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	345260	A. BUILDING _____ B. WING _____	C 01/09/2025

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ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/7/25 through 1/9/25. The following intakes were investigated NC00225395, NC00225354, and NC00225613. Intake NC00225395 resulted in immediate jeopardy. 2 of the 12 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/15/24 and was removed on 1/8/25. A partial extended survey was conducted.	F 000		
F 580 SS=D	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,	F 580		1/29/25

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

Electronically Signed | 01/27/2025

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F 580	Continued From page 1 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 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, and staff, Medical Director, and Physician Assistant interviews the facility failed to notify the physician that Resident #22 had a critically low blood glucose requiring	F 580	1. On 12/15/24 Nurse # 2 notified the on-call provider that Emergency Medical Service had been called to the facility at approximately 8:50 am regarding	

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F 580	Continued From page 2 Emergency Medical Services (EMS) intervention for 1 of 4 residents reviewed for notification of change in condition (Resident #22). The findings included: Resident #22 was admitted to the facility on 12/3/24 with diagnoses that included Diabetes Mellitus Type 2. Review of the admission Minimum Data Set (MDS) Assessment dated 12/9/24 revealed Resident #22 was cognitively intact. He was coded as receiving hypoglycemic medication during the look back period. Review of the Emergency Medical Services (EMS) patient care record report dated 12/15/24 revealed they were contacted at 8:51 AM for a male patient with a possible stroke. The EMS report revealed they arrived on scene at 8:58 AM and to Resident #22's bedside at 8:59 AM. Resident #22's blood glucose was obtained, and he had a blood glucose of 46 (normal blood glucose level is 70-100 milligrams per deciliter [mg/dL]). Resident #22 was administered dextrose 10% 100 milliliters via IV (intravenous). At 9:06 AM Resident #22 became alert and started to speak. Resident #22 refused to be transported to the Emergency Room (ER). Review of the medical record revealed no documentation in the nurses notes for notification of the physician on 12/15/24 (Sunday). An interview was conducted with Nurse #1 on 1/8/25 at 6:15 AM. Nurse #1 stated she was the primary nurse on the East Hall where Resident #22 resided on 12/15/24. Nurse #1 stated she	F 580	Resident #22. EMS identified a critically low Blood sugar (46) resident received 10% IV Dextrose. The resident immediately became alert and started speaking but he refused to be transported to the Emergency Room (ER). On 12/15/24 Nurse #2 obtained orders to monitor resident #22 blood sugar four times daily. 2. On 1/20/2025 the Regional Clinical Director performed a 14 day look back of the 24-hour report and the change in condition evaluation on current residents to ensure the Provider and the Responsible Party were notified. No issues were identified. 3. On 1/20/2025 the Director of Nursing/designee began reeducation to licensed nurses on the E Interact Change in condition with a focus on recognizing the signs and symptoms of Hyper/Hypoglycemia and notification to the medical provider. All Certified Nursing Assistants were provided reeducation on the Stop and Watch procedure when they notice a change in the resident's condition and who to report the change to. Beginning 1/20/25 the Director of Nursing / designee provided education to licenses nurses regarding notification to the medical provider when resident identified with change of condition to include hypoglycemia/ hyperglycemia outside resident parameters and/or requiring Emergency Medical Services. The education will be completed by 1/29/25. Any licensed Nurse or Nursing Assistant	

