STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

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E 000	Initial Comments An unannounced Recertification and complaint investigation survey was conducted on 2/4/19 to 2/8/19. The facility was found to be in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID # 42C911.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and complaint investigation survey was conducted on 2/4/19 to 2/8/19. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.45 at tag F760 at a scope and severity (J) The tags F684 and F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 01/25/19 and was removed on 02/08/19. An extended survey was conducted. 4/17/19 after an IDR meeting with IDR panel member changes and a final decision from an administrative review - F580 is upheld at J, F684 is deleted and F760 is lowered to a D	F 000		
F 580 SS=J	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,	F 580		2/8/19

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

Electronically Signed | 03/04/2019

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F 580	Continued From page 1	F 580		

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 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in

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F 580	Continued From page 2 §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 staff interviews, record review, and Physician interview the facility failed to notify the resident's physician of a meal refusal prior to administering insulin that was ordered by the physician to be given with meals for 1 of 4 (Resident #192) residents reviewed for insulin administration. The failure of the facility to notify the physician of the resident's refusal to eat and administering the insulin without a meal as ordered resulted in the resident becoming unresponsive and sent to the Emergency Department. She required a central line and intubation on admission to the Emergency Department. Her final diagnoses for hospital admission on 1/25/19 were acute respiratory failure, altered mental status, hypothermia (low body temperature), and hypoglycemia (low blood glucose). The facility also failed to notify the physician of an unattended weight loss for 1 of 4 (Resident #65) sampled residents reviewed for nutrition. Immediate jeopardy began on 1/25/19 when the facility staff failed to ensure Resident #192's physician was notified the resident, who was diagnosed with Diabetes Mellitus (DM) and was insulin dependent, had not eaten her breakfast meal prior to administering to the resident 58 units of Novolog 70/30, a combination of short acting and long acting insulin, which was ordered to be given with meals. The immediate jeopardy	F 580	The creation of this Letter of Credible allegation constitutes a written allegation of compliance. Preparation and submission of this letter does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the survey agency. This letter is solely prepared because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Date: 2/08/2019 Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #192 was admitted on 1/23/2019 for short term rehabilitation services. Resident #192 received skilled nursing and rehabilitation services from 1/23/2019 up to 1/25/2019. Review of facility most recent minimum data set, with Assessment reference date 1/25/2018 section I (active diagnosis) indicated resident #192 had a diagnosis of type 2 diabetes mellitus with diabetic neuropathy. Review of physician orders reveals resident #192 had an order for Novolog Mix 70-30 to be given subcutaneously	

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F 580	Continued From page 3 was removed on 2/8/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of level "D" (no actual harm with the potential for minimal than harm that is not immediate Jeopardy) for example #2. Findings included: 1. Resident #192 was admitted to the facility on 1/23/19 with the diagnoses that included Diabetes Mellitus Type 2, hypothyroidism (underactive thyroid gland), hypertension (HTN - high blood pressure), enterocolitis (inflammation in the gut that effects the small intestine and colon) related to clostridium difficile (C-diff), an infection in the colon that is caused by the bacteria called clostridium difficile. Review of the physician orders for Resident #192 revealed orders placed on 1/23/19 for Finger Stick Blood Sugar (FSBS) checks before meals & at bedtime. There was also an order to administer 58 units subcutaneously (SQ - injection into the fat layer between the skin and muscle) twice daily with meals of Novolog 70/30. According to the manufacturer, Novolog 70/30 is a mixture of a man-made fast-acting insulin to help control mealtime spikes in blood sugar and long-acting insulin that works up to 24 hours to help control blood sugar between meals. The manufacturer guidelines stated that people with type 2 diabetes should have the injection within 15 minutes before or after starting their meal. Resident #192's January 2019 medication administration record (MAR) revealed Resident #192 had her 6:00 AM scheduled FSBS check on	F 580	twice daily with meals. On 1/25/2019 resident #192 received Novolog 70-30 at 10:24am. Interview with nurse aide #1 who was caring for resident #192, on 1/25/2019 morning shift, indicated resident #192 refused her breakfast in the morning of 1/25/2019. Interview with nurse assistant #2 conducted by the facility□s Director of Nursing indicates resident #192 ate snacks during the night of 1/24/2019 to the morning of 1/25/2019. On 1/25/2018, at 12:15pm less than two hours after resident #192 received the Novolog 70-30, 58 units; licensed nurse #1 indicated; she went to resident #192 room and observed resident #192 been unresponsive. She immediately obtained vital signs as well as blood glucose. Blood glucose result was noted to be 189 (adult normal limits 70-110). Licensed nurse #1 contacted emergency medical services who then transferred resident #192 to the hospital. On 2/8/2019; the facility Medical Director had an extensive discussion with the State surveyors on site to explain the medical rationale for the reported hypoglycemic episode for resident #192 documented by both EMS and emergency room Physician on 1/25/2019. Facility Medical Director explained that resident #192 hypoglycemic episode is medically related to resident #192□s chronic thyroid condition that was not diagnosed before resident #192 was admitted to the facility on 1/23/2019, two days before the episode of hypoglycemia. The facility medical director added; on 1/24/2019, she	

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F 580	Continued From page 4 1/25/19 at 6:37 AM and the result was 109 milligrams/deciliter (mg/dl). The Novolog 70/30 58 units of insulin scheduled for 9:00 AM was documented as administered on 1/25/19 at 10:24 AM by Nurse #2. According to the meal percentage sheet, Resident #192 did not eat anything for breakfast or lunch on 1/25/19. During an interview with Nurse Aide (NA) #6 on 2/6/19 at 4:46 PM about Resident #192's condition and meal intake on 1/25/19, she stated that the resident was on the bedpan several times that morning, and that she had refused breakfast. When asked if she notified the nurse of the resident's refusal to eat breakfast, she stated Nurse#2 was made aware. During an interview with Nurse #2 on 2/7/19 at 1:17 PM she stated that at approximately 10:00 AM she went into Resident #192's room to administer medications and she was at baseline with no altered mental status. Nurse #2 stated she knew she did not eat her breakfast and had tried to get her to eat something at that time, but the resident refused any food. When asked if she gave her the full dose of Novolog 70/30 insulin when she knew the resident had not eaten breakfast, she stated that she did. She stated she had gone into Resident #192's room at approximately 12:00 PM to check her blood sugar and found her unresponsive. Nurse #2 stated she couldn't wake Resident #192 up and checked her blood sugar with a result of 189 mg/dl. She stated she applied oxygen, checked vital signs, notified the DON, and EMS was called to transfer the resident to the hospital. She stated that she checked the resident's pupils and they were fixed	F 580	ordered thyroid stimulating hormone (TSH) laboratory test following the report from facility licensed staff that resident #192 was lethargic. The facility obtained the laboratory test on 1/24/19 as ordered and received the result on 1/25/2019. TSH result from 1/24/2019 indicated resident #192 had a condition called Hypothyroidism. The facility Medical Director expressed to the state surveyors on site that resident #192□s fluctuation on blood sugar was related to her untreated and undiagnosed thyroid condition and not due to the administration of the insulin that was given less than two hours before she was observed been unresponsive. Facility Medical Director ordered Synthroid 100mcg, medication used to treat hypothyroidism but medication was not started as resident #192 was transferred to the hospital on the same day it was ordered (1/25/2019). Resident #192 is no longer in the facility, no further actions warranted at this time. On 2/08/19; State agency surveyors indicated that the root cause of this alleged noncompliance is the action by licensed nurse #1 to administer Novolog 70-30 at 10:24am while resident #192 refused her breakfast meal without notifying physician before that action. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. Audits of 100% of residents□ medication orders were completed by the Director of Nursing, Assistant director of Nursing and/or Unit Manager on 2/7/2019, and	

