STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING ______ B. WING ______	C 11/22/2023

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ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 11/16/2023 through 11/17/2023 with additional information obtained remotely through 11/21/2023. Onsite validation of immediate jeopardy removal was conducted on 11/22/2023. Therefore, the exit date was 11/22/2023. Event ID # WZ9N11. The following intake was investigated: NC00209817. Two of the two allegations resulted in deficiency. Intake NC00209817 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J CFR 483.25 at tag F684 at a scope and severity of J CFR 483.35 at tag F726 at a scope and severity of J The tag F684 constituted Substandard Quality of Care. Immediate jeopardy began on 11/12/2023 and was removed on 11/20/2023. A partial extended survey was conducted.	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, consistent with his or her authority, the resident representative(s) when there is-	F 580		11/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/07/2023

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 580	Continued From page 1 (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 §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

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F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Medical Director interview the facility failed to notify the physician of administering long-acting insulin to Resident # 1 who had not consumed dinner and had a blood glucose level of 89 mg/dL (milligrams per deciliter). The facility failed to notify the physician after significant changes in condition for Resident #1 which included: obtaining a blood glucose level of 29 mg/dL (a normal blood glucose level range is 70 to 99 mg/dL) requiring the administration of glucagon (a manmade version of a hormone made by the pancreas that raises blood glucose levels); and obtaining a blood glucose level of 27 mg/dL, and the inability to administer glucagon to the Resident during a medical emergency. Resident #1 was one of one resident reviewed for notification of the physician. Emergency Medical Services (EMS) was contacted to take Resident #1 to the emergency room on 11/12/2023 for hypoglycemia (low blood glucose). EMS treated Resident #1 with 1 mg glucagon intermuscular. Upon arrival at the hospital, a repeat glucose level of 24 mg/dL was taken, and 50 % Dextrose was intravenously administered along with a renal diet consumed orally. Immediate Jeopardy began on 11/12/2023 when the facility obtained Resident #1's blood glucose level of 29 mg/dL and administered glucagon without notifying the physician of the significant change. Immediate jeopardy was removed on 11/20/2023 when the facility provided and	F 580	1. The facility failed to notify the physician of administering long-acting insulin to Resident #1 who had not consumed dinner with a blood glucose level of 89 mg/dl; failed to notify the physician after a significant change in condition for Resident #1 which included: a blood glucose level of 29 mg/dl requiring the administration of glucagon; then obtaining a blood glucose level of 27 mg/dl and the inability to administer glucagon to Resident #1 during a medical emergency for 1 of 1 resident reviewed for notification to a physician. 2. All residents have the potential to be affected by this practice. On 11/19/23 the Director of Nursing and the Unit Managers reviewed residents who had a change of condition during the last 30 days using the 24-hour report. The 24-hour report was reviewed for indicators of a change such as not at baseline, not normal for resident, low blood sugars, lethargic, shortness of breath, new onset pain, etc. No new concerns found. 3. The measures that have been put in place to ensure the deficient practice does not recur are as follows: • On 11/19/23 the Regional Nurse Consultant educated the DON on notifying the physician/NP or on-call when a	

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Continued From page 3

implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D to ensure education is completed and monitoring systems put in place are effective.

Findings included:

Resident #1 was admitted to the facility on 11/8/2023 with cumulative diagnoses some which included Type 2 Diabetes Mellitus, and end stage renal disease.

Resident #1 had a physician's order initiated on 11/8/2023 for Accu-checks twice a day at 6:00 AM and 9:00 PM to measure blood glucose levels.

Resident #1 also had a physician's order initiated on 11/8/2023 for Levemir U-100 (insulin) to be administered subcutaneously in the amount of 20 units at 9:00 PM daily. Levemir is a long-acting insulin that starts to work several hours after injection and keeps working evenly for up to 24 hours.

Documentation on a food consumption record revealed on 11/11/2023 Resident #1 did not consume any dinner.

Documentation on the Medication Administration record (MAR) written by Nurse #6 revealed Resident #1 had a blood glucose level of 89 mg/dL on 11/11/2023 at 9:00 PM.

Documentation on the MAR revealed Resident #1 was administered 20 units of insulin subcutaneously in the abdomen at 9:00 PM on 11/11/2023 by Nurse #6.

F 580

resident has been administered glucagon, has a low blood glucose reading, or has a significant change in condition. Beginning 11/19/23 The Director of Nursing, Assistant Director of Nursing and Nursing Leadership educated Licensed Nurses regarding the requirements for notification of the Physician following a change of condition and to seek clarification for insulin administrator when a resident isn't eating. The Director of Nursing, Assistant Director of Nursing and Nursing Leadership educated Nursing Assistants on identifying a change in resident condition and reporting to the Licensed Nurse immediately.

- Beginning 11/19/23 The Director of Nursing, Assistant Director of Nursing and Nursing Leadership provided education to the nurses regarding the Medical Director's parameters for all residents on long-acting insulin to hold for a blood sugar of less than 130. The nurse will transcribe the parameter orders to the medication administration record. Including in the education was notification of the physician for blood glucose levels that are outside the parameters. Guidelines include immediate notification of the physician regarding treatment of hypoglycemia that requires glucagon administration.
- The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. It will be the responsibility of the Director of Nursing to ensure this is completed.

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F 580	Continued From page 4 Nurse #6 was interviewed on 11/17/2023 at 1:41 PM and relayed the following information. Nurse #6 worked in the facility on 11/11/2023 from 3:00 PM to 11:00 PM. Resident #1 was a new resident in the facility and Nurse #6 brought him the evening meal tray. Nurse #6 stated she set up the meal tray for Resident #1 and then left him to eat in his room after he expressed, he did not require assistance to eat. When Nurse #6 went back to pick up the tray she noted Resident #1 did not eat more than "a few bites." Nurse #6 turned over the room assignment for Resident #1 to Nurse #3 at some point in the evening and conveyed to Nurse #3, Resident #1 had not eaten the evening meal. Nurse #6 had considered not giving the 9:00 PM dose of Levemir to Resident #1. Nurse #6 explained she decided she felt comfortable giving the long-acting insulin and she did not have an order to hold the insulin for a blood glucose level below a certain level. Documentation in the nursing notes for 11/12/2023 at 3:51 AM written by Nurse #3 revealed, "Resident [#1] screaming out loud and thrashing around in the bed pushing back at staff trying to give him help. Resident [#1] was also sweating profusely. This nurse was able to check resident's blood [glucose] and the result was 29 [mg/dL]. Using standing orders for glucagon emergency kit for low blood [glucose] one single dose 1 [milliliter subcutaneously] was given. Will recheck blood [glucose] in 15 minutes. A note was left in the provider's communication book." Documentation in the nursing notes for 11/12/2023 at 4:26 AM written by Nurse #3 revealed, "Blood [glucose] at this time is 102 [mg/dL] resident is calm and is not in distress, call	F 580	4. The DON or designee will audit five (5) residents twice weekly for 4 weeks, then weekly for 8 weeks to ensure physician and NP are notified of any significant change in condition for a resident. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion date: 11/30/2023	

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bell within reach."

Nurse #3 was interviewed on 11/16/2023 at 7:15 PM. Nurse #3 relayed the following information. Nurse #3 was called to the room of Resident #1 by Nurse Aide (NA) #1 who was attempting to provide care to Resident #1. Resident #1 was thrashing around in the bed and would not allow NA #1 to provide care. It occurred to Nurse #3 that Resident #1 was a diabetic and Resident #1 allowed her to check his blood glucose level. The blood glucose level was 29 (mg/dL). Nurse #3 obtained glucagon from the automated medication dispensing system and administered it to the resident. Twenty to thirty minutes later Nurse #3 checked the blood glucose level of Resident #1, and it was 102 (mg/dL). Nurse #3 stated, "I was happy with that, and he was good." Nurse #3 did not think the physician needed to be called or notified immediately unless she was sending Resident #1 to the hospital.

Documentation in the nursing notes for Resident #1 on 11/12/2023 at 7:49 AM written by Nurse #2 revealed, "[Blood glucose] has dropped to 27 [mg/dL] [at] 7 AM unable to get [blood glucose] up tried to give apple sauce and was unable to swallow. No other attempts due to not swallowing. Called 911 to send to [emergency room]. Just left the [building] with [the] patient. [Responsible party] was made aware."

