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 _____	C 10/29/2018

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 000	INITIAL COMMENTS The survey team entered the facility on 10/8/18 to conduct a recertification and complaint investigation survey and exited on 10/11/18. As a result of management review, immediate jeopardy was identified at F580 and F684. The survey team returned to the facility on 10/29/18 to do an extended survey and validate the credible allegation of removal. Immediate Jeopardy was identified at: CFR483.10 at tag F580 at a scope and severity J CFR483.25 at tag F684 at a scope and severity J The tags F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/1/18 and was removed on 10/27/18. An extended survey was conducted. 12/3/18. Tag F684 was amended to reflect that the immediate jeopardy began on 10/2/18 instead of 9/1/18.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		12/5/18

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

Electronically Signed | 11/23/2018

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F 561	Continued From page 1 care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a shower as scheduled for 1 of 1 sampled residents reviewed for choices (Resident # 2.) Findings Included: Resident # 2 was admitted to the facility on 4/16/18. His diagnoses included: History of stroke, Non-Alzheimer's Dementia, adult failure to thrive, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 7/1/18 revealed that Resident #2 was cognitively intact and not coded for behaviors. Resident required extensive staff assistance with bathing. Review of Resident # 2's care plan revised on	F 561	Resident # 2 received a shower on 10-11-18. Resident # 2 selected his shower schedule of his choice on 10-11-18. The Social Services Director/Social Services Assistant conducted a quality review of current residents shower schedule preference. Alert and oriented residents were interviewed for their preference of shower schedule on 10/24/18. Follow up based on findings. Director of Nursing/ Unit Managers provided re-education to social services and nursing staff on resident□s preferences regarding shower schedule,	

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F 561	Continued From page 2 10/12/18 revealed resident was care planned for behaviors and needing full staff assistance to bathe. Interview conducted on 10/08/18 at 2:35 PM with Resident #2 who said he not had a shower or a bed bath in eight weeks. Resident said the staff had told him they did not have time to give him a shower. The shower schedule was reviewed, and Resident # 2 was scheduled to receive baths on Wednesday and Saturday evenings. Review of bath refusal sheets for 9/18 and 10/18 revealed Resident # 2 had refused a shower two times. Nursing assistant documentation for Resident # 2's baths was reviewed for 9/18 and 10/18. The provided documentation did not have any showers recorded. Interview conducted with the Director of Nursing (DON) on 10/9/18 at 2:10 PM. DON verified that Resident # 2 had reported that he had not received a shower in eight weeks, and that he had refused to take a shower one day because his showers were scheduled for evenings. She advised she would make sure that resident would be showered that day. Interview conducted with NA # 25 on 10/9/18 at 3:14 PM. NA said Resident # 2 needed assistance with bathing and did not know if resident had received a shower lately. Interview conducted with NA # 26 on 10/10/18 at 8:43 AM. NA was unaware of Resident # 2 refusing baths, or when the resident had last had	F 561	shower schedule revision to reflect resident□s preferences and notifying Unit Manager/Director of nursing any concern regarding resident□s shower schedule from 11-3-18 through 11-6-18. Director of Nursing/Unit Manager to conduct random Quality Improvement Monitoring using a sample size of 10 residents 3 times weekly for 12 weeks, and then monthly to ensure residents are receiving showers as per the resident□s preference and schedule. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing monthly. Monitoring schedule modified based on findings.	

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F 561	Continued From page 3 a shower. Interview conducted with Nurse # 11 on 10/10/18 at 09:11 AM. Nurse had not been advised by staff that resident had not received his scheduled showers, or that resident had refused any showers. DON was interviewed on 10/11/18 at 10:45 AM. She advised Resident # 2 had received a shower on 10/9/18. She said the resident refuses showers at times. DON also advised she had changed resident's shower schedule to Wednesdays and Saturdays on day shift. DON said her expectations were for resident to receive showers as scheduled.	F 561		
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- (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	F 580		12/5/18

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F 580	Continued From page 4 §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 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, nurse practitioner, and physician interviews, the facility failed to notify the physician of a resident's physician's hypoglycemia (low blood sugar levels) and continued to administer insulin to 1 of 3 residents with insulin dependent diabetes (Resident # 59). The resident became unresponsive and had to be hospitalized with hypoglycemia.	F 580	The physician was notified of the low blood sugars of resident #59 and orders obtained for twice daily finger stick blood sugars with high and low parameters by the Director of Nursing on 10-26-18. Resident #59 is being monitored for signs/symptoms of low blood sugar and documented every shift on the medication administration record. The daughter of	

