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	345008	A. BUILDING _____ B. WING _____	C 10/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation survey was conducted on 09/16/2020. Additional information was obtained from 9/17/2020 to 9/18/2020, with exit from the facility on 9/18/2020. The facility was notified on 9/29/2020 of Immediate Jeopardy, which was identified after management quality review. The survey team returned to the facility on 10/06/2020 to validate the credible allegation. Therefore, the exit date was changed to 10/6/2020. Event ID #NW6011. 1 of the 1 complaint allegations was substantiated resulting in deficiencies. Immediate Jeopardy (IJ) was identified at CFR 483.45 at tag F760 at a scope and severity of J. F760 constituted substandard quality of care. Immediate Jeopardy (IJ) began on 08/30/2020 and was removed on 10/01/2020. A partial extended survey was conducted on 10/06/2020.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, physician interview, hospital record review and facility record review, the facility failed to administer insulin as ordered for 1 of 3 resident reviewed for insulin administration (Resident #1). The failure of the facility to administer insulin as ordered by the physician resulted in the resident having seizure	F 760	Resident #1□s Novolog order times were changed to 08:00, 12:00 and 5:30 to ensure medication is administered with meals (9.30.20). Resident #1□s Novolog orders were also updated to include checking and documenting blood glucose levels. The Dietary Department was made	10/30/20

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

Electronically Signed | 10/23/2020

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F 760	Continued From page 1 activity and becoming unresponsive due to low blood sugar and was sent to the Emergency Department. Resident #1 was also administered a granulated sugar packet and Gluco-jell (gel that raises glucose levels quickly) while unresponsive, with seizure activity and with critically low blood sugar. Immediate jeopardy began on 8/30/2020 when the facility staff failed to ensure Resident #1 who was diagnosed with Diabetes Mellitus (DM) and was insulin dependent, received a meal when administered fast acting insulin. The immediate jeopardy was removed on 10/1/2020 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. Findings included: Resident #1 was admitted to the facility on 1/22/18 with diagnoses to include Type 2 Diabetes Mellitus (DM). A review of quarterly Minimum Data Set (MDS) dated 7/3/20 revealed Resident #1 was moderately cognitively impaired, required extensive assistance with activities of daily living and was independent with eating after set up. The MDS further revealed the Resident #1 had a diagnosis of DM and received insulin injections 7 of 7 days. A review of Resident #1's care plan dated 7/3/2020 revealed a care plan for Alteration in	F 760	aware of the incident. Residents with orders to receive fast acting insulin with meals will receive their meal trays from the first dietary cart delivered to the unit. Through the facility pharmacy, the Director of Nursing has upgraded the facility emergency medication kit to ensure a minimum of two glucagon remain present. All residents have the potential to be affected by the deficient practice. A full house audit of all residents receiving fast acting insulin was conducted by the Director of Nursing (9.30.20). Orders for all residents receiving fast acting insulin have been reviewed and updated (9.30.20). Orders have been changed to ensure residents receiving fast acting insulin do so with their meals. All resident□s with fast acting insulin orders have also been updated to include checking and documenting blood glucose levels. To help ensure the deficient practice does not reoccur, The Director of Nursing or Designee will educate all licensed nursing staff on the new scheduled times for fast acting insulin orders by 10.28.20. The Director of Nursing or Designee will also educate all Licensed Nursing Licensed staff on the following Policies by 10.28.20: " Insulin Administration (includes checking and documenting resident blood glucose levels). " Nursing Care for Residents with	

