

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/21/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SCOTTISH PINES REHABILITATION AND NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 JOHNS ROAD</b> <b>LAURINBURG, NC 28352</b>
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F 000	INITIAL COMMENTS  A complaint survey was conducted from 06/19/19 to 06/21/19. Past-noncompliance was indentified at:  CFR 483.25 at tag F684 at a scope and severity (J)  The tag F684 constituted Substandard Quality of Care.  A partial extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Physician interviews, the facility failed to follow the protocol regarding standing orders for hypoglycemia (low blood sugar) and failed to follow the physician order to administer Glucagon (a medication to treat severe low blood sugar) intramuscular injection for hypoglycemia for 1 of 3 sampled residents (Resident # 1). Resident #1 experienced prolonged hypoglycemia which resulted in the resident having a cardiac arrest.  Findings Included:	F 684	Past noncompliance: no plan of correction required.	7/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>07/11/2019</b>
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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 684	<p>Continued From page 1</p> <p>Resident # 1 was admitted to the facility on 9/21/18. Active diagnoses included; Type 2 Diabetes Mellitus with diabetic chronic kidney disease, End stage renal disease, and Dependence on renal dialysis.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 2/12/19 indicated Resident #1 was cognitively intact. She required set up assistance with eating. She received dialysis treatments three times weekly and had a diagnosis of diabetes with sliding scale insulin coverage.</p> <p>A review of the care plan revised on 3/14/19 revealed a plan of care was in place for, at risk of hypoglycemia with goals to include reducing the risk of hypoglycemia and hyperglycemia (elevated blood sugar) and associated complications. Interventions included; identifying signs of hypoglycemia such as change in mental status, confusion, lethargy, and diaphoresis (sweating), providing diet, accuchecks, and medications per order, and reporting abnormal values to the physician promptly.</p> <p>The physician's orders for May 2019 specified the resident had orders for the following diabetic medications: Novolog 100units/ml (milliliter) Sliding Scale Insulin before meals and at bedtime for blood sugar above 151, and Glimepiride 1mg (milligram) - take one tablet by mouth daily for diabetes.</p> <p>A review of the facility's investigation dated 5/2/19 documented Nurse #1 worked 3:00 - 11:00 PM on 5/1/19. At 8:45 PM, per her documentation, she performed a finger stick blood sugar on Resident</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 2</p> <p>#1 and it was noted to be 31. Nurse #1 gave the resident a container of juice with added sugar and fruit. She left the resident and went to break. Later in the evening at 10:20 PM she was told by a nurse aide that resident #1 was diaphoretic. Nurse #1 rechecked the residents blood sugar and it was 35. The on-call facility physician was notified, and verbal orders were given to administer Glucagon 1 mg (milligram) IM (intramuscular injection) and recheck the blood sugar. The nurse did not recheck the blood sugar and administered instant glucose (a rapidly absorbed gel to increase blood sugar levels) a second time. The physician gave orders to send her to the Emergency Department. Resident #1 coded in the facility after 911 was notified and the facility nurse-initiated CPR (cardiopulmonary resuscitation). The facility investigation documented that Nurse #1 left the resident unattended with a blood sugar of 31, she failed to recheck the blood sugar per facility protocol, she failed to ensure the resident recovered from the hypoglycemic episode, she failed to recheck the resident for an hour and twenty minutes and failed to carry out physician orders.</p> <p>A review of the interview conducted by the facility with Nurse #1 on 5/2/19 documented Nurse #1 stated in response to the residents' low blood sugar, that she gave two tubes of instant glucose, rechecked her blood sugar and it was 36, and stated she gave what was available. During the interview she was asked why it took her an hour and twenty-five minutes before checking on the resident again, and why she didn't follow the hypoglycemic protocol. Nurse #1 replied that the resident had low blood sugars before and they would just have her eat and replied that she didn't know there was a hypoglycemic protocol, and she</p>	F 684			

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F 684	<p>Continued From page 3</p> <p>didn't know what the standing orders were.</p> <p>A review of the physician standing orders for signs and symptoms of hypoglycemia included; for blood sugar below 50, immediately recheck and document. If the resident can safely take oral treatment, offer sweetened drink, sugar candy, or other foods that resident was known to respond to. If the resident was unable to safely take oral treatment give Glucagon 1mg IM as needed. Recheck blood sugar and if it remains low offer oral treatment or Glucagon 1mg IM. After second treatment if blood sugar remains below 50, notify the physician. If, at any time, the residents' condition declines or becomes non-responsive, notify the physician immediately.</p> <p>A review of the nursing note dated as a late entry on 5/2/19 at 12:42 AM signed by Nurse #1 documented, resident refused to eat dinner and snacks. Blood sugar at 4:40 PM was 159. Residents blood sugar at 8:45 PM was 38, orange juice and crackers were given, and she began to eat them. At 10:10 PM staff notified nurse that the resident was very warm and wet with sweat. The nurse checked blood sugar and it was 31. The facility physician was called, and he gave orders to give two Instant Glucose (gel) which were administered, and blood sugar was 36. The physician was notified and gave orders to send the resident to the hospital. EMS (emergency medical services) was called around 11:00 PM. At 11:20 PM the nurse got the crash cart and started CPR because resident was unresponsive and a full code. CPR was continued until EMS arrived and took over around 11:40 PM.</p> <p>A review of the physician interview conducted by the facility on 5/2/19 documented the physician</p>	F 684			