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F 580	Continued From page 5 Immediate Jeopardy began on 9/1/18 for Resident # 59 who was noted to have multiple low blood sugars for September 2018. On 10/2/18 at 6:00 AM the resident had a blood sugar level of 72 and was administered 4 units of insulin at 06:30 AM and 11:30 AM. The resident was hospitalized on 10/2/18 with a blood sugar level of 51. Immediate Jeopardy was removed on 10/29/18 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. Findings: Resident # 59 was admitted to the facility on 11/29/16 with a diagnoses of Type II Diabetes. Record review of Resident # 59's physician orders for 9/18 revealed the resident had the following orders: Novolin Regular 100 units (U)/1 milliliter (ML) - inject 4 units subcutaneously (SQ) with breakfast and lunch, Novolin Regular 100 units/1ML - use per sliding scale twice daily - 150-200 = 2 U; 201-250 = 4 U; 251-300 = 6 U; 301-350 = 8 U; 351-400 = 10 U, Blood sugar greater than 400 - Call physician, and Levemir 100 U/1ML - inject 24 units SQ at bedtime. Resident also had an order that stated, "Finger stick blood sugar (FSBS) of below 70 or greater than 400 notify physician." Record review of Resident # 59's Medication Administration Record (MAR) for September 2018 and October 2018 revealed resident had	F 580	Resident #59 was made aware of blood sugars below 70 and changes to orders on 10-26-18. Nurses failing to notify the physician of the low blood sugars were re-educated to notify the physician when the blood sugar is below 70 and document on 24 hours report for continued monitoring on 11-3-18. The Director of Nursing/Unit Managers conducted a quality review of residents with finger stick blood sugars to ensure parameters identified to notify MD and low blood sugars were identified and addressed on 10/26/18. Follow-up based on findings. The Director of Nursing/Unit Manager provided Nurses re-education on diabetic management to include sliding scale insulin and orders for finger stick blood sugars to include obtaining high/low parameters to notify MD from 11-3-18 through 11-6-18. The Director of Nursing/Unit Managers to conduct Quality Improvement Monitoring of 10 residents finger stick blood sugars daily for 4 weeks, then 5 times weekly for 8 weeks, then 1 time weekly for 4 weeks, and then monthly to ensure blood sugars obtained and notification of physician as ordered. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing monthly. Monitoring schedule modified based on findings.	

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F 580	Continued From page 6	F 580		

numerous days that blood sugars were recorded in the 60's. On 10/2/18 at 6:00 AM resident had a FSBS result of 72 and had 4 units of Novolin Regular insulin administered at 06:30 AM and 11:30 AM.

Record review of a hospital discharge summary dated 10/4/18 revealed Resident # 59 had a BS of 51 upon arrival at the ED. Resident was hospitalized from 10/2 - 10/4/18. The summary stated, "Per discussion with the staff at the nursing facility, resident had multiple readings of blood glucose in the 60s in the past couple of weeks. It was noted that she had poor oral intake for the past one to two weeks due to lack of appetite related to emotional distress due to the death of a family member. Given the resident's age and risk for hypoglycemia, her insulin regimen was modified to Levemir 5 U at bedtime." Resident's insulin sliding scale was discontinued.

An interview was conducted with Nurse #10 on 10/11/18 at 8:49 AM who said she was aware that Resident # 59' blood sugars went up and down. She stated she did not report it to the physician because resident did not seem to have any signs or symptoms in her overall condition.

An interview was conducted on 10/11/18 at 10:48 AM with the director of nursing (DON) who stated Resident # 59's blood sugars ranged from lower ranges to higher ranges. She was aware that resident had an order to report BS below 70 and above 400 to the physician but was not aware in September and October 2018 resident had numerous blood sugars recorded in the 60s. She said her expectation was for her managers to report any BS that were out of the physician

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F 580	Continued From page 7	F 580		

ordered BS ranges.

An interview was conducted with Nurse Practitioner (NP) on 10/11/18 at 12:41 PM. She was unaware Resident # 59's blood sugars had been in the 60s during September and October 2018. She said that the facility had reported to her that on 10/2/18 resident was unresponsive, and thought resident had a stroke. She gave an order to send the resident to the emergency room for evaluation. She said it was her expectation that the facility would report low blood sugars so that resident would be evaluated for possible treatment regimen changes.