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F 580	Continued From page 5 and dilated. A progress note dated 1/25/19 at 6:43 PM written by Nurse #2 stated she entered Resident #192's room at 12:15 PM and found Resident #192 unresponsive. The resident's SpO2 (blood oxygen saturation level) was 98%, blood pressure (BP) was 98/68 mmHg, Pulse 54 beats per minute (bpm), and FSBS was 189. Review of the January 2019 MAR revealed that Resident #192 had her 11:30 AM FSBS checked on 1/25/19 at 1:07 PM of 189 mg/dl. During an interview with the Director of Nursing (DON) on 2/6/19 at 5:02 PM she stated she was in Resident #192's room after she was notified of her being unresponsive. She stated the resident's blood sugar was 189 mg/dl and that there was no indication to be concerned about the insulin being administered or blood sugar level. Review of Resident #192's EMS report from 1/25/19 revealed the resident was found at the facility to be unresponsive. The chief complaint documented that the resident was found unresponsive by staff and it was reported to EMS that the resident was last seen normal at 11:00 AM, her vital signs were all normal, and her blood glucose was 129 mg/dL. The first blood glucose level documented by EMS at 1:05 PM was 23 mg/dL. At 1:09 PM Dextrose 50% (D50 - a hypertonic solution of dextrose, simple sugar chemically identical to glucose) 25 grams was administered. At 1:13 PM the resident's blood glucose was 273 mg/dL. At 1:30 PM her blood glucose was 110 mg/dL. At 1:30 PM her blood glucose was 110 mg/dL. Resident #192 was	F 580	2/8/19 to identify any other resident with any insulin order that need to be given with meals. The audit concluded there were eight other residents identified with orders for insulin medication to be given with meals. Audit of Insulin administration records for the last 7 days indicated all other eight identified residents received their insulin as ordered with meals. 100% audit of all current residents clinical documentation within the last 7 days completed by the Director of Nursing, Assistant Director of Nursing, Staff development Coordinator and/or Nurse Manager to determine any identified need for notification of changes that was completed in a timely manner. The audit revealed no other missing/delayed notification of changes to both physician and/or responsible party. This audit was completed on 2/08/19. Findings of this audit are documented on clinical records audit tool located in the facility compliance binder. On 2/8/2019, 100% audit was completed by the Director of Nursing, Assistant Director of Nursing, Staff development Coordinator and/or Nurse Manager of all incidents reports completed within the last 7 days to ensure notifications were done in a timely manner. The audit revealed no other missing/delayed notification of changes to both physician and/or responsible party. This audit was completed on 2/08/19. Findings of this audit are documented on incident reports audit tool located in the facility compliance	

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F 580	Continued From page 6 received by the hospital ED staff at 1:45 PM. Review of the ED Report from 1/25/19 documented the resident was found unresponsive at the facility by EMS and EMS obtained a blood glucose of 23 mg/dL. Triage Lab results from ED admission on 1/25/19 at 2:48 PM were Glucose 26 mg/dL. The resident required a central line (a catheter placed into a large vein to give medications or draw lab work) and intubation at 2:52 PM for acute respiratory failure, she received D50 for hypoglycemia, intravenous fluids (IVF) for hypotension, and admission to Intensive Care Unit (ICU). Her final diagnoses for hospital admission on 1/25/19 were acute respiratory failure, altered mental status, hypothermia, and hypoglycemia. Review of hospital records from 1/27/19 at 9:22 AM revealed a Critical Care Progress Note by Physician Assistant (PA) #1 and Hospital Physician #1 that stated problems addressed for Resident #192 involving her insulin dependent diabetes mellitus (IDDM) were "likely related to insulin dose and not eating." During an interview on 2/7/19 at 3:35 PM the Staff Development Coordinator stated NAs are educated on notifying the nurse when a resident does not eat on orientation and as needed. Nurses are educated to look at each resident receiving insulin individually during each medication administration and were educated to withhold insulin if meals were not consumed. She further stated, if the resident does not eat a meal it was expected that the nurse call the provider for further orders before insulin is administered.	F 580	binder. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur. Effective 2/8/2019 and moving forward, the facility Licensed nurse and will not administer insulin for any resident with an order to be given with meals/food when a resident refused his/her meal/food. Facility Licensed nurse on Duty will notify physician when a resident with ordered insulin refuse their meal/food and document physician decision in each resident□s medical records before the insulin is administered. Licensed nurses will add any new recommendation from Physician in a 24 hour report form as well effective 2/8/2019 Effective 2/8/2019 and moving forward the facility□s clinical team, which includes Director of nursing, Assistant Director of Nursing, and/or Nurse supervisors initiated a process for reviewing clinical documentation create for the last 24 hours for all residents, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This	

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F 580	Continued From page 7 During an interview with the facility Pharmacist on 2/7/19 at 5:11 PM she stated she would have expected the nurse to hold all short acting insulin if a meal wasn't consumed. She stated if the resident's blood sugar was 109 at 6:27 AM, and she didn't eat or have glucagon administered, the blood sugar going up to 189 mg/dl at approximately 12:15 PM seemed inconsistent. She stated Novolog 70/30 is used to regulate and lower blood sugar levels for residents with diabetes, it has an onset of action within 10-20 minutes for the short acting and the medication peaks within 1-4 hours of administration. During an interview with the Medical Director on 2/7/19 at 3:55 PM she stated she was not aware of the particular incident with Resident #192's low blood sugar and transfer to the ED and her associate was most likely contacted for transfer orders. When asked if she expected the nurse to hold insulin if a resident did not eat, she stated most residents in the nursing home don't eat all the time. When asked if she expected the nurse to check another blood sugar prior to administering insulin after a 4-hour time period and no food was consumed, she stated yes but she did not fault the nurse for administering the insulin without food. She stated most likely the resident had been receiving this ordered insulin dose for a long period of time and for whatever reason on that particular day she had an adverse reaction to the insulin, but she had probably had the insulin administered at that dose without food in the past without the same effect. On 2/7/18 at 6:37 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 2/8/19. The allegation of	F 580	process will be incorporated in a daily clinical meeting any negative findings will be documented on the daily clinical report form and maintained in the daily clinical meeting binder. Effective 2/08/2019, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation created for the last 24 hours for all residents, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. The result of this systemic process will be documented on the weekend supervisor report form maintained in the Daily Stand up meeting binder. Findings from this systemic changes will be discussed in the daily □stand up meeting Monday through Friday effective 2/8/2019. Week end supervisor #1 &#2 will be educated on this requirement before their next scheduled day to work by the facility Director of Nursing. The Facility Director of Nursing (DON), Assistant Director of Nursing and/or staff development coordinator will complete 100% education for all licensed nurses to include full time, part time and as needed	