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F 684	<p>Continued From page 4</p> <p>was called at 10:37 PM on 5/1/19, per his phone records, by Nurse #1 regarding the residents' low blood sugar. The nurse informed him that she had given glucose gel and then resident began to refuse the glucose gel and her blood sugar did not improve. Nurse #1 stated the resident was awake and alert. He ordered her to give Glucagon IM now, recheck blood sugar and call him back afterwards. No return call was received. He called the nurse back at 10:48 PM to ask what the blood sugar was and if the Glucagon was given and the nurse stated yes, she had given Glucagon. He told the nurse to call 911 and give a second glucagon in five minutes. He was not called again until 11:28 PM and informed that the resident was coding, and EMS had just arrived. The physician documented that he was concerned that a lot of time had passed from his last call until the time EMS arrived. He documented that the nurse stated EMS was called an hour before they arrived.</p> <p>A review of the Emergency Services record documented on 5/1/19 the 911 call was received at 11:05 PM, and EMS arrived on scene at 11:17 PM. Upon arrival staff were giving compressions. According to the staff the resident became unresponsive five minutes prior to arrival. She was taken to the ambulance placed on a cardiac monitor and a tube was placed to assist with ventilation. She was transported to the Emergency Department.</p> <p>The hospital progress note dated 5/13/19 documented Resident #1 was alert but not improved. The family decided the resident would enter hospice care and stop dialysis.</p> <p>An interview was conducted on 6/20/19 at 1:25</p>	F 684			

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F 684	<p>Continued From page 5</p> <p>PM with the facility physician who was on call 5/1/19. He stated he instructed the nurse to give glucagon IM for the resident's low blood sugar and call him back after she did so. He stated eight minutes passed with no return phone call. He called the nurse back and she stated she had given glucagon, he then instructed her to call EMS. He stated he expected the nurse to administer the glucagon per his order and to call him back, and to call EMS at the time he instructed her to do so which was 10:48 PM. He stated that low blood sugars can cause cardiac arrhythmias and the two-hour delay in treatment by the nurse and not administering the glucagon per his orders did lead to the resident going into cardiac arrest. He stated since that time they have gone through remediation with staff regarding managing low blood sugars and its dangers. The physician reported Glucagon was now placed in more locations and instructions have been reviewed on how to administer Glucagon IM safely. He stated he in serviced staff on 5/10/19 which included classifications of hypoglycemia, what to do, how to give glucagon, and what to do immediately after administration.</p> <p>A phone interview was conducted on 6/21/19 at 5:14 PM with Nurse #1. She stated she had been informed by the off going nurse that the resident had episodes of low blood sugars at times and the residents blood sugar was okay before dinner, but the resident did not eat dinner that night. Nurse #1 reported at around 8:30 PM her blood sugar was 38 and she gave orange juice with sugar and she still had her meal tray, so she offered fruit and crackers. She stated she felt confident the resident would eat so she went on break and came back around 9:30 PM and resident was alert and eating. The nurse stated</p>	F 684			

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F 684	<p>Continued From page 6</p> <p>she went back to check her blood sugar while the aides were changing her around 10:00 PM and it was at that time when she was lethargic, she gave instant glucose then called the doctor and the residents daughter. She stated she told the doctor that she had given instant glucose. She stated she told the nurse on the 700 halls to call EMS. She stated she made the decision to call EMS then she called the doctor. She stated Nurse #2 came in and notified her that the resident coded. She stated glucagon was administered "in the mouth" and stated the resident was alert and oriented and drinking OJ and had one bite of crackers when she left the residents room after the 8:45 PM blood sugar. She stated on the second blood sugar around 10:00 PM her blood sugar was 31 and the resident was not speaking, she was turning her head, fighting and pushing away. Nurse #1 stated she told the doctor that all she had was a tube of instant glucose and he told her to give it and call him back, and she did not have a chance to call him back. He then called her back and at that time she was busy with the resident. She stated the doctor told her to give another dose of glucagon. She stated she received no formal training upon hire as far as protocols or standing orders, and that she knew from experience as to what to do for low blood sugars. She stated a normal blood sugar was 90-95. She stated the doctor did not tell her to give an injection.</p> <p>An interview was conducted on 6/20/19 at 10:58 AM with Nurse #2 who was on duty the night of 5/1/19. She stated the resident looked as if something was wrong, and Nurse #1 informed her that her blood sugar was low. Nurse #1 asked Nurse #2 to recheck the residents blood sugar and it was 39 and her color had not changed at</p>	F 684			