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F 760	Continued From page 2 Blood Glucose due to Insulin Dependent Diabetes Mellitus. The goals were for Resident #1 to experience minimal signs and symptoms associated with hyperglycemia/hypoglycemia and maintain nutritional status and body weight. Interventions included administer medications as ordered, observe for high and low blood sugar symptoms, diet as ordered and monthly weights. Review of the physician orders for Resident #1 revealed orders dated 3/6/20 for 6 units of Novolog Insulin (a fast acting insulin) subcutaneously (SQ - injection into the fat layer between the skin and muscle) before each meal, along with a sliding scale of additional Novolog insulin based on his blood sugar. Additionally, administer 26 units of Insulin Glargine Solution SQ once a day which was scheduled for 9:00 AM daily. The manufacture instructions for Novlog were reviewed which stated a person should eat a meal within 5 to 10 minutes after taking Novolog. Review of Resident # 1's Medication Administration record (MAR) revealed he was scheduled to get Novolog Insulin 6 units at 6:30 AM. Further review of the MAR revealed on 8/30/20 Nurse #2 administered 6 units Novolog insulin at 6:11 AM. There was no documentation of what Resident #1's blood sugar was when the Novolog was administered. A review of nursing progress notes revealed a note dated 8/30/20 at 8:10 AM that read that Nurse #1 was summoned to Resident #1's room and found him with a fasting blood sugar (FSBS) of 34, unresponsive and with seizure activity. Further review of the nursing note revealed Nurse	F 760	Diabetes Mellitus (includes- assessing signs and symptoms of hypoglycemia and responding to hypoglycemic episodes Per Facility Policy) " Returning Emergency Medication Kits to Pharmacy. The facility□s practice is to notify the pharmacy when a minimum of two Glucagon are not present. Once notified, the pharmacy replaces the facility emergency kit. The Director of Nursing or designee will audit the facility emergency kit to help ensure that Glucagon is always available. If Glucagon is unavailable, Director of Nursing or designee will notify pharmacy and receive a new E-kit. This audit will be conducted 5 times weekly for 4 weeks. Thereafter, audits will be conducted 3 times weekly for 4 weeks, and then weekly for 4 weeks or until corrective action is achieved. Results will be reviewed by the Director of Nursing Services weekly and shared with facility Quality Assurance Committee monthly. The Director of Nursing or designee will audit fast acting insulin medication orders. This will help ensure orders are identified, implemented and have the appropriate administration time and that blood sugar levels will be checked. The audit will also include checking the MAR□s of residents receiving fast acting insulin. This will ensure that blood glucose levels are documented. This audit will be conducted 5 times weekly for 4 weeks. Thereafter, audits will be conducted 3 times weekly for 4 weeks, and then weekly for 4 weeks	

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F 760	Continued From page 3 #1 gave Resident #1 a small pack of granulated sugar and Gluco-jell. Interviews were conducted with Resident #1 on 9/16/20 at 12:10 PM, 12:58 PM and 2:25 PM. During these interviews, Resident #1 stated that a few Sundays ago his blood sugar dropped very low and he had to go to the hospital by ambulance. Resident #1 further stated that on the day he had to go to the hospital that a nurse gave him his morning insulin around 5:30AM to 6:00AM. He stated that he did not get anything to eat or drink with or after the insulin, went back to sleep and then the next thing he remembered was the nurses calling the Ambulance because his blood sugar was low. In an interview on 9/16/20 at 3:05 PM with Nurse Aide (NA #1) she stated when she entered Resident #1's room a little after 8:00AM on 8/30/20 to give out breakfast trays she witnessed Resident #1 having a seizure and was unresponsive. She stated Resident #1's blood sugar was checked and was 34. She stated Nurse #1 put packs of sugar into the Resident #1's mouth with no response. NA#1 further stated Emergency Medical Services (EMS) was called and the resident was transported to the hospital. The EMS records were not available for review. Review of hospital records dated 8/30/20 revealed an emergency department admission note which stated, Resident #1's indication for admission was Hypoglycemia. The hospital record revealed Resident #1 presented to the Emergency room from his facility due to an unresponsive episode and a blood sugar of 35. The hospital records further revealed Resident #1	F 760	or until corrective action is achieved. Results will be reviewed by the Director of Nursing Services weekly and shared with facility Quality Assurance Committee monthly. Completion Date for this Plan of Correction will be October 30, 2020.	

