STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to utilize blood sugar results to determine the correct insulin dose administered on 8 occasions for 2 of 3 sampled residents (Resident #56 and Resident #93) reviewed with physician orders for sliding scale insulin coverage. The findings included: 1) Resident #56 was admitted to the facility on 4/25/15, and re-entered the facility on 11/18/15 from a hospital. His cumulative diagnoses included diabetes. Resident #56's most recent quarterly Minimum Data Set (MDS) assessment dated 10/12/16 indicated the resident had intact cognitive skills for daily decision making. The resident required extensive assistance from staff for bed mobility, dressing, toileting, and personal hygiene; limited assistance with transfers, and was independent with locomotion on/off the unit and for eating. Section N of the MDS assessment indicated the resident received an insulin injection on 7 out of 7 days during the look back period.	F 309	F309 1.The physician was notified regarding resident #56 and resident #93 sliding scale. There was no negative outcome to the residents. 2.Medication Administration Record (MAR) of current residents receiving sliding scale insulin reviewed by DCS and or/Unit Manager. Follow up based on findings. 3.Licensed Nursing staff were re-educated on sliding scale insulin being administered per physician ordered sliding scale. DCS and or Unit Manager/Unit Coordinator to quality monitor Medication Administration Records 5 times a week for 12 weeks then quarterly. 4.The Director of Clinical Services will report the results of the monitoring to the QAPI committee monthly meeting for review and recommendations for the duration of the scheduled monitoring.	11/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2016

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F 309	Continued From page 1	F 309		

A review of the Resident #56's current Care Plan included a focus area related to metabolic disorders based on his diagnosis of diabetes.

A review of the resident's medical record included physician's orders for the following medications:
(Order dated 11/18/15) NovoLog insulin (a rapid-acting insulin) injected subcutaneously four times a day as sliding scale insulin (SSI) at 6:00 AM, 11:30 AM, 4:30 PM, and 8:00 PM. SSI coverage indicated that the dose of insulin administered was dependent on the resident's blood sugar (BS) result at that designated time. The SSI order utilized the following parameters:
If BS 200-250, give 2 units insulin;
If BS 251-300, give 4 units insulin;
If BS 301-350, give 6 units insulin;
If BS 351-400, give 8 units insulin;
If BS greater than 400 or greater, give 12 units.

A review of Resident #56's September 2016 Medication Administration Record (MAR) revealed the resident's blood sugar results and SSI coverage included:
9/2/16 at 6:00 AM: BS result was 382; 6 units of insulin were given (SSI regimen indicated 8 units were ordered);
9/16/16 at 6:00 AM: BS result was 289; 2 units of insulin were given (SSI regimen indicated 4 units were ordered).

A review of Resident #56's October 2016 Medication Administration Record (MAR) revealed the resident's blood sugar results and SSI coverage included:
10/15/16 at 8:00 PM: BS result was 352; 6 units of insulin were given (SSI regimen indicated 8 units were ordered);

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F 309	Continued From page 2	F 309		

10/16/16 at 4:30 PM: BS result was 256; 2 units of insulin were given (SSI regimen indicated 4 units were ordered);
10/18/16 at 6:00 AM: BS result was 318; 8 units of insulin were given (SSI regimen indicated 6 units were ordered).

An interview was conducted with the facility's Director of Nursing (DON) on 10/20/16 at 8:46 AM. During the interview, the DON reviewed the resident's MAR, BS monitoring results, and SSI coverage given. The DON stated, "It is what it is." She reported her expectation was for the nurses to follow the physician's orders exactly as they were written. The DON stated she had " no explanation" for the apparent errors in insulin dosing.

A telephone interview was conducted on 10/20/16 at 11:00 AM with Nurse #1. Nurse #1 was identified as the nurse assigned to administer medications for Resident #56 on 9/2/16 at 6:00 AM. When asked, the nurse could not recall specific details regarding this resident's blood glucose check or insulin administration. Upon further inquiry, the nurse reported she typically checked a resident's blood sugar level, wrote down the results, pulled the insulin for administration, and then recorded the amount of insulin after it was given to the resident.

Nurse #2 was not available to interview. Nurse #2 was identified as the nurse assigned to administer medications for Resident #56 on 9/16/16 at 6:00 AM.

Nurse #3 was not available to interview. Nurse #3 was identified as the nurse assigned to administer medications for Resident #56 on

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F 309	Continued From page 3	F 309		

10/15/16 at 8:00 PM and on 10/16/16 at 4:30 PM.

Nurse #4 was not available to interview. Nurse #4 was identified as the nurse assigned to administer medications for Resident #56 on 10/18/16 at 6:00 AM.

An interview was conducted on 10/20/16 at 11:45 AM with the facility's Medical Director. The Medical Director reported he was an endocrinologist. Upon review of the resident's BS results and SSI coverage, the Medical Director indicated he was somewhat surprised by the errors made in the insulin dosing. He stated, "They (nurses) need to be more precise...it's probably an education issue."

2) Resident #93 was admitted to the facility on 8/28/15 from a hospital. Her cumulative diagnoses included diabetes.

