/dl 11/20/2018 at 11:25 AM- 96 mg/dl 11/20/2018 at 11:45 AM- 63 mg/dl</p> <p>Review of the Hospital Critical Care note dated 11/21/2018 read in part: "She had hypoglycemia which may have been from an erroneous Levemir injection at rehab. Hypoglycemia- currently on Dextrose infusion at 75 cc's per hour".</p> <p>Further review of the hospital records identified hypoglycemia as a diagnosis with onset of 11/20/2018 and resolved on 11/28/2018.</p> <p>An interview was completed on 5/1/2019 at 6:30 PM with the Director of Nursing (DON). She explained she reviewed the proper steps for medication administration with Nurse #4 on 11/20/2019, which included, 1- prepare</p>	F 760			

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F 760	<p>Continued From page 44</p> <p>medication 2- identify the resident 3- ensure the correct route per order 4- right dose and 5- right time. The DON expressed proper identification of a resident would involve verifying the photo in the EHR (electronic health record) versus relying solely on the resident (residents give consent on admission for photographs for identification purposes), names were located on the outside of the doors for a semi private room and the outside of the main door for a private room, residents also have hospital bracelets in place or a facility name bracelet in place. Based on the resident's cognition, the staff may ask the resident their name for verification purposes. She stated she would need to verify with her Staff Development Coordinator (SDC) to determine if medication administration were discussed during orientation. No facility training was completed with the nursing staff after this incident. She explained the Pharmacy Consultant completed medication administration observations in May 2018 with the cart nurses. The DON indicated medication administration had not been completed with Nurse #4 after the medication administration error. The DON verbalized she expected staff to double check themselves and to follow the rights of medication administration to ensure the residents received their ordered medications.</p> <p>An interview was completed with the Staff Development Coordinator (SDC) on 5/1/2019 at 2:48 PM. The SDC explained nurses were trained on the Rights of Medication Administration- right person, route, time, medicine, and dose regarding medication administration. The SDC stated she had not completed any recent training with nurses regarding the 5 rights of medication administration nor has she completed any</p>	F 760			

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F 760	Continued From page 45	F 760			
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions</p>	F 880		6/21/19	

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F 880	<p>Continued From page 46</p> <p>to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to discard a used syringe for 1 of 7 sampled resident reviewed for medication administration (Resident #326)</p> <p>The findings included:</p> <p>Resident #326 was admitted to the facility on</p>	F 880	<p>F880</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The syringe was removed by the nurse from Resident #326's bedside table and disposed of in the sharps container on the medication cart.</p>		

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F 880	<p>Continued From page 47</p> <p>4/27/19 with medical diagnoses inclusive of hypertension and dementia.</p> <p>Review of physician orders for Resident #326 revealed an order for Heparin (anticoagulant) injection every 8 hours.</p> <p>Review of the Medication Administration Record revealed Resident #326 received an injection of Heparin on 4/28/19 at 11:20 PM administered by Nurse #7.</p> <p>On 4/29/19 at 6:32 AM an observation was made of a syringe with a safety sleeve covering the needle on the bedside table in Resident #326's room. The syringe did not contain any liquid contents. Resident #326 was in a private room.</p> <p>During an observation and interview with the Unit Manager (UM) on 4/29/19 at 6:37 AM, UM #2 removed the syringe from the bedside table and placed it in the sharp container on a medication cart. UM #2 stated the used syringe should have been discarded in the sharp container and not left on the bedside table in Resident #326's room. UM #2 also stated the used syringe could possibly be a safety hazard when not discarded in the sharp container.</p> <p>When interviewed on 4/29/19 at 6:44 AM, Nurse #7 reported she administered Heparin to Resident #326 on 4/28/19 at 11:20 PM. Nurse #7 stated she administered the Heparin, then prepared Resident #7 to receive a breathing treatment. Nurse #7 reported when she returned to remove the equipment after the breathing treatment was completed, she did not notice the used syringe on the bedside table. Nurse #7 stated the used syringe should have been</p>	F 880	<p>How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: A 100% audit of the residents in-house as of June 10, 2019 was completed by the Regional Nurse Consultant of all rooms to ensure that syringes that had been administered were not left on the bedside or over-bed table.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Development Coordinator educated all licensed nurses on correct practice of removing syringes from the resident care area and disposed of in the sharps container on the medication cart. This education will be completed prior to June 21, 2019 by the Staff Development Coordinator, Director of Nursing or Designee. If any nurses is not trained by this date they will be removed from the schedule until education is received. All New Licensed nurses will receive education during orientation on correct practice of disposing of syringes upon completion of administering the medication.</p> <p>Pharmacy Nurse Consultant will provide Random Medication Pass Observations monthly for a period of 6 months on random shifts. Current schedule will be the first observation on May 8, 2019 and then the first Wednesday every month for the months of June, July, August, September, October.</p>		

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F 880	<p>Continued From page 48</p> <p>disposed of in the sharp container on the medication cart.</p> <p>An interview on 4/29/19 at 1:15 PM, UM #2 identified that Nurse #7 completed an incident report regarding not disposing a used syringe in a sharp container. UM #2 reported she identified the infection control and safety concerns related to a used syringe left in Resident #326's room with Nurse #7. The UM #2 reported she reeducated Nurse #7 and provided education related to infection control, disposal of sharps and resident safety.</p> <p>An interview on 5/1/19 at 3:45 PM, Nurse #7 reported she was one of two nurses in the facility for the 11 PM to 7 AM shift on the night of 4/28/19. Nurse #7 reported she was assigned to administer medication for residents on 3 hallways. Nurse #7 also reported during the change of shift from the second shift (3 PM - 11PM) nurse giving report to the oncoming nurse at 11 PM, the responsibilities of meeting the needs of the residents who have requested pain medication may have impacted her memory, therefore, she left the used syringe on the bedside table in Resident #326's room. Nurse #7 recalled being called away to provide care for another resident while she was administering medication for Resident #326 on 4/29/19.</p> <p>An interview with the Director of Nursing on 5/3/19 at 6:13 PM, the DON stated her expectation was a used syringe should have a safety sleeve in place after use and discarded in the sharps container after medication administration for infection control and safety purposes.</p>	F 880	<p>Medication Pass Observations will be conducted on 3 Nurses on various shifts, weekly x4, bi-weekly x4 and monthly x9. All medication pass observations will be given to the Director of Nursing, and reviewed for errors and if the medication error rate is greater than 5% then the nurse will be removed from the schedule until remedial education, is provided by the Staff Development Coordinator. If the nurse that receives remedial education has another instance of a medication error rate of >5% will result in disciplinary action by verbal warning up to and including termination if non-compliance continues.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will compile the findings from the audits and submit this information to the QA Committee monthly for 12 months or until compliance is achieved and sustained or revisions to the Monitoring is needed and additional monitoring as directed by the QA Committee. Alleged Date of Compliance: June 21, 2019</p>		