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F 760	Continued From page 4	F 760		

"received glucose with improvement". His admitting diagnosis was Hypoglycemia (which stated resolved) and Urinary Tract Infection. Resident #1 was discharged back to the facility on 9/3/20.

Five unsuccessful attempts were made to contact the Emergency Medical Service agency. All calls were unreturned.

Interviews were conducted with Resident #1's physician on 9/16/2020 at 4:35 PM and 10/1/2020 at 12:25 PM. During these interviews the physician he stated he recalled the incident when Resident #1 had to go to the hospital due to a low blood sugar. The physician stated that Resident #1 should not have received insulin at 6:11AM on 8/30/20 without a meal. He stated a resident receiving a medication before meals such a Novolog should be eating a meal about 15 minutes after the medication was given. The physician further stated that administering sugar packets to an unresponsive residents was not appropriate and put the resident at high risk for aspiration.

Interviews were conducted with Nurse #2 (who was listed on the MAR as the nurse who administered the insulin the morning of 8/30/20) on 9/16/20 at 6:00 PM and 9/18/20 at 11:37 AM. Nurse #2 stated she had no recollection of giving Resident #1 any insulin the morning of 8/30/20 and she denied the initials on the MAR were hers. She further stated that she would check a residents blood sugar prior to administering any type of insulin.

A review of the facility Signature List identified the initials on the MAR belonged to Nurse #2. A

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F 760	Continued From page 5	F 760		

review of the facility schedule revealed Nurse #2 was the only nurse working in Resident #1's area on 8/30/20 at the time the insulin was administered.

Interviews were conducted with Nurse #1 on 9/17/20 at 11:30 AM and 9/29/20 at 2:46 PM. During these interviews, he stated he was called to Resident #1's room just after 8:00 AM on 8/30/20 and observed that Resident #1 was unresponsive. He stated Resident #1's blood sugar was in the 30's. Nurse #1 stated he observed Resident #1 seizure activity as shaking with stiffness and rigidity. He further stated he gave Resident #1 a pack of sugar inside of his cheek while another nurse called EMS.

An interview was conducted with the Director of Nursing (DON) and the facility Administrator on 9/16/20 at 2:30 PM. During this interview, they were asked about Resident #1 being administered Novolog insulin with no meal on 8/30/20. The DON stated she was not aware that Resident #1 had nothing to eat at the time the insulin was administered. The DON also stated that the initials on the MAR for administering Resident #1 the insulin at 6:11AM on 8/30 were Nurse #2's initials. During this interview, the DON stated the facility had not put any plans of correction in place to address the insulin administered to Resident #1 without a meal.

In an interview on 9/18/2020 at 2:35 PM with the Administrator, he stated the insulin was given to Resident #1 on 8/30/20 at 6:11AM because that was the scheduled time. He further stated they are reviewing medication administration times for insulin and that they are in the process of making changes to insulin administration times.

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F 760	Continued From page 6	F 760		

The Director of Nursing was notified of Immediate Jeopardy on 09/29/20 at 1:55 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

Credible Allegation of Removal of Immediate Jeopardy

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

Resident #1 was admitted to the facility on 1/22/18 with a diagnosis to include Type 2 Diabetes Mellitus (DM). On 8/30/20, Resident # 1 was scheduled to get Novolog Insulin, 6 units, at 6:30 AM. On 8/30/20 Nurse #1 administered 6 units of Novolog Insulin at 6:11 AM. There was no documentation of what Resident #1's blood glucose was when the Novolog was administered. The resident's order did not include entering a blood glucose level. Resident # 1 also had an order for Novolog insulin sliding scale, which required a blood glucose level to be entered. Nurse #1 documented "See nurse note" in the residents chart but forgot to enter the nurse's note. Resident #1 was found a little after 8am with a fasting blood glucose of 34, unresponsive, and with seizure activity by Nurse #2. Nurse #2 gave Resident #1 small packs of granulated sugar and Gluca-gel. Nurse #2 stated he could not locate the Glucagon. Emergency Medical Services were called, and Resident #1 was transported to the hospital.