An interview was conducted with physician on 10/11/18 at 12:52 PM. He was unaware Resident # 59's blood sugars had been in the 60s during 9/18 and 10/18 and was also unaware that resident had been hospitalized from 10/2-10/4/18. Physician stated it was his expectation for the facility to have notified him of resident's low blood sugars, and recent hospitalization. He said he if had been made aware of resident's blood sugars he would have assessed her for needed changes. He said he would see resident during his next visit to the facility on 10/15/18 for a follow-up visit.
On 10/26/18 at 09:45 AM the administrator was advised the facility was in immediate jeopardy for Resident # 59.

The facility provided credible allegation of compliance for immediate jeopardy as follows:

The process that led to this deficiency was the resident had numerous low blood sugars recorded in September and October 2018 that were not reported as per physician order to the

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physician. Review of Resident #59's medical record revealed the physician was notified on 10/26/18 of the low blood sugars in September. Resident #59 had new orders to check the blood sugar twice a day and call the physician if the value was below 70. Review of the October medication administration record revealed there were no blood sugars at or below 70.

An audit of all diabetic residents was conducted by the facility with no blood sugars below a value of 60 recorded for the residents.

A review of the medical records for a survey sample of residents that were insulin dependent revealed the physician orders were written, transcribed to the medication administration record per their plan of correction. Review of the blood sugars of the sampled residents revealed blood sugars were checked according to the physician orders and no blood sugars were below a value of 70.

A review of the in-service training for the nurses and all non-nursing employees was reviewed. The topics covered in the in-services were the areas identified in the facility's plan of correction.

The Administrator is responsible for submitting the plan of correction and for monitoring insulin dependent residents blood sugars.

The immediate jeopardy was removed after it was verified on 10/29/18 at 12:15 PM as evidenced by:

Interviews were conducted of various staff that included nurses and non-nursing employees. Interviews revealed the staff were knowledgeable

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F 580	Continued From page 9 of the information provided in the in-services regarding diabetics, monitoring, reporting and notification of the physician.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for behaviors for 1 of 6 sampled residents reviewed for MDS accuracy (Resident #41.) Findings: Resident # 41 was admitted to the facility on 2/1/18. Her diagnoses included: Anxiety, depression, manic depression, repeated falls, end stage renal disease, chronic pain, and attention and concentration deficit. Reviewed Resident # 41's quarterly Minimum Data Set (MDS) dated for 8/21/18. Resident had moderately impaired cognition. She required extensive assistance with her activities of daily living (ADLs.) She was coded as a zero (behaviors not exhibited) for behaviors and rejection of care. Resident # 41's care plan, last reviewed 10/19/18, revealed the resident was non-compliant with: fluid restrictions, going to dialysis, and asking for assistance with transfers.	F 641	Resident #41 MDS assessment with ARD of 8-21-18 was modified by the MDS coordinator on 11-26-18. The MDS Coordinator conducted a quality review of the most recent OBRA assessment of residents whom are care planned for care refusals to ensure accuracy completed on 11-30-18. Follow-up based on findings. The Regional MDS Coordinator provided re-education to the MDS Coordinator, Social Services Director and Assistant Social Services on coding of section E to include coding of care refusals on 11-21-18. The MDS Coordinator to conduct Quality Improvement Monitoring using a sample size of 10 residents MDS section E 2 times weekly for 12 weeks, and then monthly to ensure care refusals are coded appropriately. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement	12/5/18

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F 641	Continued From page 10 Review of Resident # 41's physicians' orders for 10/18 revealed resident had a daily 1500 milliliter (ML) fluid restriction ordered and an order to go to dialysis for treatment three times a week. According to nurses' notes, resident # 41 refused to go to dialysis on the following dates: 5/28, 6/16, 8/28, 9/5, and 9/17/18. An Interdisciplinary Team (IDT) meeting note dated for 7/18/18 revealed that resident refused dialysis at times and was noncompliant with her medical restrictions. Interview conducted on 10/10/18 at 08:51 AM with Nurse # 11 who stated that Resident # 41 frequently refused care and refused to go to dialysis treatments at times. Interview with DON conducted at 10/11/18 at 09:30 AM. She said Resident # 41 was noncompliant with care. She said her expectations were for the MDS to be coded accurately. Interview conducted with MDS coordinator on 10/11/18 10:47 AM about Resident # 41's last MDS. She said the former facility social worker had completed the behavior section of that MDS, and she would talk to current facility social worker about accurate coding for behaviors and rejection of care.	F 641	Committee by the MDS Coordinator monthly. Monitoring schedule modified based on findings.	
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	F 684		12/5/18