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F 580	Continued From page 3 was called to Resident #22's room and observed he had a change in his level of consciousness. Nurse #1 stated she called 911. Nurse #1 stated she did not call the physician because her priority was to take care of the resident. Nurse #1 stated she never called the physician to report the critically low blood glucose level. An interview was conducted with Nurse #2 on 1/7/25 at 4:03 PM. Nurse #2 stated she worked 3:00 PM to 11:00 PM on 12/15/24 and was informed about Resident #22 having a low blood glucose during the morning shift and EMS being called. She indicated she notified the on-call physician during her shift to get an order for blood glucose checks four times a day. An interview was conducted with Physician Assistant #1 on 1/8/25 at 10:22 AM. PA #1 stated she was aware that Resident #22 had an incident of hypoglycemia. PA #1 further stated she was unsure of whether she had been made aware of the incident directly. PA #1 stated she received report from the weekend provider that Resident #22 had a low blood glucose. She stated she did not recall being notified that EMS was called. PA #1 stated she would have expected Nurse #1 to make the physician aware of the change in resident condition. An interview was conducted with the Medical Director on 1/8/25 at 11:07 AM. The Medical Director confirmed Nurse #1 did not notify the physician of Resident #22's change in status that required EMS intervention. An interview was conducted with the Director of Nursing on 1/8/25 at 9:46 AM. The DON stated she had not been notified that Resident #22 had	F 580	including agency staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this education by the Director of Nursing/designee. Newly hired nurses/certified nursing assistants including agency nurses/certified nursing assistants will receive this education during their orientation period. 4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor the 24-hour report and the Change in Condition Evaluation during the Clinical Morning Meeting to ensure the Provider/Responsible Party were notified change in condition to include critically low or high blood sugars or requiring EMS intervention Monitoring will be done 5x weekly for 12 weeks. The Center Administrator held a Quality Assurance Performance Improvement meeting on 1/21/2025 with the Interdisciplinary Team (IDT) including the Director of Nursing, Social Services, MDS Coordinator, Business Office Manager, Activities Director, Admissions Director, and Unit Manger with focusing on the area of F580 Notification of Change. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring or as it is amended by the committee.	

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F 580	Continued From page 4 low blood glucose and EMS was called to the facility. The DON stated Nurse #1 should have notified the physician and followed up with her.	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, and staff, Physician Assistant and Medical Director interviews, the facility failed to implement physician orders for diabetes care for Resident #22 who was diagnosed with diabetes prior to contacting emergency medical services (EMS) for a change in condition and ensuring immediate action was taken for a resident who required emergent medical care. Physician orders were available regarding checking blood sugar for hypoglycemia (a condition in which your blood sugar (glucose) level is lower than the standard range), acting on low blood sugar, administering medications to quickly treat hypoglycemia and notifying the physician. On 12/15/24 at approximately 8:00 AM/8:15 AM, Resident #22 had slurred speech and was unable to sit up on the side of the bed followed by a change in level of consciousness. Nurse #1 did not know Resident #22 had diabetes. Nurse #1 did not assess Resident #22 for signs and symptoms of hypoglycemia. Nurse	F 684	1. Resident # 22 no longer resides in the facility. 2. On 1/7/25 an audit of all current residents with a diagnosis of diabetes was performed by the Director of Nursing to ensure diabetic orders were in place. The audit also included: Review of the last 14 days of the 24-hour summary was completed by the Director of Nursing to identify any change in condition with MD/RP notification to ensure that medical treatment was provided timely. The audit did not identify any residents that did not receive medical treatment timely. Review of the last 14 days of blood sugars that were below 70 or greater than 400 was performed by the Director of Nursing to ensure appropriate interventions and notifications were completed. The audit did not identify any residents that did not receive appropriate interventions or	1/29/25

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F 684	Continued From page 5 #1 did not check Resident #22's blood sugar. Nurse #1 did not administer any medication to Resident #22 to reverse the effects of low blood sugar. Failure to act on the existing diabetes care physician orders resulted in a delay in treating Resident #22's hypoglycemia. Nurse #1 notified EMS at 8:51 AM about Resident #22's change in the level of consciousness and told EMS the resident did not have diabetes. Resident #22 was unresponsive upon EMS arrival. EMS determined Resident #22 s blood glucose was critically low. EMS administered dextrose and Resident #22 became alert and started to speak. This deficient practice was identified for 1 of 4 residents reviewed for diabetes care (Resident #22). Immediate jeopardy began on 12/15/24 when Nurse #1 failed to recognize and treat signs and symptoms of hypoglycemia. Immediate jeopardy was removed on 1/8/25 when the facility implemented a credible allegation of Immediate jeopardy removal. The facility still remains out of compliance at a lower scope and level of severity D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Resident #22 was admitted to the facility on 12/3/24 with diagnoses that included transient ischemic attack, chronic kidney disease and diabetes mellitus (DM) type 2. Review of physician orders dated 12/3/24 included:	F 684	notification was not completed. 3. On 1/7/2025, education was provided by the Director of Nursing to Licensed Nurses, including agency licensed nurses, related to the facility policy on hypoglycemia and hypoglycemia. To include obtaining blood glucose levels as needed for signs and symptoms of hypo/hyperglycemia. The education also included reviewing resident medication administration records and diagnosis list to determine residents with Diabetes Mellitus. The education will be completed by 1/29/25. Licensed Nurse including agency staff that cannot be reached within the initial education time frame will not take an assignment until they have received this education by the Director of Nursing/designee. Newly hired nurses including agency nurses will receive this education during their orientation period. 4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor the 24-hour report and the Change in Condition Evaluation during the Clinical Morning Meeting to ensure the Provider/Responsible Party were notified of change in condition to include critically low or high blood sugars or requiring EMS intervention . Monitoring will be done 5x weekly for 12 weeks. The Director of Nursing will report on the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring or as it is	