Nurse #2 was interviewed on 11/16/2023 at 6:45 PM. Nurse #2 confirmed the 11/12/23 blood glucose of 27 (mg/dL) was an emergency and Resident #1 needed to be sent immediately to the hospital via emergency medical services (EMS). Nurse #2 stated she did not call or notify the physician Resident #1 was sent to the hospital,

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F 580	Continued From page 6 but she thought Nurse #4, who was assisting her in sending Resident #1 to the hospital, had sent the physician a text message. Nurse #4 was interviewed on 11/16/2023 at 7:41 PM. Nurse #4 stated she had never personally contacted the physician and did not send a text message to the physician on the morning of 11/12/2023 regarding Resident #1 going to the hospital. Nurse #4 explained that during the weekdays the facility had a nurse practitioner with whom she communicated information, or she would tell the supervisor of any concerns with the residents so the supervisor would contact the physician. Documentation on an EMS incident report dated 11/12/2023 for a call received at 7:26 AM revealed Resident #1 had a blood glucose reading of 27 mg/dL. The report also indicated the EMS staff administered 1 mg of glucagon in his left shoulder muscle and was placed on oxygen via a nasal cannula while in route to the hospital. Documentation on a hospital emergency discharge summary dated 11/12/2023 revealed the following information. A repeat blood glucose level, taken upon arrival of Resident #1 to the hospital, was 24 mg/dL. Resident #1 was administered 50% dextrose intravenously as well as a renal diet in the emergency room. Resident #1 became hypothermic with a temperature of 94.4 degrees Fahrenheit secondary to prolonged hypoglycemia, for which he received a warming blanket to return his temperature to 98.4 degrees Fahrenheit. Resident #1 was discharged back to the facility on 11/12/2023 at 12:39 PM.	F 580		

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F 580	Continued From page 7 The Director of Nursing (DON) was interviewed on 11/17/2023 at 12:45 PM. The DON stated that the physician should always be called if there was ever any doubt in a physician's order. The DON further explained that every diabetic had a different reaction or level of tolerance for insulin and hypoglycemia/hyperglycemia. The DON did not feel like the Physician needed to be contacted immediately after Nurse #3 administered glucagon to Resident #1 because Resident #1 normalized with a blood glucose of 102 mg/dL and breakfast was going to be served soon. The DON stated the facility did not have any policies and procedures for the treatment of hypoglycemia other than the standing orders. The DON confirmed the Physician should always be notified after a resident was sent to the hospital in an emergency. Documentation in the Facility Standing Orders, dated as last revised on 5/1/2023, revealed in part for treatment of hypoglycemia, "If a resident is unresponsive with blood [glucose] below 60 [mg/dL], give glucagon 1 mg [intramuscularly] [immediately] and notify [Medical Doctor] after administering glucagon." The Medical Director was interviewed on 11/17/2023 at 12:57 PM. The Medical Director stated he would have expected Nurse #6 to seek clarification of the physician's order for the long-acting insulin Levemir with the knowledge Resident #1 did not eat the evening meal and had a blood glucose level of 89 mg/dL. The Medical Director stated it was his expectation that the long-acting insulin should be held if the blood glucose level of the resident was less than 130 mg/dL. The Medical Director further stated he should have been called by Nurse #6 and he	F 580		

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F 580	Continued From page 8	F 580		

would have ordered Nurse #6 not to give the long-acting insulin Levemir to Resident #1 at 9:00 PM on 11/11/2023. The Medical Director confirmed he was not contacted after Nurse #3 administered glucagon to Resident #1 for a blood glucose level of 29 mg/dL nor was he notified after Resident #1 was sent to the hospital for a blood glucose level of 27 mg/dL. The Medical Director stated he did not find out about the events of the morning of 11/12/2023 for Resident #1 until he arrived at the facility on 11/13/2023 to do an admission assessment for Resident #1. The Medical Director revealed on 11/13/2023 he ordered for the 9:00 PM dose of Levemir for Resident #1 to be held if his blood glucose level was less than 130 mg/dL and his blood glucose levels to be checked three times a day. The Medical Director also revealed the facility nursing staff always had access to telehealth physicians for notification or clarification purposes.

The facility Administrator was informed of Immediate Jeopardy on 11/19/2023 at 10:55 AM.

The facility provided the following credible allegation of immediate jeopardy removal:

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

On 11/12/23, the facility failed to notify the Physician of a change in condition when Resident #1 had a blood glucose level of 29 and glucagon was administered at 3:53 AM and failed to notify the physician of a change in Resident #1's condition when a blood glucose level of 27 was obtained at 7:00 AM and the inability to administer glucagon requiring Resident #1 to be

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F 580	Continued From page 9 sent to the emergency room. On 11/19/23 the Director of Nursing and the Unit Managers reviewed residents who have had a change of condition during the last 30 days using the 24-hour report. The 24-hour report was reviewed for indicators of a change such as not at baseline, not normal for resident, low blood sugars, lethargic, shortness of breath, new onset pain, etc. No new concerns found. o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Beginning 11/19/23 The Director of Nursing, Assistant Director of Nursing and Nursing Leadership educated Licensed Nurses regarding the requirements for notification of the Physician following a change of condition and to seek clarification for insulin administrator when a resident isn't eating. The Director of Nursing, Assistant Director of Nursing and Nursing Leadership educated Nursing Assistants on identifying a change in resident condition and reporting to the Licensed Nurse immediately. Verbal education was given when a change of condition is noted or when a resident presents different than known baseline, lethargic, restless or short of breath, low blood sugars, and administering insulin when a resident doesn't eat to call the physician, even if during the night when there is a serious or life-threatening change of condition. Education was provided to the nurses regarding the medical director's parameters for all residents on long-acting insulin to hold for a blood sugar of	F 580		

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less than 130. The nurse will transcribe the parameter orders to the medication administration record. Including in the education was notification of the physician for blood glucose levels that are outside the parameters.

Guideline for treating hypoglycemia for residents that are alert, able to swallow and eat and residents that are unresponsive and/or not able to drink or eat. Guidelines include immediate notification of the physician regarding treatment of hypoglycemia that requires glucagon administration.

The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. It will be the responsibility of the Director of Nursing to ensure this is completed.

The Administrator and Director of Nursing are responsible for the implementation and completion of the removal plan.

Alleged Immediate Jeopardy removal date: 11/20/23.

The credible allegation for immediate jeopardy removal was validated onsite on 11/22/23. Staff interviews and record review verified licensed nurses were educated on the facility policy regarding the requirements for notification of the Physician following a change of condition and to seek clarification for insulin administration when a resident wasn't eating. It included educating Nursing Assistants on identifying a change in resident condition and reporting to the Licensed

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F 580	Continued From page 11 Nurse immediately. Education was given when a change of condition is noted or when a resident presents different than known baseline, lethargic, restless, or short of breath, low blood sugars, and administering insulin when a resident doesn't eat to call the physician, even if during the night when there is a serious or life-threatening change of condition. Education was provided to the nurses regarding the Medical Director's parameters for all residents on long-acting insulin to hold for a blood sugar of less than 130 mg/dL. The immediate jeopardy removal date of 11/20/23 was validated.	F 580		
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, staff interviews, Pharmacy Nurse Consultant interview, Pharmacist interview, and Medical Director interview, the facility gave long-acting insulin to Resident #1 who had a blood sugar reading of 89 milligrams/deciliter (mg/dL) and had not eaten the dinner meal; failed to monitor the resident for any signs and symptoms of hypoglycemia (low blood glucose) after insulin administration; failed to monitor and complete ongoing thorough assessments by rechecking a blood glucose level	F 684	1. The facility gave a long-acting insulin to Resident #1 who had a blood sugar reading of 89 milligrams/deciliter (mg/dL) and had not eaten the dinner meal. The facility failed to monitor the resident for any signs and symptoms of hypoglycemia (low blood sugar) after giving the long-acting insulin. The facility failed to monitor and complete ongoing through assessments by re-checking a blood glucose level as ordered after a	11/30/23

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as ordered after a hypoglycemic event requiring the intervention of glucagon (used to treat very low blood glucose); and failed to effectively respond to a medical emergency of hypoglycemia for one (Resident #1) of three residents reviewed for diabetes care. Emergency Medical Services (EMS) was contacted to take Resident #1 to the emergency room on 11/12/2023 for hypoglycemia. EMS treated Resident #1 with 1 milligram glucagon intramuscularly. Upon arrival at the hospital, a repeat glucose level resulted in a blood glucose of 24 (mg/dL), and 50 % Dextrose was intravenously administered along with a renal diet consumed orally. (A normal blood glucose level range is 70 to 99 mg/dL.)

Immediate Jeopardy began on 11/12/2023 when the facility failed to identify the seriousness of the symptoms of hypoglycemia and the need for ongoing assessments after obtaining Resident #1's blood glucose level of 29 mg/dL and failed to immediately initiate emergency medical services for a medical emergency. Immediate jeopardy was removed on 11/20/2023 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 level D to ensure education is completed and monitoring systems put in place are effective.

Findings included:

Resident #1 was admitted to the facility on 11/8/2023 with cumulative diagnoses some which included Type 2 Diabetes Mellitus, and end stage renal disease. Resident #1 received dialysis services while he was a resident at the facility.

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hypoglycemic event requiring the intervention of glucagon and failed to effectively respond to a medical emergency of hypoglycemia for resident #1.

2. All residents that receive insulin have the potential to be affected by this practice. On 11/19/2023 the Director of Nursing and the Unit Managers reviewed all residents who receive long-acting insulin, and their records were reviewed for any treatment of low glucose levels that were unreported, documented incorrectly, and not monitored. No other residents were identified.