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F 684	Continued From page 11 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, nurse practitioner, and physician interviews, the facility failed to obtain physician's orders to treat hypoglycemia (low blood sugar levels) and continued to administer insulin to 1 of 3 residents with insulin dependent diabetes (Resident # 59). The resident became unresponsive and had to be hospitalized with hypoglycemia. Immediate Jeopardy began on 10/2/18 for Resident # 59 when the resident had a blood sugar level of 72 and was administered 4 units of insulin at 06:30 AM and 11:30 AM. The resident was hospitalized on 10/2/18 with a blood sugar level of 51. Immediate Jeopardy was removed on 10/29/18 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. Findings: Resident # 59 was admitted to the facility on 11/29/16 with diagnoses of: Type II Diabetes Mellitus, Alzheimer's disease, congestive heart failure, and ischemic cardio myopathy. Record review of Resident # 59's quarterly	F 684	The physician was notified of the low blood sugars of resident #59 and orders obtained for twice daily finger stick blood sugars with high and low parameters by the Director of Nursing on 10-26-18. Resident #59 is being monitored for signs/symptoms of low blood sugar and documented every shift on the medication administration record. The daughter of Resident #59 was made aware of blood sugars below 70 and changes to orders on 10-26-18. Nurses failing to notify the physician of the low blood sugars were re-educated to notify the physician when the blood sugar is below 70 and document on 24 hours report for continued monitoring on 11/3/18. The Director of Nursing/Unit Managers conducted a quality review of residents with finger stick blood sugars to ensure parameters identified to notify MD and low blood sugars were identified and addressed on 10-26-18. Follow-up based on findings. The Director of Nursing/Unit Manager provided Nurses re-education on diabetic management to include sliding scale insulin and orders for finger stick blood sugars to include obtaining high/low parameters to notify MD from 11-3-18	

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F 684	Continued From page 12 minimum data set (MDS) assessment dated for 09/12/18 revealed resident was cognitively intact and was not coded for behaviors. Resident required extensive staff assistance with her activities of daily living (ADLs.) Record review of Resident # 59's care plan revised on 10 /4/18 revealed resident was at risk for complications related to diabetes mellitus. The care plan further revealed to monitor resident for signs and symptoms of hypoglycemia, and to report any changes in condition to the physician. An interview was conducted with Resident # 59 on 10/08/18 at 9:53 AM who advised she had recently been in the hospital due to "too much insulin." Record review of Resident # 59's physician orders for September 2018 revealed the resident had the following orders: Novolin Regular 100 units (U)/1 milliliter (ML) - inject 4 units subcutaneously (SQ) with breakfast and lunch, Novolin Regular 100 units/1ML - use per sliding scale twice daily - 150-200 = 2 U; 201-250 = 4 U; 251-300 = 6 U; 301-350 = 8 U; 351-400 = 10 U, Blood sugar greater than 400 - Call physician, and Levemir 100 U/1ML - inject 24 units SQ at bedtime. Resident also had an order that stated, "Finger stick blood sugar (FSBS) of below 70 or greater than 400 notify physician. Record review of Resident # 59's Medication Administration Record (MAR) for September 2018 and October 2018 revealed resident had numerous days that blood sugars were recorded in the 60's. On 10/2/18 at 6:00 AM resident had a FSBS result of 72 and had 4 units of Novolin Regular insulin administered at 06:30 AM and 11:30 AM.	F 684	through 11-6-18. The Director of Nursing/Unit Managers to conduct Quality Improvement Monitoring of 10 residents finger stick blood sugars 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then 1 time weekly for 4 weeks, and then monthly to ensure blood sugars obtained and notification of physician as ordered. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing monthly. Monitoring schedule modified based on findings. . F689-Quality of Care A fall mat was placed beside Resident #228s bed on 10-12-18. The Director of Nursing/Unit Managers conducted a quality review of current residents with fall mats to ensure mats were in place per plan of care on 10-15-18. Follow-up based on findings. The Director of Nursing/Unit Managers provided re-education to nursing staff and department managers on utilization of fall mats per residents plan of care for safety on 10-16-18. The Director of Nursing/Unit Managers to	