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F 684	Continued From page 6 - Januvia Oral Tablet 25 milligrams (mg)- Give 1 tablet by mouth one time a day for DM -Glipizide Extended-Release Oral Tablet 24 Hour 10 milligrams (mg)- Give 1 tablet by mouth one time a day for DM Review of physician orders dated 12/5/24 included: - Fingerstick as needed for signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. - If finger stick blood sugar is less than 70 and the resident is alert and responsive, give milk and graham cracker or instant glucose. Recheck blood sugar in 15 minutes. If blood sugar remains low or resident declines taking milk and graham cracker, give insta-glucose gel (used to raise dangerously low blood glucose concentration) as ordered. - Glucagon- Inject 1 mg intramuscularly (This injection is administered to quickly treat patients with diabetes who experience unexpected episodes of severe hypoglycemia.) as needed for low blood sugar one time only. If unconscious &/or unable to swallow and blood sugar is below 40. - Oral Glucose Gel- Give 1 application by mouth as needed for low blood sugar one time only. If the resident is symptomatic, alert and responsive &/or able to swallow and blood sugar is below 70. -Notify provider for additional orders if fingerstick	F 684	amended by the committee.	

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blood sugar remains less than 70 or greater than 400 after current orders being followed

The admission Minimum Data Set (MDS) Assessment dated 12/9/24 revealed Resident #22 was cognitively intact. The diagnoses included diabetes mellitus. He was coded as receiving hypoglycemic medication during the assessment period.

The care plan initiated on 12/9/24 revealed Resident #22 had an altered endocrine system status related to diabetes. The goal was for Resident #22 to have decreased risk of complications related to altered endocrine system. The interventions included: Observe signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Observe for signs and symptoms of behavioral changes: nervousness, increased irritability, insomnia, extreme fatigue, confusion, disorientation, delirium, psychosis, stupor, coma.

An interview was conducted with Nurse Aide (NA) #1 on 1/8/25 at 11:35 AM. NA#1 stated she was assigned to Resident #22 on 12/15/24 from 7:00 AM to 3:00 PM. NA#1 stated she went in to assist Resident #22 with getting setup for breakfast and sitting on side of the bed. She reported Resident #22 had slurred speech, facial drooping and he was unable to sit up on the side of bed. NA# 1 stated she went to get Nurse #1 immediately.

An interview was conducted with Nurse #1 on 1/8/25 at 6:15 AM. Nurse #1 stated she was the primary nurse on the East Hall where Resident #22 resided and was assigned to the resident on

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12/14/24 at 11:00 PM until 7:00 AM on 12/15/24 and also from 7:00 AM to 3:00 PM on 12/15/24. Nurse #1 stated she was called to Resident #22's room at approximately 8:00/8:15 AM, close to shift change. Nurse #1 stated she observed Resident #22 had a change in his level of consciousness and called EMS. Nurse #1 stated she assessed Resident #22 was having difficulty speaking and appeared to be in a semiconscious state. She reported vital signs were obtained but no blood glucose was done. Nurse #1 stated she did not know Resident #22 had a diagnosis of diabetes. Nurse #1 reported Resident #22 had been fine and there were no issues during the 11:00 PM - 7:00 AM shift. Nurse #1 stated she did not inform the physician of Resident #22's change in status because she was concerned the resident was exhibiting signs and symptoms of a stroke and wanted to get EMS on the way. Nurse #1 stated when EMS arrived, they got a set of vital signs and a blood glucose which indicated Resident #22 had a critically low glucose reading. Nurse #1 stated when EMS treated Resident #22 with dextrose via IV, he became alert and began talking. Nurse #1 further stated Resident #22 refused to be transported to the ER. Nurse #1 stated she reported to Nurse #2 that Resident #22 had low blood glucose and EMS was called. Nurse #1 stated to EMS that Resident #22 was not a diabetic.