3. The measures that have been put in place to ensure the deficient practice does not recur are as follows:

- The Director of Nursing, Assistant Director of Nursing and Regional Nurse began education on 11/19/2023, for Licensed nurses on the following with a posttest required to ensure understanding of new education.
- Education was provided to the nurses regarding the medical director's parameters for all residents on long-acting insulin to hold for a blood sugar of less than 130. The nurse will transcribe the parameter orders to the medication administration record. Including in the education was notification of the physician for blood glucose levels that are outside the parameters.

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Documentation on the admission nursing assessment dated 11/8/2023 indicated Resident #1 was alert, verbal, and able to take his medication whole and by mouth.

Resident #1 had a physician's order initiated on 11/8/2023 for Levemir U-100 (insulin) to be administered subcutaneously in the amount of 20 units at 9:00 PM daily. Levemir is a long-acting insulin that starts to work several hours after injection and keeps working evenly for up to 24 hours.

Resident #1 had a physician's order initiated on 11/8/2023 for Accu-checks twice a day at 6:00 AM and 9:00 PM to measure blood glucose levels.

There was no order for an evening snack for Resident #1 from 11/8/2023 to 11/12/2023.

Documentation in the Facility Standing Orders, dated as last revised on 5/1/2023, revealed in part for treatment of hypoglycemia, "If a resident is unresponsive with blood [glucose] below 60 (mg/dL), give glucagon 1 mg [intramuscularly] [immediately] and notify [Medical Doctor] after administering glucagon."

Documentation on a food consumption record revealed on 11/11/2023 Resident #1 consumed 76-100% of his breakfast, 26-50% of his lunch, and did not consume any dinner.

Documentation on the Medication Administration record (MAR) revealed Resident #1 had a blood glucose level of 89 milligrams/deciliter (mg/dL) on 11/11/2023 at 9:00 PM.

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- Education on Preventing hypoglycemia and recognizing mild, moderate, and severe symptoms.

- Following physician orders for monitoring blood glucose levels as ordered and notification of the physician when outside parameters.

- Education provided related to residents on dialysis and is at increased risk.

Anyone not receiving education will not be allowed to work until education has been completed. Education will be added to the new hire orientation for Licensed Nurses conducted by the DON or ADON by 11/19/2023. The DON will keep a list of all staff trained to ensure no staff work until training is completed.

4. The Director of Nursing (DON) or designee will audit all residents who receive insulin daily x 12 weeks to ensure that the nursing staff have followed the parameters of the insulin order as well as notifying MD/NP of blood sugar changes outside of the parameters. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing the information collected in the audits and reporting to Quality Assurance Performance Improvement Committee (QAPI) by the DON for three (3) months. At the time the QAPI committee will evaluate the effectiveness of the interventions to

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F 684	Continued From page 14 Documentation on the MAR revealed Resident #1 was administered 20 units of insulin subcutaneously in the abdomen at 9:00 PM on 11/11/2023 by Nurse #6. Nurse #6 was interviewed on 11/17/2023 at 1:41 PM and relayed the following information. Nurse #6 worked in the facility on 11/11/2023 from 3:00 PM to 11:00 PM. Resident #1 was a new resident in the facility and Nurse #6 brought him the evening meal tray at approximately 5:30 PM. Nurse #6 stated she set up the meal tray for Resident #1 and then left him to eat in his room after he expressed, he did not require assistance to eat. When Nurse #6 went back to pick up the tray she noted Resident #1 did not eat more than "a few bites." Nurse #6 turned over the room assignment for Resident #1 to Nurse #3 at some point in the evening and conveyed to Nurse #3, Resident #1 had not eaten the evening meal. Nurse #6 had considered not giving the 9:00 PM dose of Levemir to Resident #1 but, Nurse #6 explained she felt comfortable giving the long-acting insulin as she did not have an order to hold the insulin for a blood glucose level below a certain level. Documentation in the nursing notes written by Nurse #3 dated 11/12/2023 at 2:23 PM stated, "Resident (#1) was combative with staff when attempting to give care. Resident was making a fist and shaking it at this nurse. This nurse asked if he wanted to beat me up and he stated "no." This nurse asked resident if he wanted me to call his son or daughter and he calmed down and let staff give him care. Resident is calm and resting in bed with no signs of distress, call bell left within reach."	F 684	determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 11/30/2023	

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F 684	Continued From page 15 NA #1 was interviewed on 11/16/2023 at 7:28 PM and provided the following information. NA #1 was assigned to care for Resident #1 from 7:00 PM on 11/11/2023 to 7:00 AM on 7/12/2023. NA #1 did not recall if Resident #1 had an evening snack on 11/11/2023. NA #1 went to check on Resident #1 at approximately 3:30 AM on 11/12/2023 and found he had "scooted down to the end of the bed." NA #1 needed help to pull Resident #1 up in the bed because he was "thrashing around in the bed." Resident #1 kept moving around and would not allow NA #1 to provide incontinent care. Nurse #3 came in the room to assist NA #1 to provide incontinent care because it took two people to provide incontinent care due to him moving around. Nurse #3 then told NA #1 she was going to check the blood glucose level of Resident #1. NA #1 stayed in the room while Nurse #3 obtained the blood glucose level and remained in the room while Nurse #3 went to get glucagon because Nurse #3 did not think Resident #1 should be left alone. When Nurse #3 returned to the room of Resident #1, NA #1 left the room and returned to caring for her other assigned residents. NA #1 checked on Resident #1 again at the end of her shift and recalled Resident #1 did not want to be bothered, pulling the sheet up telling her "No." Documentation in the nursing notes for 11/12/2023 at 3:51 AM written by Nurse #3 revealed, "Resident [#1] screaming out loud and thrashing around in the bed pushing back at staff trying to give him help. Resident [#1] was also sweating profusely. This nurse was able to check resident's blood [glucose] and the result was 29 [mg/dL]. Using standing orders for glucagon emergency kit for low blood [glucose] one single dose 1 [milliliter subcutaneously] was given. Will	F 684		

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recheck blood [glucose] in 15 minutes. A note was left in the provider's communication book."

Documentation in the nursing notes for 11/12/2023 at 4:26 AM written by Nurse #3 revealed, "Blood [glucose] at this time is 102 [mg/dL] resident is calm and is not in distress, call bell within reach."

Nurse #3 was interviewed on 11/16/2023 at 7:15 PM. Nurse #3 relayed the following information. Nurse #3 worked the nursing shift of 7:00 PM on 11/11/2023 to 7:00 AM on 11/12/2023. Nurse #3 revealed when she was first called to the room of Resident #1 at approximately 2:20 AM, he would not calm down. Nurse #3 was again called to the room of Resident #1 around 4:00 AM, by Nurse Aide (NA) #1 who was attempting to provide care to Resident #1. Resident #1 was thrashing around in the bed and would not allow NA #1 to provide care. It occurred to Nurse #3 that Resident #1 was a diabetic and Resident #1 allowed her to check his blood glucose level. The blood glucose level was 29 mg/dL. Nurse #3 obtained glucagon from the automated medication dispensing cabinet and administered it to Resident #1. Twenty to thirty minutes later Nurse #3 checked the blood glucose level of Resident #1, and it was 102 mg/dL. Nurse #3 stated, "I was happy with that, and he was good." Nurse #3 revealed she offered Resident #1 the oatmeal cookie that was on his bedside table, but he declined before returning to sleep. Nurse #3 did note Resident #1 was sleeping comfortably and did not have any more "behaviors" before she left at 7:00 AM. Nurse #3 reiterated that Resident #1 was asleep when she looked into his room, and she did not disturb him prior to the end of her nursing shift. Nurse #3 did not think the

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physician needed to be called or notified immediately unless she was sending Resident #1 to the hospital.

Documentation on the MAR by Nurse #3 revealed Resident #1 had a blood glucose level of 102 mg/dL on 11/12/2023 at 6:00 AM.

Nurse #3 was interviewed again on 11/17/2023 at 4:45 PM. Nurse #3 revealed she did not check the blood glucose level of Resident #1 at 6:00 AM on 11/12/2023 as ordered, but used the blood glucose level she obtained at approximately 4:20 AM for her documentation on the MAR.

Documentation in the nursing notes for Resident #1 on 11/12/2023 at 7:49 AM written by Nurse #2 revealed, "[Blood glucose] has dropped to 27 [mg/dL at] 7 AM unable to get [blood glucose] up tried to give apple sauce and was unable to swallow. No other attempts due to not swallowing. Called 911 to send to [emergency room]. Just left the [building] with [the] patient. [Responsible party] was made aware."