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F 684	Continued From page 13 A review of the nurse's note for 10/2/18 at 12:30 PM revealed Resident # 59 was unresponsive, and a physician's order was obtained for the resident to be sent to the hospital emergency department (ED) for evaluation. Record review of an EMS transfer report dated 10/2/18 at 12:45 PM revealed Resident # 59 was treated for hypoglycemia. The report further revealed, "Arrived to find resident alone in her room supine on her bed. Nursing staff advised resident had been having altered mental status changes for two days, but resident had worsened 30 minutes earlier. The resident was conscious and alert but had slurred speech with weakness noted on both sides of the body. Vitals were obtained and a FSBS of 35 was noted. Staff was unable to advise of last check of BS. Intravenous (IV) access was established and Dextrose 50 % fluids were administered. Several minutes later FSBS was rechecked with a result of 328. Resident began speaking normally and the weakness had subsided. Resident's stroke screen was negative." Record review of a hospital discharge summary dated 10/4/18 revealed Resident # 59 had a BS of 51 upon arrival at the ED. Resident was hospitalized from 10/2 - 10/4/18. The summary stated, "Per discussion with the staff at the nursing facility, resident had multiple readings of blood glucose in the 60s in the past couple of weeks. It was noted that she had poor oral intake for the past one to two weeks due to lack of appetite related to emotional distress due to the death of a family member. Given the resident's age and risk for hypoglycemia, her insulin regimen was modified to Levemir 5 U at	F 684	conduct random Quality Improvement Monitoring using a sample size of 5 residents with fall mats 3 times weekly for 12 weeks, and then monthly to ensure fall mat in place per resident□s plan of care for safety. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing Monthly. Monitoring schedule modified based on findings.	

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bedtime." Resident's insulin sliding scale was discontinued.

An interview was conducted with nursing assistant (NA)# 26 on 10/11/18 at 8:44 AM who stated resident ate fairly well but had not been eating as well over the past couple of weeks. She did not report it to the nurse because the resident snacked on foods that her family brought in for her.

An interview was conducted with Nurse #10 on 10/11/18 at 8:49 AM who said she was aware that Resident # 59' blood sugars went up and down. She stated she did not report it to the physician because resident did not seem to have any signs or symptoms in her overall condition.

An Interview was conducted on 10/11/18 at 10:48 AM with the director of nursing (DON.) DON stated Resident # 59's blood sugars ranged from lower ranges to higher ranges. She stated Resident was a picky eater who ate food and snacks provided by her family. On 10/2/18 the DON said she thought the resident had a stroke and had obtained an order to send resident to the emergency room for evaluation. She was aware that resident had an order to report BS below 70 and above 400 to the physician but was not aware in September and October 2018 resident had numerous blood sugars recorded in the 60s. She said her expectation was for her managers to report any BS that were out of the physician ordered BS ranges.

An interview was conducted with Resident # 59's daughter/power of attorney (POA) on 10/11/18 at 12:18 PM. She revealed the facility had called to advise her the resident was being sent to the

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hospital for a possible stroke on 10/2/18.
An interview was conducted with Nurse Practitioner (NP) on 10/11/18 at 12:41 PM. She was unaware Resident # 59's blood sugars had been in the 60s during September and October 2018. She said that the facility had reported to her that on 10/2/18 resident was unresponsive, and thought resident had a stroke. She gave an order to send the resident to the emergency room for evaluation. She said it was her expectation that the facility would report low blood sugars so that resident would be evaluated for possible treatment regimen changes.

An interview was conducted with physician on 10/11/18 at 12:52 PM. He was unaware Resident # 59's blood sugars had been in the 60s during 9/18 and 10/18 and was also unaware that resident had been hospitalized from 10/2-10/4/18. Physician stated it was his expectation for the facility to have notified him of resident's low blood sugars, and recent hospitalization. He said he if had been made aware of resident's blood sugars he would have assessed her for needed changes. He said he would see resident during his next visit to the facility on 10/15/18 for a follow-up visit.

On 10/26/18 at 09:45 AM the administrator was advised the facility was in immediate jeopardy for Resident # 59.

The facility provided credible allegation of compliance for immediate jeopardy as follows:

The process that led to this deficiency was the resident had numerous low blood sugars recorded in September and October 2018 that were not reported as per physician order to the

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physician. Review of Resident #59's medical record revealed the physician was notified on 10/26/18 of the low blood sugars in September. Resident #59 had new orders to check the blood sugar twice a day and call the physician if the value was below 70. Review of the October medication administration record revealed there were no blood sugars at or below 70.

An audit of all diabetic residents was conducted by the facility with no blood sugars below a value of 60 recorded for the residents.

A review of the medical records for a survey sample of residents that were insulin dependent revealed the physician orders were written, transcribed to the medication administration record per their plan of correction. Review of the blood sugars of the sampled residents revealed blood sugars were checked according to the physician orders and no blood sugars were below a value of 70.

A review of the in-service training for the nurses and all non-nursing employees was reviewed. The topics covered in the in-services were the areas identified in the facility's plan of correction.