The medical record revealed no documentation in the nurses' notes for 12/15/24 from 7:00 AM to 3:00 PM. Further review of the medical record revealed no documentation for the entire date of 12/15/24.

The Emergency Medical Services (EMS) patient care record report dated 12/15/24 revealed they

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were contacted at 8:51 AM for a male patient with a possible stroke. The EMS report revealed they arrived on scene at 8:58 AM and to Resident #22's bedside at 8:59 AM. Facility staff were asked if the resident was diabetic and staff responded that resident was not. The onset of symptoms was reported as "probably" 20 minutes prior and staff stated Resident #22 had a history of stroke. The report revealed when EMS arrived at the facility, they found Resident #22 lying in bed with his eyes closed and not responding when spoken to. The resident's breathing was normal, and he had a strong radial pulse. Resident #22's blood glucose was obtained, and he had a blood glucose level of 46. The staff was informed of Resident #22's critically low blood glucose and asked about his medical history and medications. Staff retrieved Resident #22's medical record paperwork and stated he was on two diabetes medications which were taken by mouth, but his blood glucose was not being monitored. EMS established an IV (intravenous) access and Resident #22 was administered dextrose 10% 100 milliliters via IV. At 9:06 AM Resident #22 became alert and started to speak. Staff brought a tray with Resident #22' s breakfast and after assuring he was alert and able to answer all questions, he was given his food which he ate. Resident #22's blood glucose was rechecked prior to him eating and his blood glucose was 169. Resident #22 refused to be transported to the Emegency Room (ER).

EMS Paramedic #1 who assisted on 12/15/24 was not available for interview.

An interview was conducted with Physician Assistant #1 on 1/8/25 at 10:22 AM. PA #1 stated she was aware that Resident #22 had an incident

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of hypoglycemia. The PA stated Resident #22 would not have had scheduled glucose monitoring due to his hemoglobin A1C (a measure of the average glucose reading over a 3-month period) being at 6.2 (normal range is below 5.7%). The PA stated she did expect the nurse would have recognized the signs and symptoms of hypoglycemia.

An interview was conducted with the Director of Nursing on 1/8/25 at 9:46 AM. The Director of Nursing reviewed the nurse progress notes for 12/15/24. The DON confirmed there was no documentation for the 7:00 AM to 3:00 PM shift on 12/15/24. The DON stated she had not been notified that Resident #22 had low blood glucose and EMS was called to the building. The DON stated Nurse #1 should have assessed Resident #22 and recognized the signs and symptoms of hypoglycemia. The DON further stated Nurse #1 should have notified her of the incident and written a note in the resident's medical record. The DON stated since there was no documentation, the information was not part of the 24-hour summary report. The DON stated Nurse #1 should have notified the physician and followed up with her.

An interview was conducted on the Medical Director on 1/8/25. The Medical Director stated a diagnosis of diabetes was part of the report process and he expected that Nurse #1 would have recognized the signs and symptoms of hypoglycemia.

The Administrator was notified of immediate jeopardy on 1/8/24 at 12:30 PM.

The facility provided the following immediate

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jeopardy removal plan.

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

On 12/15/2024 at 8:00 /8:15 am, Resident #22 was noted by CNA #1 to have slurred speech and was unable to sit up on the side of bed as he normally did.

CNA #1 immediately went to get Nurse #1 who came to the resident ' s room to assess the resident. Nurse #1 immediately went to assess the resident; the nurse observed the resident to have slurred speech and facial droop. A blood glucose level was not obtained. Nurse #1 called EMS at 8:51am.

EMS arrived at 8:58 am. EMS asked Nurse #1 if resident was a diabetic and she stated that he was not. Staff retrieved paperwork and stated that he was on two diabetic medications. EMS checked Resident #22 ' s blood sugar which was 46.

At 9:06am EMS initiated an IV on Resident #22 and gave 10% Dextrose 100 milliliters via IV and resident became alert and started to speak.

At 9:30am EMS rechecked Resident #22 ' s blood sugar which was 169.