Resident #93's most recent quarterly Minimum Data Set (MDS) assessment dated 8/26/16 indicated the resident had intact cognitive skills for daily decision making. The resident was independent for most of her Activities of Daily Living (ADLs), with the exception of requiring supervision only for bed mobility and transfers. Section N of the MDS assessment indicated the resident received an insulin injection on 7 out of 7 days during the look back period.

A review of the Resident #93's current Care Plan included a focus area related to metabolic disorders based on her diagnosis of diabetes.

A review of the resident's medical record included physician's orders for the following medications: (Order dated 8/28/15) HumaLog insulin (a

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F 309	Continued From page 4	F 309		

rapid-acting insulin) injected subcutaneously four times a day as sliding scale insulin (SSI) at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. SSI coverage indicated that the dose of insulin administered was dependent on the resident's blood sugar (BS) result at that designated time. The SSI order utilized the following parameters:
If BS 150-200, give 2 units insulin;
If BS 201-250, give 4 units insulin;
If BS 251-300, give 6 units insulin;
If BS 301-350, give 8 units insulin;
If BS 351-400, give 10 units of insulin;
If BS greater than 400, call the Medical Doctor (MD).

A review of Resident #93's September 2016 Medication Administration Record (MAR) revealed the resident's blood sugar results and SSI coverage included:
9/2/16 at 11:30 AM: BS result was 155; no insulin was given (SSI regimen indicated 2 units were ordered);
9/24/16 at 9:00 PM: BS result was 188; 4 units of insulin were given (SSI regimen indicated 2 units were ordered).

A review of Resident #93's October 2016 Medication Administration Record (MAR) revealed the resident's blood sugar results and SSI coverage included:
10/6/16 at 9:00 PM: BS result was 297; 8 units of insulin were given (SSI regimen indicated 6 units were ordered).

An interview was conducted with the facility's Director of Nursing (DON) on 10/20/16 at 8:46 AM. During the interview, the DON reviewed the resident's MAR, BS monitoring results, and SSI coverage given. The DON stated, "It is what it is."

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F 309	Continued From page 5	F 309		

She reported her expectation was for the nurses to follow the physician's orders exactly as they were written. The DON stated she had "no explanation" for the apparent errors in insulin dosing.

An interview was conducted on 10/20/16 at 9:20 AM with Nurse #5. Nurse #5 was identified as the nurse assigned to administer medications to Resident #93 on 9/2/16 at 11:30 AM. Nurse #5 reviewed the process she employed when checking a resident's BS level and determining the SSI coverage required. The nurse stated she typically checked the resident's BS, reviewed the SSI orders, wrote down the BS results and insulin coverage required, and then administered the insulin to the resident. Upon inquiry, Nurse #5 stated if she documented that no insulin was given, she was confident she did not give any to the resident at that time.

A telephone interview was conducted on 10/20/16 at 11:00 AM with Nurse #1. Nurse #1 was identified as the nurse assigned to administer medications for Resident #93 on 9/24/16 at 9:00 PM and on 10/6/16 at 9:00 PM. When asked, the nurse could not recall specific details regarding this resident's blood glucose check or insulin administration. Upon further inquiry, the nurse reported she typically checked a resident's blood sugar level, wrote down the results, pulled the insulin for administration, and then recorded the amount of insulin after it was given to the resident.

An interview was conducted on 10/20/16 at 11:45 AM with the facility's Medical Director. The Medical Director reported he was an endocrinologist. Upon review of the resident's BS

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F 309	Continued From page 6 results and SSI coverage, the Medical Director indicated he was somewhat surprised by the errors made in the insulin dosing. He stated, "They (nurses) need to be more precise...it's probably an education issue."	F 309		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the pre-planned menu the facility failed to provide the correct meat portion (sliced pork loin) for 2 of 2 residents. Findings Included: A review of the pre-planned menu for 10/19/16 revealed the lunch entrée was sliced pork loin and the portion size to be served was 3 ounces. An observation of the tray line lunch service on 10/19/16 at 11:55 am revealed a steam table pan of 2 different size slices of pork loin; one slice appeared to be a double size slice and one slice appeared to be a single size slice. Cook #1 served 2 resident ' s plates with one piece of the double size slice of pork loin. Cook #1 was asked what portion of pork was being served. She stated the " double size slices " were equal to 3 ounces and the " single size slices " were equal to 2 ounces. Cook #1 was asked to weigh the meat slices. Cook #1 obtained the portion scale.	F 363	F363 1.Correct portion size of meat was placed on the tray line plates and served to the residents. Cook #1 was educated by the Dietary Manager on portion size of meats being accurate prior to the meal service. 2.All residents were served proper weight portions of the pork entr¿e for lunch as per tray line observation by Dietary Manager. 3.Dietary staff was educated to weigh food products after the cooking process is complete to ensure they receive the correct portion size. Dietary/Supervisor will do tray line observations for appropriate portion size of all meals 5 times a week for 12 weeks, then monthly	11/23/16