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F 580	Continued From page 8 Immediate Jeopardy removal indicated: Credible Allegation of Immediate Jeopardy removal: Date: 2/08/2019 Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #192 was admitted on 1/23/2019 for short term rehabilitation services. Resident #192 received skilled nursing and rehabilitation services from 1/23/2019 up to 1/25/2019. Review of facility most recent minimum data set, with Assessment reference date 1/25/2018 section I (active diagnosis) indicated resident #192 had a diagnosis of type 2 diabetes mellitus with diabetic neuropathy. Review of physician orders reveals resident #192 had an order for Novolog Mix 70-30 to be given subcutaneously twice daily with meals. On 1/25/2019 resident #192 received Novolog 70-30 at 10:24am. Interview with nurse aide #1 who was caring for resident #192, on 1/25/2019 morning shift, indicated resident #192 refused her breakfast in the morning of 1/25/2019. Interview with nurse assistant #2 conducted by the facilitys Director of Nursing indicates resident #192 ate snacks during the night of 1/24/2019 to the morning of 1/25/2019. On 1/25/2018, at 12:15pm less than two hours after resident #192 received the Novolog 70-30, 58 units; licensed nurse #1 indicated; she went to resident #192 room and observed resident #192 been unresponsive. She immediately obtained vital signs as well as blood glucose. Blood glucose result was noted to be 189 (adult normal limits 70-110). Licensed nurse #1 contacted emergency medical services who then transferred resident #192 to the hospital.	F 580	staff. The emphasis of this education was on the importance of notifying Physician and the responsible party in a timely manner for any incident/accidents, resident□s change of condition, change of treatment/intervention an injury of unknown source and/or Medication error if any. The education also emphasized the responsibility of the licensed nurse on Duty to notify physician when a resident with ordered insulin refuse their meal/food and document physician decision in each resident□s medical records before the insulin is administered. Licensed nurses were also educated to document any new physician recommendation on the 24 hour report sheets effective 2/8/19. This education will be completed by 2/8/2019. Any Licensed Nurse not educated by 2/8/2019 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and will also be provided annually effective 2/8/2019. The facility plans to monitor its performance to make sure that solutions are sustained. Effective 2/8/2019, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician and/or responsible party to include notification to physician for any resident with insulin order who refuse their meal. This monitoring process will be accomplished by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be	

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F 580	Continued From page 9 On 2/08/19; State agency surveyors indicated that the root cause of this alleged noncompliance is the action by licensed nurse #1 to administer Novolog 70-30 at 10:24am while resident #192 refused her breakfast meal without notifying physician before that action. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. Audits of 100% of resident - medication orders were completed by the Director of Nursing, Assistant director of Nursing and/or Unit Manager on 2/7/2019, and 2/8/19 to identify any other resident with any insulin order that need to be given with meals. The audit concluded there were eight other residents identified with orders for insulin medication to be given with meals. Audit of Insulin administration records for the last 7 days indicated all other eight identified residents received their insulin as ordered with meals. 100% audit of all current residents clinical documentation within the last 7 days completed by the Director of Nursing, Assistant Director of Nursing, Staff development Coordinator and/or Nurse Manager to determine any identified need for notification of changes that was completed in a timely manner. The audit revealed no other missing/delayed notification of changes to both physician and/or responsible party. This audit was completed on 2/08/19. Findings of this audit are documented on clinical records audit toollocated in the facility compliance binder. On 2/8/2019, 100% audit was completed by the Director of Nursing, Assistant Director of Nursing, Staff development Coordinator and/or Nurse Manager of all incidents reports completed within the last 7 days to ensure notifications were done	F 580	addressed promptly. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Director of Nursing will review the completion of daily clinical report, and proper follow through and ensure notification of changes is rendered as appropriate. Director of nursing document findings from this monitoring process daily clinical checklist form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will take place daily Monday through Friday for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Facility Quality Assurance & Performance Improvement Committee was notified of this plan of action on 2/8/2019. Effective 2/08/19, Facility Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 580	Continued From page 10 in a timely manner. The audit revealed no other missing/delayed notification of changes to both physician and/or responsible party. This audit was completed on 2/08/19. Findings of this audit are documented on incident reports audit toollocated in the facility compliance binder. Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not occur. Effective 2/8/2019 and moving forward, the facility Licensed nurse and will not administer insulin for any resident with an order to be given with meals/food when a resident refused his/her meal/food. Facility Licensed nurse on Duty will notify physician when a resident with ordered insulin refuse their meal/food and document physician decision in each residents medical records before the insulin is administered. Licensed nurses will add any new recommendation from Physician in a 24 hour report form as well effective 2/8/2019 Effective 2/8/2019 and moving forward the facilitys clinical team, which includes Director of nursing, Assistant Director of Nursing, and/or Nurse supervisors initiated a process for reviewing clinical documentation create for the last 24 hours for all residents, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in a daily clinical meeting any negative findings will be documented on the daily clinical report formand	F 580	The title of the person responsible for implementing the acceptable plan of correction Effective 2/8/2019 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance. Compliance Date 2/8/2019 Tag 580 Part 2 Root Cause Analysis Based on the root cause analysis by the facility□s administrative staff, it was determined the facility failed to provide notification to the physician for resident # 65 concerning a significant weight loss. Immediate Action Resident # 65 was discharged from the facility on 2-16-19. No further action is warranted at this time. Identification of Others On 2-8-19, a 100% audit was completed by the Director of Nursing and Assistant Director of Nursing of all incident reports completed within the last 7 days to ensure notifications were done in a timely manner. The audit revealed no missing/ delayed notifications of changes to both physicians and/ or responsible party. This audit was completed on 2-8-19. Findings of this audit are documented and can be found in the facility compliance binder.	

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F 580	Continued From page 11 maintained in the daily clinical meeting binder. Effective 2/08/2019, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation created for the last 24 hours for all residents, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday & Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. The result of this systemic process will be documented on the weekend supervisor report form maintained in the Daily Stand up meeting binder. Findings from this systemic changes will be discussed in the daily stand up meetingMonday through Friday effective 2/8/2019. Week end supervisor #1 &#2 will be educated on this requirement before their next scheduled day to work by the facility Director of Nursing. The Facility Director of Nursing (DON), Assistant Director of Nursing and/or staff development coordinator will complete 100% education for all licensed nurses to include full time, part time and as needed staff. The emphasis of this education was on the importance of notifying Physician and the responsible party in a timely manner for any incident/accidents, residents change of condition, change of treatment/intervention an injury of unknown source and/or Medication error if any. The education also emphasized the responsibility of the licensed nurse on Duty to notify physician when a resident with ordered insulin refuse their meal/food and document physician decision in	F 580	Systemic Changes Effective 2-8-19, the Director of Nursing/ Assistant Director of Nursing or Designated Licensed Nurse will review clinical documentation created for the last 24 hours for all residents, 24 hour report sheets, incident reports for the last 24 hours and physician orders written in the last 24 hours to ensure any needed notification of changes to the physician and/ or responsible part was done in a timely manner. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON and ADON. This process will be incorporated in a daily clinical meeting and negative findings will be documented on the daily clinical report form and maintained in the daily clinical meeting binder. The weekend nurse supervisor or designated licensed nurse will review clinical documentation for the last 24 hours for all residents, 24 hour report sheets, incident reports for the last 24 hours and physician orders written in the last 24 hours to ensure any needed notification of changes to the physician and/ or responsible party was done in a timely manner. This systemic process will take place every Saturday and Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON or ADON. The result of this process will be documented on the weekend supervisor report form. Findings of this process will be reviewed by the DON or ADON and will be discussed in the daily stand up meeting.	

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F 580	Continued From page 12 each residents medical records before the insulin is administered. Licensed nurses were also educated to document any new physician recommendation on the 24 hour report sheets effective 2/8/19. This education will be completed by 2/8/2019. Any Licensed Nurse not educated by 2/8/2019 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and will also be provided annually effective 2/8/2019. The facility plans to monitor its performance to make sure that solutions are sustained. Effective 2/8/2019, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician and/or responsible party to include notification to physician for any resident with insulin order who refuse their meal. This monitoring process will be accomplished by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Director of Nursing will review the completion of daily clinical report, and proper follow through and ensure notification of changes is rendered as appropriate. Director of nursing document findings from this monitoring process daily clinical checklist form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will take place daily Monday	F 580	Monitoring Effective 2-8-19, the DON and/ or ADON will monitor compliance with notification of changes to physicians and/ or responsible party. This monitoring will be accomplished by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. Findings of this monitoring process will be documented on the daily clinical report form and filed in the clinical meeting binder after proper follow ups are complete. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.	