NA #4 was interviewed on 11/17/2023 at 10:13 AM. NA #4 described the following information. NA #4 stated that she worked the 7:00 AM to 7:00 PM shift on 11/12/2023 and was assigned to care for Resident #1. NA #4 revealed she heard in report from NA #1 that Resident #1 was moaning in pain all night. NA #4 indicated she went directly to the room of Resident #1 at the start of her shift. NA #4 described Resident #1 as moaning, moving all over the bed, in a cold nasty sweat, teeth clenched tight, foaming at the mouth, and with eyes that were looking right through her. NA #4 stated she hollered for Nurse #2 to come immediately. NA #4 stated Nurse #2 and Nurse

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F 684	Continued From page 18 #4 came to the room immediately. The nurses took the blood glucose of Resident #1, and it was 27 (mg/dL). Nurse #2 announced that around 4:00 AM the blood glucose of Resident #1 had dropped, and he had been given glucagon. One of the nurses tried to give Resident #1 some applesauce but his mouth was clenched tight, and he was moving all over the place. One nurse left the room and the other nurse stayed in the room. Nurse #5 was in and out of the room. NA #2 and NA #5 came to the room of Resident #1 to help keep him in bed. NA #4 stated, "It seemed like nobody could get their hands on some glucagon." Finally, Nurse #4 announced Resident #1 was going to the emergency room. NA #4 revealed Nurse #2 checked his blood glucose again and it was 24 mg/dL. NA #4 explained she was just trying to keep Resident #1 from falling out of the bed and trying to keep him awake because he was fading in and out. The facility Pharmacist was interviewed on 11/17/2023 at 12:09 PM. The Pharmacist revealed that after glucagon was administered a repeat blood glucose level should be checked after 15 minutes and another dose of 1 mg glucagon could be administered if the blood glucose had not returned to normal. The Pharmacist confirmed 1 mg of glucagon should be administered if the blood glucose level was in the 20's and it was potentially life threatening if immediate action was not taken. The Pharmacist explained the supply of glucagon can change, and glucagon was available in various forms for administration. One form of glucagon was in a kit which contains a vial of glucagon along with a syringe for immediate administration. Another form of glucagon was a vial of sterile glucagon which needed to be reconstituted with a syringe	F 684		

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F 684	Continued From page 19 and a vial of sterile diluent. The Pharmacist confirmed all the glucagon kits came with instructions. The Pharmacist also revealed the automated medication dispensing systems also contained an oral glucose gel that could be put underneath the lip. Nurse #2 was interviewed on 11/16/2023 at 6:45 PM. Nurse #2 described the following events as happening on the morning of 11/12/2023 after she arrived at the start of her shift at 7:00 AM. Nurse #2 received report and was counting of the medications on the medication cart with Nurse #3. During the receiving of the report, Nurse #3 explained to Nurse #2 that she had to give Resident #1 glucagon for a hypoglycemic episode that occurred at approximately 4:00 AM but that his blood glucose returned to normal. Nurse #2 asked Nurse #3 if Resident #1 had eaten anything or had anything to drink after receiving the glucagon and she was told he had not. Nurse #2 revealed she thought to herself she would have to check his blood glucose. Nurse #2 stated as soon as Nurse #3 left the facility, a nurse aide called out that Resident #1 needed help. Nurse #2 and Nurse #4 went to the room of Resident #1. Nurse #2 saw that Resident #1 was sweaty, shaking violently and moving his limbs all over the bed. Nurse #2 checked his blood glucose and saw that it was 27 mg/dL. Nurse #2 attempted to give Resident #1 some applesauce, but his mouth was clenched shut. Nurse #2 stayed with Resident #1 while Nurse #4 went to get the glucagon from the medication room. Nurse #5 came to the room of Resident #1 and Nurse #2 asked her to stay while she went to the medication room. At this point Nurse #5 and three nurse aides were in the room with Resident #1. Nurse #2 then went to the medication room and	F 684		

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F 684	Continued From page 20 signed into the automated medication dispensing cabinet. The automated medication dispensing cabinet showed that there were two different options of glucagon kits or boxes, and Nurse #2 was selecting the second option. At that point, Nurse #4 entered the medication room and told Nurse #2 she was getting the wrong glucagon kit/box. Nurse #2 did not remove a glucagon kit/box and when she attempted to select another glucagon kit/box option, the machine told her the option she previously choose was no longer available. Nurse #2 and Nurse #4 ran to the other side of the building together to find the correct glucagon kit/box that would only require one step instead of several steps to prepare the glucagon. When Nurse #2 and Nurse #4 arrived at the automated medication dispensing cabinet on other side of the building in the medication room, Nurse #4 told Nurse #2 that the machine did not have the type of glucagon kit/box that was needed either. On the way back to the hallway on which Resident #1 resided, Nurse #4 called the Director of Nursing (DON) to tell her there was no glucagon in the building. The DON told Nurse #4 the resident needed to be sent to the emergency room. Nurse #4 called 911 while Nurse #2 returned to the room of Resident #1 to take vital signs. Nurse #4 was interviewed on 11/16/2023 at 7:41 PM. Nurse #4 related that the following events happened on the morning of 11/12/2023 when she was working the 7:00 AM to 7:00 PM shift. Nurse #4 stated she heard one of the nursing aides calling for help and for Nurse #2 to hurry up. Nurse #4 went to the room of Resident #1 to see if she could help. Nurse #4 described Resident #1 as "jerking hard" and diaphoretic. Nurse #2 grabbed a glucometer off the nursing	F 684		

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F 684	Continued From page 21 cart and when she took the blood glucose of Resident #1 it registered as "Lo." (The screen display on the glucometer will read "Lo" when a blood glucose test result is below 20 mg/dL.) Nurse #2 left the room and went to obtain glucagon from the medication room while Nurse #4 stayed in the room of Resident #1. It seemed to Nurse #4 that it was taking Nurse #2 a long time to get the glucagon, so she left the room to find Nurse #2. Before Nurse #4 went into the medication room, she asked Nurse #5 to go to the room of Resident #1 to check on him. When Nurse #4 arrived in the medication room the automated medication dispensing cabinet locked up on Nurse #2 and it was a screen she had never seen before. Nurse #4 and Nurse #2 then ran to the other side of the building to attempt to get glucagon from the other medication room and the other automated medication dispensing cabinet. Nurse #2 searched for the glucagon in the automated medication dispensing cabinet and it was telling her there was no glucagon in that cabinet either. Nurse #4 was adamant it was Nurse #2 who was searching in the electronic medication dispensing system for the glucagon because it was her resident. Nurse #4 stated she called her DON to tell her the facility did not have any glucagon and Resident #1 had to be sent out. Nurse #4 revealed she called 911 while Nurse #2 returned to Resident #1 to get vital signs to give to EMS. Nurse #4 explained she prepared the paperwork required by EMS and then left Nurse #2 to handle everything else while she returned to her assigned hall. Nurse #5 was interviewed on 11/17/2023 at 9:09 AM. Nurse #5 stated she was working on the 7:00 AM to 7:00 PM shift on 11/12/2023. Nurse #5 stated she heard NA #4 calling for help so she	F 684		

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went to the room of Resident #1. Nurse #5 stated when she entered the room Resident #1 was shaking uncontrollably and foaming at the mouth. Both Nurse #2 and Nurse #4 were in the room trying to give Resident #1 applesauce, but his mouth was closed shut. Nurse #5 stated that Nurse #2 and Nurse #4 both left the room together to get glucagon from the medication room. Nurse #5 stated when Nurse #2 and Nurse #4 returned they stated they were calling 911 because the facility did not have any glucagon. Nurse #5 revealed the paramedics arrived very quicky and Resident #1 never lost consciousness.

Documentation on an EMS incident report dated 11/12/2023 for a call received at 7:26 AM revealed Resident #1 was found being held down by staff with a blood glucose reading of 27 mg/dL. The report also indicated the EMS staff administered 1 mg of glucagon in his left shoulder muscle and was placed on oxygen via a nasal cannula while in route to the hospital.

Documentation on a hospital emergency discharge summary dated 11/12/2023 revealed the following information. A repeat blood glucose level, taken upon arrival of Resident #1 to the hospital, was 24 mg/dL. Resident #1 was administered 50% dextrose intravenously as well as a renal diet in the emergency room. Resident #1 became hypothermic with a temperature of 94.4 degrees Fahrenheit secondary to prolonged hypoglycemia, for which he received a warming blanket to return his temperature to 98.4 degrees Fahrenheit. Resident #1 was discharged back to the facility on 11/12/2023 at 12:39 PM.