The hospital record revealed Resident #1 presented to the Emergency room from his facility

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F 760	Continued From page 7	F 760		

due to an unresponsive episode and a blood glucose of 35. Hospital records further revealed Resident #1 received glucose with improvement. His admitting diagnosis was Hypoglycemia. Resident #1 was discharged back to the facility on 9/3/20.

" Nurse #1 was educated by the Director of Nursing on administering fast acting insulin with food and checking and documenting blood glucose levels on 9.22.20. Nurse #2 was educated by the Director of Nursing on 9.30.20 on the following procedures:
o Insulin Administration (includes checking and documenting resident blood glucose levels).
o Nursing Care of Residents with Diabetes Mellitus (includes- assessing signs and symptoms of hypoglycemia and responding to hypoglycemic episodes).
o Returning Emergency Medication Kits to Pharmacy. The facility's practice is to notify the pharmacy when a minimum of two Glucagon are not present. Once notified, the pharmacy replaces the facility emergency kit.

Resident #1's Novolog order times were changed to 08:00, 12:00 and 5:30 to ensure medication is administered with meals (9.30.20). Resident #1's Novolog orders were also updated to include checking and documenting blood glucose levels. The Dietary Department was made aware of the incident. Residents with orders to receive fast acting insulin with meals will receive their meal trays from the first dietary cart delivered to the unit.

" A full house audit of all residents receiving fast acting insulin was conducted by the Director of Nursing (9.30.20). Orders for all residents

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receiving fast acting insulin have been reviewed and updated (9.30.20). Orders have been changed to ensure residents receiving fast acting insulin do so with their meals. All resident's with fast acting insulin orders have also been updated to include checking and documenting blood glucose levels. The facility emergency kit was exchanged on 9.18.20 by the pharmacy. Audits will be conducted by the Director of Nursing or Designee Five times weekly to help ensure a minimum of two Glucagon remain available in the emergency kit. If two Glucagon are not present, the Director of Nursing or Designee will contact the pharmacy to replace the emergency kit. In order to help ensure significant insulin medication orders are identified and implemented, a report of the previous day's insulin medication orders are reviewed daily during the facility Clinical Nurse Meeting. Meeting attendees include Nursing, Therapy Services, Dietary, Social Services and Activities. The Director of Nursing or Designee will educate all licensed nursing staff on the new scheduled times for fast acting insulin orders by 10.1.20.

The Director of Nursing or Designee will also educate all Licensed Nursing Licensed staff on the following Policies by 10.1.20:

o Insulin Administration (includes checking and documenting resident blood glucose levels).

o Nursing Care for Residents with Diabetes Mellitus (includes- assessing signs and symptoms of hypoglycemia and responding to hypoglycemic episodes - Per Facility Policy)

o Returning Emergency Medication Kits to Pharmacy. The facility's practice is to notify the pharmacy when a minimum of two Glucagon are not present. Once notified, the pharmacy replaces the facility emergency kit.

Licensed staff who have not been educated by

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the completion date shall be educated prior to the start of their next shift by the Director of Nursing or Designee. The facility Consulting Pharmacist, Attending Physician, and Medical Director have been notified of this adverse event and the plan for credible allegation (10.1.20).

Alleging Removal of Immediate Jeopardy effective 10.1.2020.

On 10/6/2020 the facility's credible allegation for Immediate Jeopardy removal was validated by the following: Review of in-service training records of Nurse #1, Nurse #2 and others licensed nurses working. The topics of training received were titled, "Insulin Administration, Nursing Care for Residents with Diabetes and Returning Emergency Kits to Pharmacy". Record Reviews for Resident #1 and other resident on fast acting insulin were reviewed for revised orders and times to administer insulin with meals. Interviews with facility staff revealed they received training and were able to describe the training received. Interviews with residents on insulin revealed insulin was administered with food and at revised times per physician orders. Observations revealed residents with insulin orders received their meals from the first cart from the kitchen during the noon meal on day of survey. The facility's date of Immediate Jeopardy removal of 10/1/2020 was validated.