The Administrator is responsible for submitting the plan of correction and for monitoring insulin dependent residents blood sugars.

The immediate jeopardy was removed after it was verified on 10/29/18 at 12:15 PM as evidenced by:

Interviews were conducted of various staff that included nurses and non-nursing employees. Interviews revealed the staff were knowledgeable

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F 684	Continued From page 17 of the information provided in the in-services regarding diabetics, monitoring, reporting and notification of the physician.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement a floor mat beside the bed for 1 of 4 (Resident # 228) reviewed for accidents. Findings included: Resident #228 was admitted to the facility on 4/30/18 with diagnoses of chronic obstructive pulmonary disease, atrial fibrillation and a history of falls. Review of the 30 day Minimum Data Set (MDS) assessment dated 8/21/18 revealed the resident had moderately impaired cognition. She required extensive assistance with 2 people for bed mobility, transfers, ambulating, dressing, toileting and hygiene. She was frequently incontinent of bowel and bladder. A review of the care plan revealed a problem for risk for falls related to forgetfulness, physical	F 689	The physician was notified of the low blood sugars of resident #59 and orders obtained for twice daily finger stick blood sugars with high and low parameters by the Director of Nursing on 10-26-18. Resident #59 is being monitored for signs/symptoms of low blood sugar and documented every shift on the medication administration record. The daughter of Resident #59 was made aware of blood sugars below 70 and changes to orders on 10-26-18. Nurses failing to notify the physician of the low blood sugars were re-educated to notify the physician when the blood sugar is below 70 and document on 24 hours report for continued monitoring on 11/3/18. The Director of Nursing/Unit Managers conducted a quality review of residents with finger stick blood sugars to ensure parameters identified to notify MD and low	12/5/18

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F 689	Continued From page 18 limitations, a history of falls and failure to utilize call bell consistently. Interventions included quarter side rails, give support and encouragement during transfers and ambulation, and provide assistance if resident observed ambulating unassisted. Interventions updated on 6/8/18 included a bed alarm and on 6/27/18 placing the bed against the wall and utilizing a fall mat beside the bed. A record review revealed resident had a fall on 6/8/18 from her bed while trying to get up unassisted. A bed alarm was initiated. A review of the Kardex revealed a fall mat to floor added on 6/27/18. An observation on 10/10/18 at 3:39 PM revealed the resident lying in bed with no fall mat on floor. An observation on 10/11/18 at 8:47 AM revealed the resident lying in bed with no fall mat on floor. An interview on 10/11/18 at 9:59 AM with nursing assistant #3 revealed she knew what the residents safety needs were from the Kardex. She stated she didn't know where the fall mat for Resident #228 was and looked under and around the bed. An interview on 10/11/18 at 10:07 with Nurse #1 revealed Resident #228 was a fall risk and did try to get up unassisted. She found the fall mat behind Resident #228's bed and stated the nursing staff didn't put it down and must have overlooked it. An interview on 10/11/18 at 12:15 PM with the Director of Nursing revealed Resident #228 only	F 689	blood sugars were identified and addressed on 10-26-18. Follow-up based on findings. The Director of Nursing/Unit Manager provided Nurses re-education on diabetic management to include sliding scale insulin and orders for finger stick blood sugars to include obtaining high/low parameters to notify MD from 11-3-18 through 11-6-18. The Director of Nursing/Unit Managers to conduct Quality Improvement Monitoring of 10 residents finger stick blood sugars 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then 1 time weekly for 4 weeks, and then monthly to ensure blood sugars obtained and notification of physician as ordered. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing monthly. Monitoring schedule modified based on findings.	

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F 689	Continued From page 19 had one fall since admission. She stated she did expect safety interventions to be in place according to the care plan.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to dispose/discard expired medications in 1 of 2 medication storage rooms (Meadowview Storage Room.)	F 761	The back up narcotic Morphine Sulfate extended release 15mg was removed from circulation on 10-12-18 by the Director of Nursing.	12/5/18