An interview was conducted with the DON on

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F 684	Continued From page 23 11/16/2023 at 8:09 PM. The DON stated that the facility pharmacy kept track of the medications in the automated medication dispensing cabinet, sending more medication if the cabinet ran low. The DON revealed the facility had three automated medication dispensing cabinets in the building and each had multiple doses of glucagon. The DON further revealed she received an email from the pharmacy on 11/8/2023 informing her she had too many glucagon doses in the automated medication dispensing cabinet to which she responded that she would like to have too many doses of glucagon in each automated medication dispensing cabinet. The DON also confirmed Nurse #4 called her on the morning of 11/12/2023 to tell her the facility did not have any glucagon to which she responded the facility did have glucagon but to send Resident #1 to the hospital. The nurse consultant representing the pharmacy was interviewed on 11/17/2023 at 10:30 AM. The nurse consultant explained that a part of his services to the facility were to audit the automated medication dispensing cabinet to assure the facility had enough medications as a backup and in emergencies. The nurse consultant was able to tell through the electronic record when, by who, and what was removed from the automated medication dispensing cabinet on 11/12/2023. The nurse consultant revealed the following information. On 11/12/2023 at 3:46 AM, Nurse #3 removed a 1 mg glucagon emergency kit for Resident #1 from the automated medication dispensing cabinet. The nurse consultant confirmed Nurse #3 removed the only glucagon 1 mg emergency kit containing a diluent syringe and a glucagon vial. On 11/12/2023 at 7:21 AM the electronic record	F 684		

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showed, Nurse #2 removed a glucagon box for Resident #1 from the automated medication dispensing cabinet. The nurse consultant confirmed Nurse #2 selected the glucagon box that contained a diluent and a glucagon vial requiring the extra step of having to locate a syringe to reconstitute the glucagon. On 11/12/2023 at 7:25 AM, Nurse #2 logged into another automated medication dispensing cabinet on another hall, did not remove any medication, and the machine logged Nurse #2 out at 7:30 AM. The nurse consultant was able to tell from audit records before and after 11/12/2023 that each of the three automated medication dispensing cabinets in the facility had multiple 1 mg doses of glucagon available to the nurses on the morning of 11/12/2023.

The facility Medical Director was interviewed on 11/17/2023 at 12:57 PM. The Medical Director stated he would have expected Nurse #6 to seek clarification of the physician's order for the long-acting insulin Levemir with the knowledge Resident #1 did not eat the evening meal and had a blood glucose level of 89 mg/dL. The Medical Director stated it was his expectation that the long-acting insulin should be held if the blood glucose level of the resident was less than 130 mg/dL. The Medical Director further stated he should have been called by Nurse #6 and he would have ordered Nurse #6 not to give the long-acting insulin Levemir to Resident #1 at 9:00 PM on 11/11/2023. The Medical Director stated he did not find out about the events of the morning of 11/12/2023 for Resident #1 until he arrived at the facility on 11/13/2023 to do an admission assessment for Resident #1. The Medical Director indicated someone should have been able to get glucagon for Resident #1 and

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F 684	Continued From page 25 should not have been running from hall to hall before calling EMS. The Medical Director revealed on 11/13/2023 he ordered for the 9:00 PM dose of Levemir for Resident #1 to be held if his blood glucose level was less than 130 mg/dL and his blood glucose levels to be checked three times a day. The facility Administrator was informed of Immediate Jeopardy on 11/19/2023 at 10:55 AM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. " Resident #1 was a diabetic resident who received dialysis services while a resident of the facility. The facility failed to obtain parameters for insulin orders for Resident #1 upon admission for when to hold long-acting insulin. On 11/11/23 Resident #1 received his long-acting insulin with a blood glucose level of 89 and he had not eaten dinner. On 11/12/23 the facility failed to monitor and recheck a blood glucose level for Resident #1 at 6:00 AM as ordered and after a hypoglycemic event requiring the intervention of Glucagon at 3:51 AM. A blood sugar taken at 4:26 AM of 102 was entered on the MAR as taken at 6:00 AM. The facility failed to effectively respond to a medical emergency when Resident #1 had a blood glucose level of 27 and was observed to be thrashing, moaning, sweating, and foaming at the	F 684		

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F 684	Continued From page 26 mouth. " Resident #1 was sent to the ER via Emergency Medical Services (EMS) for treatment of a blood glucose level of 27 upon their arrival at the facility. EMS treated Resident #1 with 1 milligram (mg) Glucagon. Upon arrival at the hospital a repeat glucose level of 24 was taken and Dextrose was given intravenously along with a renal diet consumed orally. Resident #1 was discharged back to the facility with a blood glucose level of 149. " All residents with orders for insulin were at risk for this deficient practice. Record review was conducted by the Director of Nursing/Assistant Director of Nursing and Unit Manager on 11/19/23 of residents with insulin orders to ensure there were parameters for insulin, records were reviewed for any treatment of low glucose levels that were unreported, documented incorrectly and not monitored. No other residents were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. " The Director of Nursing, Assistant Director of Nursing and Regional Nurse began education on 11/19/2023, for Licensed nurses on the following with a posttest required to ensure understanding: " Education was provided to the nurses regarding the medical director's parameters for all residents on long-acting insulin to hold for a blood sugar of less than 130. The nurse will transcribe the parameter orders to the medication administration record. Including in the education	F 684		

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F 684	Continued From page 27 was notification of the physician for blood glucose levels that are outside the parameters. " Preventing hypoglycemia and recognizing mild, moderate, and severe symptoms. Mild symptoms: hunger, sweating, clammy, dizziness, feeling light-headed, nausea, increased heart rate, blurry vision, mood change, tingling or numbness around the mouth, lips or tongue. Moderate symptoms: confusion, poor judgement, behavior changes, weakness, irregular heartbeat and change in coordination. Severe Symptoms: A severe low blood glucose level is a medically emergency and can present as loss of consciousness, fainting, seizures, frothing at the mouth and death. " Guideline for treating hypoglycemia for residents that are alert, able to swallow and eat and residents that are unresponsive and/or not able to drink or eat. Guidelines include immediate notification of the physician regarding treatment of hypoglycemia that requires glucagon administration. Treatment of hypoglycemia: 15/15 Rule If blood glucose level is less than 70 and resident is alert and able to swallow give 4oz of fruit juice and 15gm of carbs. (peanut butter crackers, 1 tube of glucose gel) recheck in 15 minutes if blood glucose level has come up repeat 4oz fruit juice and 15gm carbs. Recheck in 15 minutes. If the resident is unresponsive and/or not able to drink or eat administer 1 mg/IM Glucagon stat, notify 911 and immediately notify MD. " Following physician orders for monitoring blood glucose levels as ordered and notification of the	F 684		

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physician when outside parameters.

" Education provided related to residents on dialysis are at increased risk.

Anyone not receiving education will not be allowed to work until education has been completed. Education will be added to the new hire orientation for Licensed Nurses conducted by the DON or ADON by 11/19/2023. The DON will keep a list of all staff trained to ensure no staff work until training is completed.

Date of alleged Immediate Jeopardy removal: 11/20/2023

The credible allegation for immediate jeopardy removal was validated on 11/22/2023. The credible allegation for immediate jeopardy removal was validated onsite on 11/22/23. Record review verified an audit was completed of residents with insulin orders to ensure there were parameters for insulin, records were reviewed for any treatment of low glucose levels that were unreported, documented incorrectly and not monitored. Staff interviews and record review verified licensed nurses were educated with a posttest required to ensure understanding of: medical director's parameters for all residents on long-acting insulin to hold for a blood sugar of less than 130; transcribing parameters; notification of the physician for blood glucose levels outside the parameters; preventing hypoglycemia and recognizing mild, moderate, and severe symptoms; guidelines for treating hypoglycemia; guidelines for immediate notification of physician regarding treatment of

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F 684	Continued From page 29 hypoglycemia that requires glucagon administration; and 911 notification is the resident is unresponsive and/or not able to drink or eat administer 1 mg/IM Glucagon stat, immediately notify 911 followed by notifying the MD. Education was also provided related to residents on dialysis being at increased risk. The immediate jeopardy removal date of 11/20/23 was validated.	F 684		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and	F 726		11/30/23

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F 726	Continued From page 30 techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacist, Pharmacy Nurse Consultant, and Medical Director interviews the facility failed to demonstrate competency knowing what effective immediate interventions needed to be implemented for treatment of hypoglycemia (low blood glucose) and competency in obtaining life-saving medication from an automated medication dispensing system for one (Resident #1) of one resident reviewed for nursing competency. Emergency Medical Services (EMS) was contacted to take Resident #1 to the emergency room on 11/12/2023 for hypoglycemia. EMS treated Resident #1 with 1 mg glucagon intermuscular. (Glucagon is a manmade version of a hormone made by the pancreas that raises blood glucose levels.) Upon arrival at the hospital, a repeat glucose level of 24 mg/dL (a normal blood glucose level is 70 to 90 milligrams per deciliter) was taken, and 50 % Dextrose was intravenously administered along with a renal diet consumed orally. Immediate Jeopardy began on 11/12/2023 when nursing staff failed to demonstrate competency in treatment of hypoglycemia and obtaining glucagon for Resident #1 who had a blood glucose level of 27 mg/dL. Immediate jeopardy was removed on 11/20/2023 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 level D to ensure education is completed and monitoring systems put in place	F 726	1. The facility failed to demonstrate competency knowing what effective immediate interventions needed to be implemented for treatment of hypoglycemia (low blood glucose) and competency in obtaining life- saving medication from an automated medication dispensing system for one (Resident #1) of one resident reviewed for nursing competency. 2. The deficient practice could affect all residents. On 11/19/23 the Director of Nursing and the Unit Managers reviewed residents who had a change of condition or any medical emergency during the last 30 days using the 24-hour report. The 24-hour report was reviewed for indicators of low blood sugar, medications not being accessed from the medication management system, medical emergency, and not notifying the physician of a change in condition. No new concerns were found. 3. Beginning 11/19/23 the Director of Nursing/Assistant Director of Nursing and Regional Nurse provided the following education to Licensed Nurses: • Licensed Nurses were provided education regarding the protocol for insulin parameters for resident's with long-acting insulin and notification of the	

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are effective.