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F 684	<p>Continued From page 7</p> <p>the time and stated she could not recall the time that occurred. Nurse #2 stated while she was near the residents room watching for EMS to arrive, the residents color changed so she ran and grabbed the crash cart across from the nurses station. Nurse #2 stated she looked like she was coding so she grabbed the crash cart, and back board, and started CPR until EMS arrived. She stated EMS arrived quickly maybe within 5-10 minutes.</p> <p>A phone interview was conducted on 6/20/19 at 7:30 PM with the Emergency Medical Services lead medic who responded to the call. She stated compressions were given by the facility staff and EMS took over compressions upon arrival and stated the blood sugar was up to 118 at the time of transport the hospital. She stated the EMS low blood sugar protocol was not initiated due to blood sugar of 118.</p> <p>A review of the hospital progress note dated 5/2/19 documented that Resident #1's cardiac arrest was suspected to be due to prolonged hypoglycemia.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/21/19 at 1:15 PM. She stated Nurse #1 was terminated on 5/2/19. She stated nursing staff were oriented to facility protocols and standing orders at the time of hire and were instructed on how to access the standing orders located in the electronic charting system. The DON stated it was her expectation that the nurses administered medications as ordered by the physicians and followed facility protocols in the provision of care. She stated the glucagon injections were available on 5/1/19 and were kept in the facility Omnicell (medication dispensing</p>	F 684			



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F 684	<p>Continued From page 8 system), and on the crash carts which are located on each hall.</p> <p>The corrective action for noncompliance dated 5/23/19 was as follows:</p> <p>1.A thorough investigation was initiated on 5/2/19 to determine the root cause regarding failure to follow the physicians order to administer glucagon injections and failure to follow the facility policy regarding standing orders for hypoglycemia. The facility documented that on 5/1/19 resident #1 was experiencing symptoms of hypoglycemia. Nurse #1 noted her blood sugar to be 38 at 8:45 PM and crackers, juice and snacks were provided at that time. Her blood sugar at 10:10 PM was 31. The physician was notified, and orders were given to administer glucagon and glucose was administered by the nurse. A code was initiated, and the resident was sent to the hospital for evaluation. Her primary diagnoses included; End Stage Renal Disease, and Type 2 Diabetes. She has a history of noncompliance with dialysis and medications. The responsible party and the physician were made aware.</p> <p>The Director of Nursing (DON) provided statements from staff that were working on 5/1/19. The DON completed in services and provided education to the nursing staff regarding standing orders for hypoglycemia, how to access standing orders in electronic charting, and the facility policy on nursing care of residents with diabetes. The facility medication carts were audited on 5/3/19 and additional glucagon and glucose were purchased for all carts.</p> <p>The corrective actions for the affected resident included: The physician was notified on 5/1/19</p>	F 684			

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F 684	<p>Continued From page 9</p> <p>and orders given to send to the hospital. The resident's responsible party was notified on 5/1/19. The nurse was reported to the Health Care Personnel Registry and the North Carolina Board of Nursing on 5/2/19 and was terminated.</p> <p>The corrective action for residents with the potential to be affected included; all licensed nurses were in serviced prior to their next scheduled shift on standing orders for hypoglycemia, and how to access standing orders, and care of diabetic residents on 5/5/19. The facility Medical Director provided in-service training to licensed nurses on care of residents with diabetes on 5/10/19. On 5/23/19 nurse aides were in serviced regarding reporting abnormal signs and symptoms to the nurses.</p> <p>2.Measures implemented to assure the deficient practice would not reoccur include; all medication carts were audited on 5/3/19, and glucagon purchased for all carts on 5/12/19. New hires would be educated on how to access standing orders and return demonstration with nurse instructor to ensure understanding. The facility standing orders were laminated and placed in the physician phone order notebook for nursing reference on 5/3/19.</p> <p>3.Outcomes of compliance with the plan of action will be monitored by discussion in the morning administrative meeting by the Director of Nursing, or appropriate designee, five times a week for four weeks, followed by weekly for four weeks, and as needed beginning on 5/3/19 and continuing as outlined in the plan. The DON will bring outcomes of compliance with designated plan to the facility monthly meeting Quality Assurance (QA) meeting for three months</p>	F 684			

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F 684	<p>Continued From page 10</p> <p>beginning 6/26/19, then quarterly for one year. The facility Quality Assurance Performance Improvement (QAPI) committee will review during morning administrative meetings, as well as monthly and quarterly meetings. Noncompliance with the corrective action plan will be discussed and the plan revised as needed.</p> <p>As part of the validation process on 6/21/19 the plan of correction was reviewed which included dates and content of the in-services that were conducted, laminated copies of the facility protocol, supplying the med carts with glucagon, and interviews with the nurses and nurse aides to ensure their understanding and knowledge of hypoglycemia and reporting abnormal signs and symptoms. During the investigation twelve direct care staff were interviewed regarding training that was conducted and knowledge of diabetic care to include recognizing symptoms of hypoglycemia. Multiple observations were conducted of the medication carts, the crash cart, and locations of where glucagon was stored. All nurses interviewed were able to demonstrate where the facility standing orders were located, and where to find glucagon IM injections, and where the crash carts were located.</p> <p>The facility alleges full compliance with this plan of correction effective date 5/23/19.</p>	F 684			