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F 761	Continued From page 20 Findings included: A review of the facility policy titled, "Medication Storage In The Facility" with an effective date of 12/1/17, that was provided by the Director of Nursing (DON) read in part: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal. An observation of the Meadowview facility medication storage room was conducted on 10/11/18 at 9:35 am. During the observation, there were ten tablets of, Morphine Sulfate Extended Release 15 milligrams (mg) noted to have an expiration date of 4/18 in the house stock medication lock box. During an interview with Nurse #10 at 9:49 AM on 10/11/18, the nurse verified that the tablets were expired. She said the tablets should have been discarded. An interview was conducted with the Director of Nursing (DON) on 10/11/18 at 10:50 AM. The DON validated that the tablets were expired and should have been discarded.	F 761	The Director of Nursing conducted a quality review of narcotics in back up on 10-12-18 to ensure all medications are in date. Director of Nursing provided Nurses re-education on prevention and monitoring of expired medications from 11/3/18-11/6/18. Director of Nursing to conduct Quality Improvement monitoring on back up narcotics 3 times weekly for 12 weeks, and then monthly to ensure all medications are in date. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing Monthly Monitoring schedule modified based.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/5/18

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 22 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to ensure staff used personal protective equipment when providing care and maintained the resident's wheel chair in the resident's room for one (Resident #69) of two residents on contact isolation precautions. The findings included: The facility policy and procedure dated 7/2016 for precautions to be used for residents with multi-drug resistant organisms (MRDO) revealed staff would use standard precautions as the primary approach to prevent transmission. The staff and practitioner would evaluate each individual known or suspected to have infection and initiate contact precautions on a case by case basis. Risks for transmission (included in	F 880	Resident #69 was removed from contact isolation on 10-10-18. Director of nursing was re-educated by the Executive Director on contact precautions on 10/10/18. The Director of Nursing re-educated NA#1, NA#2 and housekeeper on contact precautions to include wearing of personal protective equipment and handwashing. The Director of Nursing/Unit Managers conducted a quality review of current residents on isolation precautions to ensure contact isolation being observed with wearing protective personal equipment and handwashing practice on 10-12-18. Follow-up based on findings.	

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	345089	A. BUILDING _____ B. WING _____	C 10/29/2018

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F 880	Continued From page 23 part) personal hygiene of the resident (i.e. handwashing, keeping hands away from infected/colonized areas) and total dependence for activities of daily living. Environmental precautions included non- critical resident-care items will be dedicated for individual use or decontaminated prior to use with another resident. Resident #69 was re- admitted to the facility on 9/12/18 with diagnoses including dementia, malnutrition and pneumonia. Review of the significant change Minimum Data Set (MDS) dated 9/19/18 indicated Resident #69 had severe impairment with short and long-term memory, had behaviors of physically directed towards others, and behaviors not directed towards other such as screaming or scratching self. This MDS indicated Resident #69 required extensive to total assistance with activities of daily living and was incontinent of bowel and bladder. Review of a lab result for a culture and sensitivity report dated 10/3/18, indicated Resident #69 had a urine that grew a MDRO organism greater than 100,000 colony count per milliliter of urine. The organism was VRE (vancomycin resistant E. Coli). Review of a telephone order dated 10/5/18 for contact precautions and administration of an antibiotic orally every 12 hours for three days. Observations on 10/8/18 at 11:08 AM revealed nursing assistant (NA) #2 entered the room of Resident #69. The NA did not put on a gown or gloves before entering the room. An over the door container of personal protective equipment (PPE) was observed on the resident's door. There was no signage indicating if the one of the two residents were on isolation. The NA#2 gave Resident #69 a drink of juice. Upon leaving the	F 880	The Director of Nursing/Unit Manager provided staff re-education on isolation precaution to include wearing of personal protective equipment and handwashing practice from 11/3/18-11/6/18. The Regional Director of Housekeeping services re-educated the housekeeping staff on contact isolation to include placement of the cart when cleaning of isolation room, use of gloves when changing out mop heads with use of personal protective equipment, and handwashing practice on 11/21/18. Director of Nursing/Unit Managers to conduct random Quality Improvement Monitoring on residents on isolation to ensure contact isolation precautions are maintained by observation of staff to ensure personal protective equipment in use, handwashing complete and housekeeping staff maintain isolation with placement of housekeeping cart and wearing of gloves and personal protective equipment 3 times weekly for 12 weeks, and then monthly. The Housekeeping Supervisor to conduct random Quality Improvement Monitoring on changing mop heads by housekeeping staff to ensure proper infection control practices 3 times weekly for 12 weeks, and then monthly. The results of the Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing and Housekeeping Supervisor respectively monthly. Monitoring schedule modified based on findings.	

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room she did not wash her hands.

Observations on 10/8/18 at 11:15 AM the supply clerk entered the room of Resident #69. She offered the resident a drink of juice, pulled the privacy curtain between the two beds and turned off the call bell at the wall. The supply clerk did not put on a gown or gloves. She used hand sanitizer in the hallway after leaving the room and pushed a cart down with respiratory supplies down the hall.