Findings included:

Resident #1 was admitted to the facility on 11/8/2023 with cumulative diagnoses some of which included diabetes mellitus and end stage renal disease. Resident #1 was receiving dialysis services while he was in the facility.

Documentation in the nursing progress notes for Resident #1 dated 11/12/2023 at 7:49 AM written by Nurse #2 revealed, "[Blood glucose] has dropped to 27 [mg/dL] [at] 7 AM unable to get [blood glucose] up tried to give apple sauce and was unable to swallow. No other attempts due to not swallowing. Called 911 to send [Resident #1] to [Emergency room]. Just left the [building] with the patient. [Responsible Party] made aware."

NA (Nurse Aide) #4, who was working the 7:00 AM to 7:00 PM shift on 11/12/2023, was interviewed on 11/17/2023 at 10:13 AM. NA #4 revealed she entered the room of Resident #1 on the morning of 11/12/2023 at approximately 7:00 AM. NA #4 described Resident #1 as moaning, moving all over the bed, in a cold nasty sweat, teeth clenched tight, foaming at the mouth, and with eyes that were looking right through her. NA #4 stated she hollered for Nurse #2 immediately.

Nurse #2 was interviewed on 11/16/2023 at 6:45 PM. Nurse #2 described the following events as happening on the morning of 11/12/2023 after she arrived at the start of her shift at 7:00 AM. Nurse #2 received report from Nurse #3 that she had to give Resident #1 glucagon for a hypoglycemic episode that occurred at approximately 4:00 AM but that his blood glucose

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physician when glucose readings are outside those parameters.

- Education provided included treatment and care of the resident with signs and symptoms of hypoglycemia. A protocol for treatment was developed and approved by the medical director. The nurses were educated on said glucose protocol that wa approved by the medical director.

- Included in the education for licensed and unlicensed staff was identification and notification of a change in condition to the unit nurse, or unit manager, ADON or DON followed by notifying the physician. Included was change from baseline, low blood sugar, change in behavior, poor appetite, and any change in condition.

- A review with the license nurse was completed regarding residents at risk for a hypoglycemic reaction which included dialysis, poor appetite, and certain specific medications.

- Education was provided for recognizing signs symptoms of mild, moderate, and severe hypoglycemia which included but not limited to:

Mild symptoms: hunger, sweating, clammy, dizziness, feeling light-headed, nausea, increased heart rate, blurry vision, mood change, tingling or numbness around the mouth, lips, or tongue.
Moderate symptoms: confusion, poor

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level returned to normal. Nurse #2 indicated she thought to herself she would have to check his blood glucose level. Nurse #2 revealed from her nursing experience and training, after a resident was given glucagon, it was important to have them eat something or else it was likely the blood glucose would drop again. Nurse #2 heard a nurse aide call out that Resident #1 needed help. Nurse #2 and Nurse #4 went to the room of Resident #1. Nurse #2 saw that Resident #1 was sweaty, shaking violently and moving his limbs all over the bed. Nurse #2 checked his blood glucose level and saw that it was 27 mg/dL. Nurse #2 explained in her training the first step to treat hypoglycemia was to try to get the resident to eat something, knowing Resident #1 did not have anything to eat after glucagon administration at approximately 4:00 AM. Nurse #2 attempted to give Resident #1 some applesauce, but his mouth was clenched shut. Nurse #2 stayed with Resident #1 while Nurse #4 went to get the glucagon. Nurse #5 came to the room of Resident #1 and Nurse #2 asked her to stay while she went to the medication room. Nurse #2 then went to the medication room and signed into the automated medication dispensing cabinet. The automated medication dispensing cabinet showed that there were two different kinds of glucagon and Nurse #2 was selecting the second option. At that point, Nurse #4 entered the medication room and told Nurse #2 she was getting the wrong kind of glucagon. Nurse #2 and Nurse #4 ran to the other side of the building together to find the correct glucagon that would only require one step instead of three steps to prepare the glucagon. When Nurse #2 and Nurse #4 arrived at the automated medication dispensing cabinet on the other side of the building in the medication room, Nurse #4 told

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judgement, behavior changes, weakness, irregular heartbeat and change in coordination.
Severe Symptoms: loss of consciousness, fainting, seizures, foaming at the mouth, and death.

- The pharmacy provided a step-by-step guide to remove medication from the emergency medication machine. (Nexsys) machine including pictures of the glucagon screen shot. Nurses were to verbalize step by step to show accuracy to obtain medication via the Nexsys emergency medication machine.

- The licensed nurses completed a post education knowledge test to show competency to provide care and treatment for a resident showing signs and symptoms of hypoglycemia.

The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. It will be the responsibility of the Director of Nursing to ensure this is completed.

4. The DON or designee will monitor the completion of competencies for five (5) nursing staff for 4 weeks, then monthly for 3 months. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality

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F 726	Continued From page 33 Nurse #2 that the machine did not have the type of glucagon that was needed either. Nurse #2 stated she was not aware glucagon came in a form that required two to three steps and was only familiar with the glucagon that was just one step to administer. Nurse #2 revealed she since then had been educated by the Director of Nursing (DON) on the multiple forms of glucagon and how to administer them. On the way back to the hallway on which Resident #1 resided, Nurse #4 called the DON to tell her the correct kind of glucagon was not in the building. The DON told Nurse #4 the resident needed to be sent to the emergency room. Nurse #4 called 911 while Nurse #2 returned to the room of Resident #1 to take vital signs. Nurse #4 was interviewed on 11/16/2023 at 7:41 PM. Nurse #4 related that the following events happened on the morning of 11/12/2023 when she was working the 7:00 AM to 7:00 PM shift. Nurse #4 stated she heard one of the nursing aides calling for help and for Nurse #2 to hurry up. Nurse #4 went to the room of Resident #1 to see if she could help. Nurse #4 described Resident #1 as "jerking hard" and diaphoretic (perspiring profusely). Nurse #2 grabbed a glucometer off the nursing cart and when she took the blood glucose level of Resident #1 it registered as "Lo." (A screen display will read "Lo" when a blood glucose test result is below 20 mg/dL.) Nurse #2 left the room and went to obtain glucagon from the medication room while Nurse #4 stayed in the room of Resident #1. It seemed to Nurse #4 that it was taking Nurse #2 a long time to get the glucagon, so she left the room to find Nurse #2. Before Nurse #4 went into the medication room, she asked Nurse #5 to go to the room of Resident #1 to check on him. When	F 726	Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion date 11/30/2023	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Nurse #4 arrived in the medication room the automated medication dispensing cabinet locked up on Nurse #2 and it was a screen she had never seen before. Nurse #4 and Nurse #2 then ran to the other side of the building to attempt to get glucagon from the other medication room and the automated medication dispensing cabinet. After Nurse #2 searched for the medication in the automated medication dispensing cabinet and it was telling her there was no glucagon in that machine either. Nurse #4 was adamant it was Nurse #2 who was searching in the electronic medication dispensing system for the glucagon because it was her resident. Nurse #2 detailed the steps to remove medication from the automated medication dispensing cabinet but indicated she could not have removed glucagon from the cabinet because she did not know the personal information required for Resident #1 required for removing medication. Nurse #4 stated she called her DON to tell her the facility did not have any glucagon and Resident #1 had to be sent out. Nurse #4 revealed she called 911 while Nurse #2 returned to Resident #1 to get vital signs to give to EMS (emergency medical services). Nurse #4 explained she prepared the paperwork required by EMS and then left Nurse #2 to handle everything else while she returned to her assigned hall.