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through Friday for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.
Facility Quality Assurance & Performance Improvement Committee was notified of this plan of action on 2/8/2019. Effective 2/08/19, Facility Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.
The title of the person responsible for implementing the acceptable plan of correction Effective 2/8/2019 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.
Date of immediate jeopardy removal 2/8/19

The credible allegation of Immediate Jeopardy removal was verified 2/8/19 at 8:02 PM as evidenced by:

Review of facility's records revealed in-services were completed with all active facility staff on 2/7/19 through 2/8/19. The DON, ADON, SDC, and nursing supervisors were trained to provide all education regarding abuse/neglect policy, insulin administration and documentation, and physician notification/orders to every employee before they were able to work at the facility either by phone or in-person.

Review of facility audits from 2/7/19 to 2/8/19

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revealed that they were completed and that orders were changed to reflect the new insulin order verbiage for all resident's receiving insulin or other types of diabetic medications. Clinical records audit tool, Incident reports audit tool, 24-hour report, and the clinical meeting binder were reviewed for completion.

During an interview with NA #3 on 2/8/19 at 7:41 PM revealed that she was educated on the facility Abuse and Neglect Policy and stated that she would report any concerns or suspicions to the DON. She also received education that stated if a resident did not eat she would offer alternates and/or report the refusal to the nurse and document the meal intake percentage in her charting.

An interview with NA #4 on 2/8/19 at 7:41 PM revealed that education was provided on the facility Abuse and Neglect Policy. She stated that all concerns or suspicions would be reported to the DON or administrator. She stated she also received education that stated if a resident refuses their meal, offer alternatives to ensure they don't want anything, always document their meal percentage, and notify the nurse.

During an interview with NA #1 on 2/8/19 at 7:49 PM she stated that if she suspected any type of abuse she was to report her suspicions to the DON and/or the administrator. She also received education that stated if a resident did not eat she was supposed to offer alternates or offer several more times, but that the resident had the right to refuse. If the resident still refused to eat she would notify the nurse and document the meal percentage.

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During an interview with Nurse #1 on 2/8/19 at 7:55 PM she stated that she was educated to ensure a snack or food was consumed before giving insulin. If the resident refused to eat, notify the provider and follow orders given for insulin administration, then document changes on the 24-hour report. Education on the facility Abuse and Neglect Policy stated that any and all suspicions of abuse should be reported to the DON and/or administrator.

During an interview with Nurse #3 on 2/8/19 at 8:00 PM she stated that she was educated to ensure a snack or food was consumed before giving insulin. If the resident refused to eat anything she was supposed to notify the provider, and follow orders given for insulin administration. She would then document changes on the 24-hour report for the on-coming nurses.

2. Resident #65 was admitted to the facility on 1/5/19 with diagnoses of, in part, right femur fracture, right wrist fracture and vascular dementia. She was admitted from hospital. She was not in facility prior.

Review of Resident #65's physician orders revealed on 1/5/19 and order was written for weekly weights and she was admitted on a regular, no added salt diet. Review of the resident's medical record revealed on 1/6/19, Resident #65 weighed 157 pounds.

Record review revealed a Nutritional Screening and Assessment dated 1/10/19 which indicated Resident #65 had a fair appetite, consuming 50-75% of most meals. Weight stable over last 6 months per family member's report, usual body weight prior to illness 158 pounds, and ideal body

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weight 130 pounds.

A nutritional care plan note dated 1/10/19 written by the dietician revealed Resident #65's weight was 157 pounds. The registered dietician recommend adding a protein supplement twice a day with medication pass. The note specified the resident was at risk for weight changes related to use of therapeutic diet, dementia, and weight above average body weight. Will proceed to care plan.

A care plan for nutrition dated 1/10/19 revealed Resident #65 was at risk for weight changes related to use of therapeutic diet, diagnosis of dementia and weight above average body weight. A handwritten addition of significant weight loss was added with no date entry. The care plan goal included resident will eat at least 75% of all meals through next review with an additional handwritten goal of no significant weight changes through next review handwritten. Interventions included: maintain current listing of likes and dislikes, administer vitamins as ordered, obtain weight monthly and as needed, encourage dining room for all meals, dietary recommendation add 30 milliliters of a protein supplement max twice a daily with medication pass for nutritional support.

A review of an Admission/5 day Minimum Data Set assessment dated 1/11/19 revealed Resident #65 had severely impaired cognition. She was assessed as being independent with meals after set-up, having no swallowing disorder, was on a therapeutic diet, weighed 157 pounds and was 66 inches tall.

An observation on 2/7/19 at 12:47 PM of Resident #65 revealed she was sitting at a table

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in the main dining room with lunch tray in front of her. Resident #65 had only consumed bites of her beans. A follow-up observation on 2/7/19 at approximately 1:00 PM revealed the activity assistant assisting Resident #65 to eat. Resident #65 had consumed approximately 75 percent of her meal.

On 2/7/19 at 1:13 PM, an interview with NA #2 revealed Resident #65 was able to feed herself, but did need assistance at times. She stated she had good days and bad days. The family or family friend would visit frequently and assist the resident to eat. She stated she encouraged the resident to eat in the dining room if no one came in to visit, but sometimes she refused to go.

Review of Resident #65's weight record revealed on 1/12/19 a weekly weight of 146.8 pounds was documented which was a 10.2 pounds or 6.5 percent significant weight loss since the resident's previous weight of 157 pounds obtained on 1/6/19.

Lab results of a Liver Function Panel collected on 1/7/19 revealed an albumin of 2.5 and a total protein of 4.8. Normal lab values are 3.5-5.2 and 6.0-8.7, respectively.

Review of Resident #65's medical record revealed there were no nutritional interventions or physician orders written to address the resident's significant weight loss from 1/5/19 to 1/12/19. Additionally, review of the resident's medical record revealed the RD's 1/10/19 recommendation for the resident to receive a daily protein supplement was not implemented.

On 2/7/19 at 9:32 AM, an interview with the

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dietary manager (DM) revealed she was unaware of the weight that was obtained for Resident #65 on 1/12/19 which reflected a significant weight loss from 1/6/19. She stated she tried to keep up with the weekly weights. She stated she pulled the report weekly and if there was a concerning weight, she requested nursing to reweigh the resident. If there was still a concern, she would notify the dietician by phone and get a recommendation for the physician to stop the resident's weight loss. The DM confirmed no interventions were implemented to address Resident #65's weight loss experienced from 1/6/19 to 1/12/19.

On 2/6/19 at 11:20 AM the Assistant Director of Nursing (ADON) was interviewed. She stated weights were done on admission. In January 2019, the facility initiated weekly weights x 4 after admission. Nursing assistants were to obtain the residents' weights and give the result to the nurse on the hall to enter into the computer. She stated if there was a 3 pound variance, a reweight was obtained. If the weight was still concerning, the physician was notified as well as dietary so that interventions could be put into place.

Review of Resident #65's weight record revealed on 1/19/19 a weekly weight was not documented.