Observations on 10/8/18 at 11:30 AM revealed the Director of Nursing (DON) entered the room of Resident #69 and did not put a gown or gloves on before entering the room. The DON knelt on the floor looking for something for the roommate of Resident #69.

Interview with NA#2 on 10/08/18 at 11:11 AM revealed she didn't usually work on that hall. She explained she had provided care for Resident #69's roommate. She further explained the resident in A bed (Resident #69) was on precautions, and she was not sure for what. During the interview she explained she did not know if she needed a gown on since she provided care for the roommate.

Observations of NA#2 on 10/08/18 at 11:13 AM revealed she left room, put soiled items in a dirty cart with her bare hands and entered another resident's room. After entering the other resident's room, she touched the door knob, went into the bathroom and washed her hands.

Observations on 10/8/18 at 12:30 PM revealed NA#1 obtained a high-back wheelchair from another hall, put on a gown and gloves and

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entered Resident #69's room. Resident #69 was observed in a wheelchair for her lunch.

Observations on 10/08/18 at 2:59 PM revealed housekeeper #1 put on a gown, gloves and a mask. He brought Resident #69 out of her room and left her in the middle of the hallway in her wheelchair. Housekeeper #1 cleaned the wall around Resident #69's bed. He then came out of the room, walked around the housekeeping cart and got the mop out of the mop bucket. He mopped the floor and continued past door threshhold. He kept the same gloves and gown on, got bottles of cleaning solution and air freshener out of the cart. Once the cleaning of the room was completed, he came out of the room, placed the items in the cart with his gloved hands, put the mot in the mop bucket and removed his gown and gloves. There was some liquid on the floor around the housekeeping cart. He used a rage on the floor, using his foot to mop up the water. The housekeeping director was in attendance with housekeeper #1 during the room cleaning.

Observations on 10/8/18 at 3:15 PM revealed housekeeper #1 took his cart to the housekeeping closet. He explained he was going to change the water in the mop bucket and change the mop head. He was observed picking up the mop head with bare hands. Immediately after this observation, an interview with housekeeper #1 revealed the mop head was just used to mop the floor in Resident #69's room. He didn't put gloves on because he forgot.

Observation on 10/8/18 at 3:31 PM revealed Resident #69 sitting in a different type of wheelchair from the observations made at 12:30

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PM that day.

Interview with NA#1 on 10/10/18 at 8:53 AM revealed she had gone to another hall to look for Resident #69's wheelchair. She explained it was a high back chair and was located on another hall. Further interview revealed therapy had worked with the resident and had provided the different wheelchair on 10/9/18. During the interview, she did not know why the high back wheelchair was on another hall.

Interview with the occupational therapist on 10/10/18 at 8:58 AM revealed she had switched out the chairs yesterday. Further interview revealed she was aware the resident was on contact precautions and to wear a gown and gloves when in her room. She had no knowledge where the high back wheelchair was located.

Interview with the housekeeping supervisor on 10/10/18 at 9:22 AM revealed a gown and gloves would be required for cleaning a room with contact isolation. She would expect the housekeeper to remove their gown and gloves and put them in the trash after cleaning and before going into the hallway. The housekeeping cart should be at the doorway of the room, with the door to the cart facing the resident's room. The housekeepers could remove items from the cart and get the mop without leaving the room. She was not aware housekeeper #1 came out of the room wearing the gown and gloves. She further explained he should have put gloves on to remove the used mop head when changing it. During the interview, she explained the resident on contact precautions was in B bed (Resident #69's roommate) and she was not aware it was Resident #69. Housekeeping would be informed

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during morning department head meeting of any residents on isolation precautions. They had not had the meeting on 10/8/18.

Interview on 10/10/18 at 2:11 PM with the DON revealed department heads would be informed of residents on isolation during the morning meeting. The DON was asked how other departments would be informed if the morning meeting did not happen. She replied she did not have another means of communication in place. She would expect staff to use PPE, and remove the PPE when coming out of the room when providing care for a resident on contact precautions. During the interview, she was asked if she had surveillance of staff infection control practices. The DON explained she had surveillance of staff but did not have for isolation on a routine basis. The policy and procedure for contact isolation for VRE was reviewed with the DON. She explained the resident was incontinent but wore a brief which would contain the urine. She could not ensure Resident #69 would have good hygiene practices per policy. Further interview revealed she was not aware the isolation sign had not been posted on the door, or the wheelchair was removed from the room. She explained the wheelchair should have remained in Resident #69's room.