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F 363	Continued From page 7 The Dietary Manager calibrated the ounce scale to 0. Cook #1 placed one piece of the " double size slice " on the scale and it weighed 1.5 ounces. Cook #1 stated it must have shrunk when I cooked it. An interview with the facility Dietary Manager and the Regional Dietary Manager on 10/20/2016 at 9:55 pm revealed that the portion of pork served at the lunch meal on 10/19/16 was not correct. The facility dietary manager stated that Cook #1 had portioned the pork slices prior to the meat being cooked and that the portions should have been weighed after the cooking process. An interview with the facility Administrator on 10/20/2016 at 11:03 am revealed that her expectation was that the correct food portions should be served according to the menu. She stated that the dietary staff should have weighed the meat after it was cooked to ensure that the right portion was served.	F 363	for 3 months quarterly. 4.The Executive Director will report the results of the monitoring to the QAPI committee monthly meeting for review and recommendations for the duration of the scheduled monitoring.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 371	F371	11/23/16

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F 371	Continued From page 8 facility failed to ensure: opened food items were sealed, labeled and dated in the dry storage room, walk-in freezer and 1 of 2 nourishment rooms, service and cookware were not stacked wet, service ware were free from food particles and chemicals were not stored next to food products. This had the potential to affect 81 of 82 residents who reside in the facility. Findings Included: An observation of the kitchen and nourishment rooms on 10/17/16 at 10:30 am revealed: 1. Dry Storage Room - A bottle of a chemical labeled Grease Lightning was on a shelf next to food products, an open container of rice that was exposed to the air and a dented can of peaches. 2. Walk -In Freezer - An open, unsealed case of breaded chicken that was exposed to the air and an open, unsealed case of pork patties exposed to the air. 3. Nourishment Room - A carton of a thawed, unopened health shake that was not labeled or dated and did not have a manufacturer ' s expiration date identified. An observation of the kitchen on 10/19/16 at 10:45 am revealed: 1. 17 of 43 dinner plate domes and bases were stored on a table near the steam table stacked together wet. 2. 3 of 7 divided plastic plates were stored on a shelf underneath the steam table that were stained and had food particles on them. 3. 2 of 5 steam table pans were stored on a shelf and stacked together wet.	F 371	1. Grease lightening bottle was removed from the food storage area and placed in the chemical storage area. The unsealed chicken, pork patties and unlabeled health shake were discarded. The dented can of peaches was removed and placed on designated dented can shelf for return to the distributor for replacement. All other cans of food in storage areas were checked to ensure that all dented cans were removed and placed on dented can shelf. The dinner plates, domes, bases and divided plates were removed from the storage area due to being wet and rewashed, sanitized and air dried. 2. All food storage areas were checked to ensure that no other chemicals were stored in the food storage areas. The walk-in freezer was checked to ensure that all food is properly sealed and labeled. All cans of food were checked to ensure that no other cans had any dents. The old domes, bases and divided plates were replaced were discarded and new ones were purchased. The facility also purchased a drying rack for the dishes. 3. Dietary staff were reeducated on proper storage of chemicals in the kitchen. Dietary manager will monitor storage of chemicals 5 times a week for 12 weeks and then monthly for 3 months then quarterly. Staff was also in-serviced on labeling and storing food items properly. Dietary manager/cooks will check labeling and storing of food 3x a day after meal service	

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F 371	Continued From page 9 An interview with the facility Dietary Manager and the Regional Dietary Manager on 10/20/16 at 9:55 am revealed that chemicals should not be stored next to food products. The facility Dietary Manager stated that the food storage issues were not acceptable and that food items should be sealed and not exposed to air. She also stated that the dented can of peaches should have been placed in the area designated for dented cans in the dry storage room. The Regional Dietary Manager stated that the health shake should have been dated when thawed and before being taken to the nourishment room. The Dietary Manager stated that dish ware should not have been stacked together wet and that any items with food particles should have been re-washed before being put away. An interview with the facility Administrator on 10/20/16 at 11:03 am revealed that her expectation was that chemicals would not be stored near any food. She stated that open food products should have been sealed with a date on it. She also stated that she expects that dishes would not be put away wet and any dishes with food particles on them should have been re-washed.	F 371	5 times a week for 12 weeks and then monthly for 3 months to ensure that all food is properly sealed and labeled. In-services were done with all dietary staff to ensure that all dented cans are placed on the dented cans shelf to be returned to the distributor. Dietary manager/cooks will check canned foods 3 times a week for 12 weeks. Then monthly for 3 months and then quarterly to ensure that all cans with dents are placed on the dented can shelf for return to the distributor. Staff was educated on proper use of the air drying rack and making sure everything is dry prior to being stored. Dietary manager/cook will check domes, bases, and plates to make sure they are dry prior to being stored. Dietary manager/cook will check domes, bases, and plates to make sure they are dry prior to meal services 3x a day 5 times a week for 12 weeks. Then monthly for 3 months then quarterly. 4.The Executive Director will report the results of the monitoring to QAPI committee monthly meeting for review and recommendations for the duration of the scheduled monitoring.	