On 2/6/19 at 12:40 PM, Nurse #1 was interviewed. Nurse #1 stated she was assigned to the E/F halls on 1/19/19, where Resident #65 resided. She stated nursing assistants obtained the resident weights and gave them to either her or the supervisor to enter into the computer system.

The 14 day MDS dated 1/18/19 had a weight of

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157 pounds.

Review of Resident #65's weight record revealed on 1/26/19 a documented weekly weight of 139.8 which equates into a 17.2 pound or 10.96 percent weight loss since 1/6/19.

A review of meal percentages from 1/6/19 to 1/26/19 for Resident #65 revealed she consumed between 50-75% of her meals.

On 2/7/19 at 9:14 AM, the dietician was interviewed. She stated she didn't recall Resident #65 and that she wasn't sure if the resident was on weekly weights. She stated she would get the report when she rounded monthly and the Dietary Manager would notify her of any significant changes related to weekly weights. She stated she would ask the facility's risk committee why she didn't get the information regarding Resident #65 's weight loss identified on 1/12/19 and why no weekly weight was obtained for Resident #65 on 1/19/19. The RD confirmed no approaches were implemented to address the resident's weight loss which began on 1/12/19 until 1/30/19 when a house shake supplement was ordered.

On 2/7/19 at 9:32 AM, an interview with the DM revealed on 1/29/19 she rounded with the dietician and saw Resident #65. She stated she spoke with the resident's family member who had several things listed that she did not want Resident #65 to eat due to her bowel trouble. The DM updated the resident's tray card. The DM also confirmed no interventions were implemented to address Resident #65's weight loss which began on 1/12/19 until 1/30/19 when a house shake was ordered.

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F 580	Continued From page 20 On 2/7/19 at 3:48 PM, an interview was conducted with the resident's physician. She stated she didn't have Resident #65's chart in front of her but wasn't aware she had experienced weight loss. She stated she expected to be notified of a weight loss.	F 580		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide incontinence care from two people as care planned. Resident #62 slid out of the bed to the floor and received abrasions to his right forearm and right side of head. One of 5 residents (Resident #62) were reviewed for falls. Findings include: Resident #62 was admitted to the facility on 9/12/06 with diagnoses that included quadriplegia and neurogenic bladder. A review of Resident #62's 10/16/18 quarterly Minimum Data Set revealed the resident was cognitively impaired. Resident #62 was coded under functions as totally dependent with 2-person assistance required for bed mobility, transfers, toileting, eating, and bathing. Active	F 689	F689 Root cause Analysis Based on root cause analysis by the facility□s administrative staff it was determined that staff did not provide adequate supervision and assistances to prevent accidents. Immediate: On 2/8/2019 care guide for resident #62 was updated for the Certified Nursing Assistants to indicate two person assist with incontinent care. On 2/26/2019 Certified Nursing Assistant #5 was re-educated on reviewing and following the resident□s care guide regarding the amount of assistance needed for activities of daily living care (incontinent care).	2/27/19

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F 689	Continued From page 21 diagnoses included neurogenic bladder, paraplegia, neoplasm of brain, and aphasia. A review of Resident #62's care plan dated 6/18/18 and reviewed 10/16/18 revealed the resident was care planned for staff assistance for all Activities of Daily Living related to his limited mobility. Interventions on Resident #62's care plan included for the resident to have 2-person assistance with bathing and incontinence care. A review of the facility's incident report dated 1/1/19 revealed the NA (Nursing Assistant) was turning Resident #62 in bed for perineal care and the resident slid out of the bed and rubbed his shoulder and forearm on the wall. It was reported Resident #62 received an abrasion to the right top of his head and right forearm. The resident was assessed and put back in bed with 2-person assistance. Resident #62's responsible party and the physician were notified. A review of Resident #62's medical record revealed a physician's order dated 1/1/19 that ordered for x-rays to be obtained of the resident's right shoulder and right side of head due to fall. Resident #62's x-ray of the right mandible with two views revealed no fracture or dislocation seen. The x-ray results were viewed and signed by the physician on 1/4/19. A telephone interview was conducted with NA #5 (Nursing Assistant) on 2/8/19 at 3:50pm. She reported that she was providing incontinence care to Resident #62 on 1/1/19 early in the morning. She reported she had the resident turned on his left side and was washing his buttocks and rectal area. NA #5 reported her gloves were wet and the resident moved his head and started sliding. She reported she tried to catch him but because he	F 689	Identification of Others: All residents are at risk for the deficient practice therefore effective 2/25/2019 a 100% audit was conducted by the MDS Nurses to identify residents in need of two person assist while providing incontinent care. 49 residents were identified for requiring 2 assist with incontinent care. For each resident identified, care guides were updated as of 2/25/19 to indicate two person assist with incontinence care. Systemic Changes: Effective 2/27/19, 100% of nursing staff was re-educated by the Director of Nursing and Assistant Director of Nursing on following the residents□ care guide regarding the number of persons needed to provide assist with incontinent care. Care guides were updated for residents identified as needing two person assist with incontinent care. The nurses are to include on the 24 hour report if there is a change in a resident□s need for assistance with incontinence care. Monitoring: The Director of Nursing/ Assistant Director of Nursing will monitor the 24 hour report daily during clinical meeting 5 days per week (Monday □Friday) for any residents with a change in assistance with incontinence care. Monitoring will continue on Saturday and Sunday by the charge nurse. This monitoring will be conducted daily x2 weeks, then weekly x2, and then monthly x3 months. Findings will be reported to the monthly QAPI committee for recommendations or modifications until a pattern of compliance is achieved.	

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F 689	Continued From page 22 was still wet, and her gloves were wet, he slid off the bed. She reported the bed was elevated approximately 3 feet. She reported she knew she was supposed to have someone help her with Resident #62 but because he was "tiny and little," she thought she could manage. She reported he only could move his head. NA #5 reported she often provided care to Resident #62 without assistance prior to the fall. An interview was conducted with the DON (Director of Nursing) on 2/8/19 at 5:50pm. She reported it was her expectation that the nursing assistants follow the care plans of the residents. She reported it was her expectation that the nurses on the floor and the unit manager make sure the nursing assistants follow the care plans.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		3/4/19

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F 692	Continued From page 23 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility failed to identify and implement measures to address an unintended weight loss for 1 of 4 (Resident #65) sampled residents reviewed for nutrition. Findings included: Resident #65 was admitted to the facility on 1/5/19 with diagnoses of, in part, right femur fracture, right wrist fracture and vascular dementia. She was admitted from hospital. She was not in facility prior. Review of Resident #65's physician orders revealed on 1/5/19 and order was written for weekly weights and she was admitted on a regular, no added salt diet. Review of the resident's medical record revealed on 1/6/19, Resident #65 weighed 157 pounds. Record review revealed a Nutritional Screening and Assessment dated 1/10/19 which indicated Resident #65 had a fair appetite, consuming 50-75% of most meals. Weight stable over last 6 months per family member's report, usual body weight prior to illness 158 pounds, and ideal body weight 130 pounds. A nutritional care plan note dated 1/10/19 written by the dietician revealed Resident #65's weight was 157 pounds. The registered dietician recommend adding a protein supplement twice a day with medication pass. The note specified the resident was at risk for weight changes related to	F 692	F692 Root Cause Analysis Based on the root cause analysis by the facility Administrative staff and the facility Executive Director, the facility did not follow policy and procedure by failing to put interventions in place for a resident having been identified with significant weight loss. Immediate Action On 2/16/2019 resident #65 was discharged from the facility Identification of Others All residents are at risk for the deficient practice therefore on February 27, 2019 a 100% audit was completed by the Dietary manager and the Registered Dietitian on residents on monthly and weekly weights to identify any residents with significant weight loss. If any resident was identified with significant weight loss the physician was notified, and an intervention was put in place. Systemic Changes Effective March 1, 2019 The Dietary Manager will review weekly and monthly weights to identify any residents with significant weight loss. The dietary manager will place those residents identified on the weekly standards of care list to be reviewed by the IDT during the weekly standards of care meeting to discuss interventions to put in place. The residents will be placed on the Dietitian□s	