Nurse #5 was interviewed on 11/17/2023 at 9:09 AM. Nurse #5 stated she was working on the 7:00 AM to 7:00 PM shift on 11/12/2023. Nurse #5 stated she heard NA #4 calling for help so she went to the room of Resident #1. Nurse #5 stated when she entered the room Resident #1 was shaking uncontrollably and foaming at the mouth. Both Nurse #2 and Nurse #4 were in the room trying to give Resident #1 applesauce, but his

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F 726	Continued From page 35 mouth was closed shut. Nurse #5 stated that Nurse #2 and Nurse #4 both left the room together to get glucagon from the medication room. Nurse #5 stated when Nurse #2 and Nurse #4 returned they stated they were calling 911 because the facility did not have any glucagon. Nurse #5 revealed the paramedics arrived very quicky and Resident #1 never lost consciousness. Documentation on an EMS incident report dated 11/12/2023 for a call received at 7:26 AM revealed Resident #1 was found being held down by staff with a blood glucose reading of 27 mg/dL. The report also indicated the EMS staff administered 1 mg of glucagon in his left shoulder muscle and was placed on oxygen via a nasal cannula while in route to the hospital. Documentation on a hospital emergency discharge summary dated 11/12/2023 revealed the following information. The repeat blood glucose level, taken upon arrival of Resident #1 to the hospital, was 24 mg/dL. Resident #1 was administered 50% dextrose intravenously as well as a renal diet in the emergency room. Resident #1 became hypothermic with a temperature of 94.4 degrees Fahrenheit secondary to prolonged hypoglycemia, for which he received a warming blanket to return his temperature to 98.4 degrees Fahrenheit. Resident #1 was discharged back to the facility on 11/12/2023 at 12:39 PM. The Nurse Consultant representing the pharmacy was interviewed on 11/17/2023 at 10:30 AM. The Nurse Consultant explained that a part of his services to the facility were to audit the automated medication dispensing cabinet to assure the facility had enough medications as a	F 726		

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backup and in emergencies. The nurse consultant was able to tell through the electronic record when, by who, and what was removed from the automated medication dispensing cabinet on 11/12/2023. The nurse consultant revealed the following information. On 11/12/2023 at 7:21 AM, Nurse #2 removed a glucagon kit for Resident #1 from the automated medication dispensing cabinet. On 11/12/2023 at 7:25 AM, Nurse #2 logged into another automated medication dispensing cabinet on another hall, did not remove any medication, and the machine logged Nurse #2 out at 7:30 AM.

The facility Pharmacist was interviewed on 11/17/2023 at 12:09 PM. The Pharmacist confirmed 1 mg of glucagon should be administered if the blood glucose level was in the 20's and it was potentially life threatening if immediate action was not taken. The Pharmacist explained the supply of glucagon can change, and glucagon was available in various forms for administration. One form of glucagon was in a kit which contains a vial of glucagon along with a syringe for immediate administration. Another form of glucagon was a vial of sterile glucagon which needed to be reconstituted with a syringe and a vial of sterile diluent. The Pharmacist confirmed all the glucagon kits came with instructions. The Pharmacist also revealed the automated medication dispensing systems also contained an oral glucose gel that could be put underneath the lip. The Pharmacist confirmed all the nursing staff should know how and when to use the various types of glucagon.

The Medical Director was interviewed on 11/17/2023 at 12:57 PM. The Medical Director confirmed the nursing staff needed to know how

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and when to use glucagon for hypoglycemia. The Medical Director indicated that one nursing staff member could obtain the glucagon while another nursing staff member could call emergency medical services instead of everybody running around. It was also confirmed by the Medical Director that the nursing staff need to know how to use the automated mediation dispensing system.

An interview with the Administrator was conducted on 11/17/2023 at 3:36 PM. The Administrator provided the following information. It was identified that Nurse #2 was not able to locate the glucagon in the automated medication dispensing cabinet while Resident #1 was having a medical emergency with a low blood glucose requiring glucagon. The Director of Nursing conducted an audit of all three automated medication dispensing cabinets on 11/13/2023 and found there were 5 available glucagon doses in the building. The Director of Nursing reviewed with Nurse #2 how to use the automated medication dispensing cabinet as well as provided education on how to respond to a low blood glucose level on 11/15/2023. Nurse #2 knew exactly how to use the automated medication dispensing cabinet when she was asked to demonstrate its use on 11/15/2023. The facility investigation concluded Nurse #2 went to obtain the glucagon from the automated medication dispensing cabinet but, before she opened the drawer to remove the glucagon, she panicked, and hit "done," making the machine think the glucagon drawer was empty. The Administrator revealed the facility had started educating and monitoring the nursing staff knowledge of what to do when a blood glucose level was low and how and where to find

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glucagon. The Administrator provided documentation that 4 nurses had been a part of this monitoring process since 11/15/2023 to include Nurse #4 and Nurse #2.

The DON was interviewed on 11/17/2023 at 5:00 PM. The DON relayed the steps she expected the nurses to follow for treatment of hypoglycemia because the facility did not have a set protocol for treatment of hypoglycemia. The DON expected a nurse to check the blood glucose level of a diabetic resident if symptoms of an altered mental status are present. The DON expected the nursing staff to attempt to provide sugary food under the tongue to a resident who was alert and oriented with a low blood glucose level. If the nurse was unable to put sugary food in the resident's mouth, then the DON expected the nurse to obtain glucagon from the automated medication dispensing system and administer the glucagon. The DON stated that if it was a true emergency after obtaining the blood glucose level the nurse should send the resident to the emergency room and notify the physician.

The facility Administrator was informed of Immediate Jeopardy on 11/19/2023 at 10:55 AM.

The facility provided the following credible allegation of immediate jeopardy removal:

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

The facility nursing staff failed to show competency in knowing immediate steps and measures to be taken when Resident #1 showed signs and symptoms of hypoglycemia, when

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Resident #1 received his long acting insulin when he did not eat dinner and staff did not communicate with the MD. Resident #1 had a blood glucose level of 29 obtained at approximately 3:53 AM with I milligram of Glucagon given and staff did not communicate with the Physician of a change in condition. At approximately 7:00 AM Resident #1 had a blood glucose level of 27 and Glucagon was unable to be obtained from the medication management system for Resident #1. 911 was not called immediately which caused a delay in Resident #1 being sent to the emergency room.

The deficient practice could affect all residents. On 11/19/23 the Director of Nursing and the Unit Managers reviewed residents who had a change of condition or any medical emergency during the last 30 days using the 24-hour report. The 24-hour report was reviewed for indicators of low blood sugar, medications not being accessed from the medication management system, medical emergency, and not notifying the physician of a change in condition. No new concerns were found.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 11/19/23 the Director of Nursing/Assistant Director of Nursing and Regional Nurse provided the following education to Licensed Nurses:

" Licensed Nurses were provided education regarding the protocol for insulin parameters for resident's with long-acting insulin and notification of the physician when glucose readings are

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F 726	Continued From page 40 outside those parameters. Protocol as follows: Residents with orders for long-acting insulin will have a parameter of if blood glucose is less than 130, hold insulin and call physician for further orders. " Education provided included treatment and care of the resident with signs and symptoms of hypoglycemia. A protocol for treatment was developed and approved by the medical director. The nurses were educated on said protocol which included: If blood glucose is less than 70 and resident is alert and able to swallow, give 4oz of fruit juice and 15 grams of carbs. (15/15 rule) recheck blood glucose in 15 minutes. If resident is unresponsive and/or unable to drink or eat do not try to place any type of food or drink in their mouth, give glucagon 1 mg. IM stat, call 911 immediately, and notify the physician after administering glucagon for any further orders. Recheck in 15 minutes. " Included in the education for licensed and unlicensed staff was identification and notification of a change in condition to the unit nurse, or unit manager, ADON or DON followed by notifying the physician. Included was change from baseline, low blood sugar, change in behavior, poor appetite, and any change in condition. " A review with the license nurse was completed regarding residents at risk for a hypoglycemic reaction which included dialysis, poor appetite, and certain specific medications. " Education was provided for recognizing signs symptoms of mild, moderate and severe hypoglycemia which included:	F 726		

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Mild symptoms: hunger, sweating, clammy, dizziness, feeling light-headed, nausea, increased heart rate, blurry vision, mood change, tingling or numbness around the mouth, lips or tongue.
Moderate symptoms: confusion, poor judgement, behavior changes, weakness, irregular heartbeat and change in coordination.
Severe Symptoms: loss of consciousness, fainting, seizures, foaming at the mouth, and death.

" The pharmacy provided a step-by-step guide to remove medication from the emergency medication machine. (Nexsys) machine including pictures of the glucagon screen shot. Nurses were to verbalize step by step to show accuracy to obtain medication via the Nexsys emergency medication machine.

" The licensed nurses completed a post education knowledge test to show competency to provide care and treatment for a resident showing signs and symptoms of hypoglycemia.

The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. It will be the responsibility of the Director of Nursing to ensure this is completed.

The Administrator and Director of Nursing are responsible for the implementation and completion of the removal plan.