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F 692	Continued From page 24 use of therapeutic diet, dementia, and weight above average body weight. Will proceed to care plan. A care plan for nutrition dated 1/10/19 revealed Resident #65 was at risk for weight changes related to use of therapeutic diet, diagnosis of dementia and weight above average body weight. A handwritten addition of significant weight loss was added with no date entry. The care plan goal included resident will eat at least 75% of all meals through next review with an additional handwritten goal of no significant weight changes through next review handwritten. Interventions included: maintain current listing of likes and dislikes, administer vitamins as ordered, obtain weight monthly and as needed, encourage dining room for all meals, dietary recommendation add 30 milliliters of a protein supplement max twice a daily with medication pass for nutritional support. A review of an Admission/5 day Minimum Data Set assessment dated 1/11/19 revealed Resident #65 had severely impaired cognition. She was assessed as being independent with meals after set-up, having no swallowing disorder, was on a therapeutic diet, weighed 157 pounds and was 66 inches tall. An observation on 2/7/19 at 12:47 PM of Resident #65 revealed she was sitting at a table in the main dining room with lunch tray in front of her. Resident #65 had only consumed bites of her beans. A follow-up observation on 2/7/19 at approximately 1:00 PM revealed the activity assistant assisting Resident #65 to eat. Resident #65 had consumed approximately 75 percent of her meal.	F 692	list to review during her next visit; nurse management will notified the Physician/ Nurse Practitioner to inform of weight loss and approve interventions suggested. Effective February 27, 2019 the Dietary Manager was in-serviced by the Executive Director to report any residents identified with significant loss to the Dietitian , Executive Director, and Nurse management weekly/monthly to ensure interventions are put in place to prevent future weight loss or to maintain weight. Each resident identified must be placed on the weekly standards of care meeting list and the Dietitian list for review. Effective March 1, 2019 100% of nursing staff was in-serviced to report a decline in residents intake or the ability to feed self or any weight changes to nursing administration as soon as identified. Licensed staff to place on 24 hour report sheet. Nursing administration will review 24 hour report sheet daily during clinical rounds. This education was provided by the Director of Nursing/ Assistant Director of Nursing, any staff not educated will not be allowed to work until educated. This education will also be added to the new hire process. Monitoring Effective March 1, 2019 the Director of Nursing/ Assistant Director of Nursing / Unit Manager will review the 24 hour report to identify any residents with poor intake, decrease in the ability to feed self and weight changes during daily clinical meeting 5 days per week (Monday Friday). This Monitoring will be continued by the Charge nurses on Saturdays and	

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F 692	Continued From page 25 On 2/7/19 at 1:13 PM, an interview with NA #2 revealed Resident #65 was able to feed herself, but did need assistance at times. She stated she had good days and bad days. The family or family friend would visit frequently and assist the resident to eat. She stated she encouraged the resident to eat in the dining room if no one came in to visit, but sometimes she refused to go. Review of Resident #65's weight record revealed on 1/12/19 a weekly weight of 146.8 pounds was documented which was a 10.2 pounds or 6.5 percent significant weight loss since the resident's previous weight of 157 pounds obtained on 1/6/19. Lab results of a Liver Function Panel collected on 1/7/19 revealed an albumin of 2.5 and a total protein of 4.8. Normal lab values are 3.5-5.2 and 6.0-8.7, respectively. Review of Resident #65's medical record revealed there were no nutritional interventions or physician orders written to address the resident's significant weight loss from 1/5/19 to 1/12/19. Additionally, review of the resident's medical record revealed the RD's 1/10/19 recommendation for the resident to receive a daily protein supplement was not implemented. On 2/7/19 at 9:32 AM, an interview with the dietary manager (DM) revealed she was unaware of the weight that was obtained for Resident #65 on 1/12/19 which reflected a significant weight loss from 1/6/19. She stated she tried to keep up with the weekly weights. She stated she pulled the report weekly and if there was a concerning weight, she requested nursing to reweigh the resident. If there was still a concern, she would	F 692	Sundays. The Dietary manager will monitor weekly /monthly weights to identify residents with significant weight loss and verify an intervention is put in place. This monitoring will be conducted daily x2 weeks, then weekly x2 weeks, then monthly x3. Findings will be reported monthly to the QAPI committee for recommendations or modifications until a pattern of compliance is achieved.	

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notify the dietician by phone and get a recommendation for the physician to stop the resident's weight loss. The DM confirmed no interventions were implemented to address Resident #65's weight loss experienced from 1/6/19 to 1/12/19.

On 2/6/19 at 11:20 AM the Assistant Director of Nursing (ADON) was interviewed. She stated weights were done on admission. In January 2019, the facility initiated weekly weights x 4 after admission. Nursing assistants were to obtain the residents' weights and give the result to the nurse on the hall to enter into the computer. She stated if there was a 3 pound variance, a reweight was obtained. If the weight was still concerning, the physician was notified as well as dietary so that interventions could be put into place.

Review of Resident #65's weight record revealed on 1/19/19 a weekly weight was not documented.

On 2/6/19 at 12:40 PM, Nurse #1 was interviewed. Nurse #1 stated she was assigned to the E/F halls on 1/19/19, where Resident #65 resided. She stated nursing assistants obtained the resident weights and gave them to either her or the supervisor to enter into the computer system.

The 14 day MDS dated 1/18/19 had a weight of 157 pounds.

Review of Resident #65's weight record revealed on 1/26/19 a documented weekly weight of 139.8 which equates into a 17.2 pound or 10.96 percent weight loss since 1/6/19.

A review of meal percentages from 1/6/19 to

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F 692	Continued From page 27 1/26/19 for Resident #65 revealed she consumed between 50-75% of her meals. On 2/7/19 at 9:14 AM, the dietician was interviewed. She stated she didn't recall Resident #65 and that she wasn't sure if the resident was on weekly weights. She stated she would get the report when she rounded monthly and the Dietary Manager would notify her of any significant changes related to weekly weights. She stated she would ask the facility's risk committee why she didn't get the information regarding Resident #65 's weight loss identified on 1/12/19 and why no weekly weight was obtained for Resident #65 on 1/19/19. The RD confirmed no approaches were implemented to address the resident's weight loss which began on 1/12/19 until 1/30/19 when a house shake supplement was ordered. On 2/7/19 at 9:32 AM, an interview with the DM revealed on 1/29/19 she rounded with the dietician and saw Resident #65. She stated she spoke with the resident's family member who had several things listed that she did not want Resident #65 to eat due to her bowel trouble. The DM updated the resident's tray card. The DM also confirmed no interventions were implemented to address Resident #65's weight loss which began on 1/12/19 until 1/30/19 when a house shake was ordered. On 2/7/19 at 3:48 PM, an interview was conducted with the resident's physician. She stated she didn't have Resident #65's chart in front of her but wasn't aware she had experienced weight loss. She stated she expected to be notified of a weight loss.	F 692		
F 760	Residents are Free of Significant Med Errors	F 760		2/8/19