Alleged immediate jeopardy removal date

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F 726	Continued From page 42 11/20/23 The credible allegation for immediate jeopardy removal was validated on 11/22/2023. The credible allegation of immediate jeopardy removal was verified on 11/22/23 as evidenced by record review and staff interview. A change in condition audit using the 24-hour report was verified as complete. Education for licensed nurses was confirmed as completed on the protocol for insulin parameters for resident's with long-acting insulin and notification of the physician when glucose readings are outside those parameter; protocol for treatment and care of the resident with signs and symptoms of hypoglycemia; residents at risk for hypoglycemic reactions; recognizing mild, moderate, and severe symptoms of hypoglycemia; and how to obtain medication via the Nexsys emergency medication machine. Licensed nurses completed a post education knowledge test to show competency to provide care and treatment for a resident showing signs and symptoms of hypoglycemia. Education for licensed nurses and unlicensed staff was confirmed related to identification and notification of a change in condition to the unit nurse, or unit manager, ADON or DON followed by notifying the physician.. The immediate jeopardy removal date of 11/20/23 was validated.	F 726		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		11/30/23

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 44 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately document a blood glucose reading as ordered for one (Resident #1) of one resident reviewed for accuracy of medical records. Findings included: Resident #1 was admitted to the facility on 11/8/2023 with cumulative diagnoses some of which included Type 2 Diabetes Mellitus and end stage renal disease. Resident #1 had a physician's order initiated on 11/8/2023 for Accu-checks twice a day at 6:00 AM and 9:00 PM to measure blood glucose levels. Documentation in the nursing notes for 11/12/2023 at 3:51 AM written by Nurse #3	F 842	1. The facility failed to accurately document a blood glucose reading as ordered for one (Resident #1) of one resident reviewed for accuracy of medical records. 2. All residents that receive insulin have the potential to be affected by this practice. On 11/19/2023 the Director of Nursing and the Unit Managers reviewed all residents who receive blood glucose level checks, their records were reviewed for any missed or incorrectly documented blood glucose checks. No other residents were identified. 3. All licensed nurses were educated by the Director of Nursing, Assistant Director	

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F 842	Continued From page 45 revealed, "Resident (#1) screaming out loud and thrashing around in the bed pushing back at staff trying to give him help. Resident (#1) was also sweating profusely. This nurse was able to check resident's blood [glucose] and the result was 29 (mg/dL). Using standing orders for glucagon emergency kit for low blood [glucose] one single dose 1 [milliliter subcutaneously] was given. Will recheck blood [glucose] in 15 minutes. A note was left in the provider's communication book." Documentation in the nursing notes for 11/12/2023 at 4:26 AM written by Nurse #3 revealed, "Blood [glucose] at this time is 102 (mg/dL) resident is calm and is not in distress, call bell within reach." Nurse #3 was interviewed on 11/16/2023 at 7:15 PM. Nurse #3 relayed the following information. Nurse #3 was called to the room of Resident #1 by Nurse Aide (NA) #1 who was attempting to provide care to Resident #1. Resident #1 was thrashing around in the bed and would not allow NA #1 to provide care. It occurred to Nurse #3 that Resident #1 was a diabetic and Resident #1 allowed her to check his blood glucose level. The blood glucose level was 29 mg/dL. Nurse #3 obtained glucagon from the automated medication dispensing cabinet and administered it to Resident #1. Twenty to thirty minutes later Nurse #3 checked the blood glucose level of Resident #1, and it was 102 mg/dL. Nurse #3 stated, "I was happy with that, and he was good."	F 842	of Nursing and Regional Nurse on 11/19/2023 for the following: all blood glucose level checks will be documented at the time the check is completed. Education will be added to the new hire orientation for Licensed Nurses conducted by the DON or ADON by 11/19/2023. The DON will keep a list of all staff trained to ensure no staff work until training is completed. 4. The Director of Nursing (DON) or designee will audit all residents who receive blood glucose level checks daily x 12 weeks to ensure that the nursing staff have documented the blood glucose check at the time it is completed. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing the information collected in the audits and reporting to Quality Assurance Performance Improvement Committee (QAPI) by the DON for three (3) months. At the time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Date of Completion 11/30/2023	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		11/30/23

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F 867	Continued From page 46 A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action.	F 867		

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	345036	A. BUILDING ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH CITY HEALTH AND REHABILITATION	**1075 US HIGHWAY 17 SOUTH** **ELIZABETH CITY, NC 27909**

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§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance

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F 867	Continued From page 48 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with Medical Director, Pharmacy Nurse Consultant, Pharmacist, and staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the focused infection control and complaint investigation survey of 1/19/21 and the	F 867	1. The facility failed to maintain implemented procedures and monitor the interventions the committee put into place following the focused infection control and complaint investigation survey of 1/19/21 and the recertification and complaint investigation survey of 1/27/23. This was for 3 deficiencies recited on the current	

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recertification and complaint investigation survey of 1/27/23. This was for 3 deficiencies recited on the current complaint investigation survey of 11/22/23 in the areas of: Notification of Changes (F580), Quality of Care/Professional Standards (F684), and Complete and Accurate Medical Records (842). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

This tag is cross referenced to:

F580: Based on record review, staff interviews, and Medical Director interview the facility failed to notify the physician of administering long-acting insulin to Resident # 1 who had not consumed dinner and had a blood glucose level of 89 mg/dL (milligrams per deciliter). The facility failed to notify the physician after significant changes in condition for Resident #1 which included: obtaining a blood glucose level of 29 mg/dL (a normal blood glucose level range is 70 to 99 mg/dL) requiring the administration of glucagon (a manmade version of a hormone made by the pancreas that raises blood glucose levels); and obtaining a blood glucose level of 27 mg/dL, and the inability to administer glucagon to the Resident during a medical emergency. Resident #1 was one of one resident reviewed for notification of the physician. Emergency Medical Services (EMS) was contacted to take Resident #1 to the emergency room on 11/12/2023 for hypoglycemia (low blood glucose). EMS treated Resident #1 with 1 mg glucagon intermuscular. Upon arrival at the hospital, a repeat glucose level of 24 mg/dL was taken, and 50 % Dextrose

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complaint investigation survey of 11/22/23 in the areas of: Notification of Changes (F580), Quality of Care/Professional Standards (F684), and Complete and Accurate Medical Records (842). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

2. On 11/30/23 the Quality Assurance Committee held a meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewing the ongoing compliance related to the issues regarding the F580, F684, and F842 Tags received on the complaint survey of 1/19/21 and the recertification and complaint survey of 1/27/23.

3. By 11/30/2023, the Director of Clinical Services educated the Administrator, the Director of Nursing, and the Assistant Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identifying issues and correction of repeat deficiencies, use of rounding tools, daily review of documentation, and observations during leadership rounds. By 11/30/2023, the Director of Clinical Services will provide weekly oversight for 12 weeks and will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other

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was intravenously administered along with a renal diet consumed orally.

During a focused infection control and complaint investigation survey of 1/19/21 the facility failed to notify a physician and the responsible party of a resident's change inability to swallow and eat.

F684: Based on record review, staff interviews, Pharmacy Nurse Consultant interview, Pharmacist interview, and Medical Director interview, the facility gave long-acting insulin to Resident #1 who had a blood sugar reading of 89 milligrams/deciliter (mg/dL) and had not eaten the dinner meal; failed to monitor the resident for any signs and symptoms of hypoglycemia (low blood glucose) after insulin administration; failed to monitor and complete ongoing thorough assessments by rechecking a blood glucose level as ordered after a hypoglycemic event requiring the intervention of glucagon (used to treat very low blood glucose); and failed to effectively respond to a medical emergency of hypoglycemia for one (Resident #1) of three residents reviewed for diabetes care. Emergency Medical Services (EMS) was contacted to take Resident #1 to the emergency room on 11/12/2023 for hypoglycemia. EMS treated Resident #1 with 1 milligram glucagon intramuscularly. Upon arrival at the hospital, a repeat glucose level resulted in a blood glucose of 24 (mg/dL), and 50 % Dextrose was intravenously administered along with a renal diet consumed orally. (A normal blood glucose level range is 70 to 99 mg/dL.)

During a recertification and complaint investigation survey of 1/27/23 the facility failed to provide the care of ear wax removal as recommended by a physician.

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interventions. By 11/30/2023, the Administrator educated the QAPI committee members consisting of Medical Director, Administrator, Director of Nursing, Assisted Director of Nursing/Staff Development Coordinator, Unit Managers, Minimum Data Set Nurse, Wound Nurse, Activities Director, Dietary Manager, Environmental Services Manager, Director of Social Services, and the Director of Rehabilitation, on weekly risk review of the audit findings for compliance and/or revision when necessary.

4. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns.

5. Completion date 11/30/2023

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F842: Based on record review and staff interview, the facility failed to accurately document a blood glucose reading as ordered for one (Resident #1) of one resident reviewed for accuracy of medical records.

During a focused infection control and complaint investigation survey of 1/19/21 the facility failed to ensure physician's orders and documentation regarding initiation of orders were entered into the medical record.

An interview was completed on 11/22/23 at 2:10 P.M. with the Administrator. The Administrator indicated the QAA committee meets monthly to discuss the facility's ongoing performance improvement plans. The Administrator stated there was a current monitoring plan in place by the facility related to the identified F580, F684, F842 deficient practices. The Administrator explained the monitoring plan included regular audits and the appointed manager who will lead in monitoring the implementation and effectiveness of the action plan. The Administrator stated it was her expectation that the facility continued to follow the QAA process and monitor those issues within the facility so they would not receive a recited deficiency.