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F 760 SS=D	Continued From page 28 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 interviews, emergency medical service (EMS) personnel interviews, and emergency department (ED) Physician interview, the facility failed to prevent a significant medication error by not following physician orders to administer insulin with meals for 1 of 4 (Resident #192) sampled residents reviewed for insulin administration. Prior to administering 58 units of Novolog 70/30 Insulin, which was ordered to be given with meals, staff did not make sure Resident #192 had eaten her breakfast meal. As a result, Resident #192 became unresponsive and was admitted to the hospital. She required a central line and intubation. Resident #192's final diagnoses for hospital admission on 1/25/19 were acute respiratory failure, altered mental status, hypothermia (low body temperature), and hypoglycemia (low blood glucose). Findings included: Resident #192 was admitted to the facility on 1/23/19 with the diagnoses that included Diabetes Mellitus Type 2, hypothyroidism (underactive thyroid gland), hypertension (HTN - high blood pressure), enterocolitis (inflammation in the gut that effects the small intestine and colon) related to clostridium difficile (C-diff), an infection in the colon that is caused by the bacteria called clostridium difficile.	F 760	F760 Root Cause Analysis Based on the root cause analysis by the facility's administrative staff, it was determined that the staff administered Novolog 70/30 insulin to resident #192 with the order reading to give with meals. Resident #192 did not eat her breakfast meal. Immediate Action: Resident #192 was sent to the emergency room for evaluation and treatment. Resident #192 was admitted to the hospital and did not re-admit to this facility. Identification of Others: 100% of resident's medication orders were completed by the DON/ ADON on 2/7/19 and 2/8/19 to identify any other resident with any insulin order that needed to be given with meals. The audit concluded there were eight other residents identified with orders for insulin to be administered with meals. Attending physician for these eight identified residents was contacted and approved all of these orders to be given with any food to include a meal or snack between meals. Those orders were clarified to be given with food as of 2/8/19.	

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F 760	Continued From page 29 Review of the physician orders for Resident #192 revealed orders placed on 1/23/19 for Finger Stick Blood Sugar (FSBS) checks before meals & at bedtime. There was also an order to administer 58 units subcutaneously (SQ - injection into the fat layer between the skin and muscle) twice daily with meals of Novolog 70/30. According to the manufacturer, Novolog 70/30 is a mixture of a man-made fast-acting insulin to help control mealtime spikes in blood sugar and long-acting insulin that works up to 24 hours to help control blood sugar between meals. The manufacturer guidelines stated that people with type 2 diabetes should have the injection within 15 minutes before or after starting their meal. Resident #192's January 2019 medication administration record (MAR) revealed Resident #192 had her 6:00 AM scheduled FSBS check on 1/25/19 at 6:37 AM and the result was 109 milligrams/deciliter (mg/dl). The Novolog 70/30 58 units of insulin scheduled for 9:00 AM was documented as administered on 1/25/19 at 10:24 AM by Nurse #2. According to the meal percentage sheet, Resident #192 did not eat anything for breakfast or lunch on 1/25/19. During an interview with Nurse Aide (NA) #6 on 2/6/19 at 4:46 PM about Resident #192's condition and meal intake on 1/25/19, she stated that the resident was on the bedpan several times that morning, and that she had refused breakfast. When asked if she notified the nurse of the resident's refusal to eat breakfast, she stated Nurse#2 was made aware. During an interview with Nurse #2 on 2/7/19 at	F 760	Systemic Changes: Effective 2/8/19 and moving forward, the facility licensed nurse will not administer insulin for any resident with an order to be given with food when a resident refuses his/ her food. Facility licensed nurse will notify the physician when a resident with ordered insulin to give with food refuses food and document the physician's decision in the resident's medical record before the insulin is administered. Effective 2/8/19 and moving forward, the DON/ ADON or nurse supervisor will review any new insulin orders for the last 24 hours to ensure that each resident with an order for insulin has an indication of whether it needs to be given with food or not, and validate that licensed nurses administer those orders as specified by the physician. The facility DON/ ADON and/or SDC will complete 100% education for all licensed nurses to include full time, part time and as needed staff. The emphasis of this education will be on the importance of administering medication as ordered by the physician and in a timely manner for any medication specifically insulin. The education also emphasized the responsibility of the licensed nurse to notify the physician when a resident with ordered insulin to be given with food refuses their food. The education also emphasizes the need to document the physician's decision in the medical record. The education was completed by 2/8/19. This education will be added to the new hire orientation process for all new	

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F 760	Continued From page 30 1:17 PM she stated that at approximately 10:00 AM she went into Resident #192's room to administer medications and she was at baseline with no altered mental status. Nurse #2 stated she knew she did not eat her breakfast and had tried to get her to eat something at that time, but the resident refused any food. When asked if she gave her the full dose of Novolog 70/30 insulin when she knew the resident had not eaten breakfast, she stated that she did. She stated she had gone into Resident #192's room at approximately 12:00 PM to check her blood sugar and found her unresponsive. Nurse #2 stated she couldn't wake Resident #192 up and checked her blood sugar with a result of 189 mg/dl. She stated she applied oxygen, checked vital signs, notified the DON, and EMS was called to transfer the resident to the hospital. She stated that she checked the resident's pupils and they were fixed and dilated. A progress note dated 1/25/19 at 6:43 PM written by Nurse #2 stated she entered Resident #192's room at 12:15 PM and found Resident #192 unresponsive. The resident's SpO2 (blood oxygen saturation level) was 98%, blood pressure (BP) was 98/68 mmHg, Pulse 54 beats per minute (bpm), and FSBS was 189. Review of the January 2019 MAR revealed that Resident #192 had her 11:30 AM FSBS checked on 1/25/19 at 1:07 PM of 189 mg/dl. During an interview with the Director of Nursing (DON) on 2/6/19 at 5:02 PM she stated she was in Resident #192's room after she was notified of her being unresponsive. She stated the resident's blood sugar was 189 mg/dl and that there was no indication to be concerned about	F 760	licensed nurses and will also be provided annually effective 2/8/19. Monitoring: Effective 2/8/19, the DON/ ADON will monitor compliance with timely and accurate insulin administration by reviewing insulin administration records from previous day to ensure timely administration, correct administration and documentation as ordered by physician. This will include verifying any resident with orders to be given with food is given as ordered. Findings from this monitoring process will be documented on the daily clinical report form and filed in the clinical meeting binder after proper follow ups are completed. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks and then monthly x 3 months or until the pattern of compliance is maintained. Facility QA was notified of this plan of action on 2/8/19. Effective 2/8/19, the DON/ ADON will report findings of this monitoring process to the QA committee for any additional monitoring or modification of this plan x 3 meetings or until a pattern of compliance is maintained. The QA committee can modify this plan to ensure the facility remains in substantial compliance	

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the insulin being administered or blood sugar level.

Review of Resident #192's EMS report from 1/25/19 revealed the resident was found at the facility to be unresponsive. The chief complaint documented that the resident was found unresponsive by staff and it was reported to EMS that the resident was last seen normal at 11:00 AM, her vital signs were all normal, and her blood glucose was 129 mg/dL. The first blood glucose level documented by EMS at 1:05 PM was 23 mg/dL. At 1:09 PM Dextrose 50% (D50 - a hypertonic solution of dextrose, simple sugar chemically identical to glucose) 25 grams was administered. At 1:13 PM the resident's blood glucose was 273 mg/dL. At 1:30 PM her blood glucose was 110 mg/dL. At 1:30 PM her blood glucose was 110 mg/dL. Resident #192 was received by the hospital ED staff at 1:45 PM.

Review of the ED Report from 1/25/19 documented the resident was found unresponsive at the facility by EMS and EMS obtained a blood glucose of 23 mg/dL. Triage Lab results from ED admission on 1/25/19 at 2:48 PM were Glucose 26 mg/dL. The resident required a central line (a catheter placed into a large vein to give medications or draw lab work) and intubation at 2:52 PM for acute respiratory failure, she received D50 for hypoglycemia, intravenous fluids (IVF) for hypotension, and admission to Intensive Care Unit (ICU). Her final diagnoses for hospital admission on 1/25/19 were acute respiratory failure, altered mental status, hypothermia, and hypoglycemia.

Review of hospital records from 1/27/19 at 9:22 AM revealed a Critical Care Progress Note by

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F 760	Continued From page 32	F 760		

Physician Assistant (PA) #1 and Hospital Physician #1 that stated problems addressed for Resident #192 involving her insulin dependent diabetes mellitus (IDDM) were "likely related to insulin dose and not eating."

During an interview on 2/7/19 at 3:35 PM the Staff Development Coordinator stated NAs are educated on notifying the nurse when a resident does not eat on orientation and as needed. Nurses are educated to look at each resident receiving insulin individually during each medication administration and were educated to withhold insulin if meals were not consumed. She further stated, if the resident does not eat a meal it was expected that the nurse call the provider for further orders before insulin is administered.

During an interview with the facility Pharmacist on 2/7/19 at 5:11 PM she stated she would have expected the nurse to hold all short acting insulin if a meal wasn't consumed. She stated if the resident's blood sugar was 109 at 6:27 AM, and she didn't eat or have glucagon administered, the blood sugar going up to 189 mg/dl at approximately 12:15 PM seemed inconsistent. She stated Novolog 70/30 is used to regulate and lower blood sugar levels for residents with diabetes, it has an onset of action within 10-20 minutes for the short acting and the medication peaks within 1-4 hours of administration.

During an interview with the Medical Director on 2/7/19 at 3:55 PM she stated she was not aware of the particular incident with Resident #192's low blood sugar and transfer to the ED and her associate was most likely contacted for transfer orders. When asked if she expected the nurse to

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F 760	Continued From page 33 hold insulin if a resident did not eat, she stated most residents in the nursing home don't eat all the time. When asked if she expected the nurse to check another blood sugar prior to administering insulin after a 4-hour time period and no food was consumed, she stated yes but she did not fault the nurse for administering the insulin without food. She stated most likely the resident had been receiving this ordered insulin dose for a long period of time and for whatever reason on that particular day she had an adverse reaction to the insulin, but she had probably had the insulin administered at that dose without food in the past without the same effect.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		3/4/19

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F 761	Continued From page 34 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date one opened vial of tuberculin in 1 of 1 medication storage room. The facility also failed to maintain correct refrigerator temperature in 1 of 1 medication refrigerator in the medication storage room. Findings include: 1. An observation was made on 2/8/19 at 9:50 am with Nurse #13 of the medication storage room refrigerator. It was observed that there was an opened vial of tuberculin not dated. An interview was conducted with Nurse #13 on 2/8/19 at 9:50 am. She reported all medication vials opened should be dated and labeled. She reported it was the responsibility of whoever opened the vial to date it. An interview was conducted with the DON (Director of Nursing) on 2/8/19 at 5:55pm. She reported it was her expectation that all opened medications in the medication storage refrigerator should be labeled and dated. 2. A review of the medication refrigerator temperature log for February 2019 revealed the refrigerator's temperatures were logged daily at 8:00am. The temperature readings were 2/8/19: 30 degrees F (Fahrenheit), 2/7/19: 32 degrees F, 2/6/19: 32 degrees F, 2/5/19: 28 degrees F. A review of the manufacturing recommendations for Trulicity, Risperdal, Tuberculin, and insulin revealed that the medications should be stored between 35 degrees and 46 degrees Fahrenheit. An observation was made on 2/8/19 at 9:50 am	F 761	Ftag 761 Root Cause Analysis Based on root cause analysis by the facility administrative staff it was determined the facility failed to follow the facility□s policy for medication storage and labeling. Immediate: On February 8, 2019 the undated opened vile of tuberculin was removed from the refrigerator and discarded. The refrigerator temperature was set to maintain a temperature between 36 to 46 degrees according to facility policy. Identification of others: All residents are at risk for deficient practice. On February 18, 2019 a 100% audit of the medication refrigerator , medication storage room, and each medication cart was conducted by pharmacy any medications not dated when opened were removed and discarded. The refrigerator settings were verified to maintain a temperature between 36 to 46 degrees according to policy. Systemic Changes: Effective March 1, 2019 100% of licensed nurses and medication aides were re-educated by the Director of nursing / Assistant Director of Nursing and/ or the Staff Development Coordinator on the facility□s policy on medication storage	

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F 761	Continued From page 35 with Nurse #13 of the medication storage room refrigerator. The medication refrigerator temperature was noted to be 30 degrees. It was observed that 3 Trulicity 0.75mg(milligrams)/0.5ml(milliliters) (type 2 diabetes mellitus medication) pens had a frosty type material on them. The refrigerator was observed to contain 25 insulin pens, 5 insulin vials, 2 boxes of Risperdal filled syringes, and 4 vials of Tuberculin. It was observed on the Trulicity, Risperdal, Tuberculin and insulin packaging information that the medication should be stored between 35 degrees and 46 degrees Fahrenheit. An interview was conducted on 2/8/19 at 9:50 am with Nurse #13. She reported she was responsible for checking the refrigerator temperatures every day. She reported the refrigerator temperature should be below 41 degrees. She reported there was no set temperature that the refrigerator should not fall below. An interview was conducted with the ADON (Assistant Director of Nursing) on 2/8/19 at 10:45 am. She reported the refrigerator temperature should be below 41 degrees. She reported that the temperature was occasionally below freezing but if the medication was not frozen there was no concern. She reported if any medication was found frozen, it would be disposed of immediately. An interview was conducted with the Pharmacy Consultant on 2/8/19 at 12:38pm. She reported all medication refrigerators should be between 34 and 41 degrees. She reported medications such as insulin, Trulicity, and Risperdal should not be stored at 32 degrees or below as it was contraindicated and could affect the effectiveness of the medications.	F 761	and labeling. Nursing staff was educated to document any findings of undated opened medications and out of range refrigerator temperatures on the 24 hour report, discard undated opened medications, reset refrigerator temperature to maintain a range of 36 to 46 degrees and to document in the maintenance book. Monitoring: The Director of nursing and/or Assistant Director of nursing will review the 24 hour report and verify refrigerator temperatures during clinical meeting 5 days per week (Monday □ Friday). Findings will be documented on the clinical report form. Monitoring will continue on Saturday and Sunday by the charge nurse. This monitoring will be conducted daily x two weeks, then weekly x2, and monthly for 3 months. The Director or nursing, Assistant Director of nursing and/ or designated licensed nurse will audit medication carts/ medication room and medication room refrigerator for expired/ undated items weekly x 4 weeks and then monthly thereafter. The monthly audits will be an ongoing monitoring process. Findings will be reported to the monthly QAPI committee meeting for recommendations or modifications until a pattern of compliance is maintained.	

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F 761	Continued From page 36 An interview was conducted with the DON (Director of Nursing) on 2/8/19 at 5:55pm. She reported it was her expectation that the medication refrigerator temperature should not be above 41 degrees or below 34 degrees. She reported she was not sure who was responsible for auditing the refrigerator logs as she was new to the facility.	F 761		