Resident #22 returned to baseline and was alert and oriented to person, place, and time, answered all questions appropriately per EMS documentation dated 12/15/24.

Resident #22 was able to eat breakfast without

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ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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difficulty.

Resident #22 refused to go to the hospital for further evaluation. EMS left the facility at 0936 per EMS documentation 12/15/24.

An Ad Hoc (Quality Assurance Performance Improvement) QAPI meeting was conducted on 1/7/2025 by the QAPI Committee (Administrator, Director of Nursing (DON), Medical Director, Infection Preventionist, Activities Director, Admission Director, Social Service Director, Medical Records Director, and Director of Therapy).

Based upon record review and staff interview(s) the QAPI Committee has identified the following root cause of the event:

- Nurse #1 failed to recognize and treat the signs and symptoms of hypoglycemia and notify the Medical Provider.

- Nurse 1 communicated to EMS that she was unaware that the resident was diabetic, which potentially delayed treatment even further. The nurse failed to review the resident Diagnosis list.

On 1/7/25 an audit of all current residents with a diagnosis of diabetes was performed by the Director of Nursing to ensure diabetic orders were in place. The audit also included:

- On 1/7/25 a review of the last 14 days of the 24-hour summary was completed by the Director of Nursing to identify any change in condition with MD/RP notification to ensure that medical treatment was provided timely. The audit did not identify any residents that did not receive medical

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treatment timely.

- On 1/7/25 a review of the last 14 days of blood sugars that were below 70 or greater than 400 was performed by the Director of Nursing to ensure appropriate interventions and notifications were completed. The audit did not identify any residents that did not receive appropriate interventions or notification was not completed.

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 1/7/25 Nurse #1 was given immediate education on diabetic protocol and change in condition with MD notification by Director of Nursing. The education also included reviewing resident medication administration record and diagnosis list to determine residents with Diabetes Mellitus.

On 1/7/2025, education was initiated by the Director of Nursing to Licensed Nurses, including agency licensed nurses, related to the facility policy on hyperglycemia and hypoglycemia. To include obtaining blood glucose levels as needed for signs and symptoms of hypo/hyperglycemia. The education also included reviewing resident medication administration record and diagnosis list to determine residents with Diabetes Mellitus.

- If signs and symptoms of Hyperglycemic or hypoglycemic are identified immediate action is required.

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- When EMS is called to the facility it is vital that accurate information is communicated to EMS, to include if resident is Diabetic.

- Parameters for MD notification and follow-up for diabetic residents.

- Insulin hyperglycemic and hypoglycemic orders to include monitoring and when to obtain a re-check of blood glucose level per facility policy and/or physician order:

- Blood glucose levels as needed for signs and symptoms of hypo/hyperglycemia

- Monitor/document/report to provider PRN s/s of hypoglycemia: Shakiness, nervousness, irritability, anxiety, or changes in the personality. Confusion including delirium, rapid/fast heartbeat, weakness, lightheaded, dizziness, or faintness, hunger or excessive eating, or nausea, blurred or impaired vision, tingling or numbness in the lips or tongue, trembling or tremors, headaches, anger or stubbornness, lack of coordination, weakness or fatigue, not able to wake up or appears to be in a coma, unconscious, or partially unconscious or (stupor), seizures. Hyperglycemic and hypoglycemic orders to include monitoring and when to obtain a re- check of blood glucose level per facility policy and /or physician order

- If resident is symptomatic, conscious, and able to shallow:

Give the resident 15-20 grams of glucose or simple carbohydrates

Then recheck your blood glucose after 15 minutes.

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If hypoglycemia continues, repeat steps.

- If the resident responds immediately and is able to swallow, follow up with food if it is more than 30 minutes until the next meal. These are considered additional snacks and are not to be deducted from the next meal.

Once blood sugar returns to normal, eat a small snack if the meal or snack is more than an hour or two away.

Call the physician for further orders.

a. Follow orders.

b. Repeat blood glucose level 15-30 minutes after food is consumed.

If the resident is semi-conscious, use some form of instant glucose or I.M. Glucagon, based on physician orders.

When the resident can swallow 15-20grams of glucose or simple carbohydrates. Document on the resident ' s record.

Licensed staff and agency staff that don't receive the education on 1/7/24 will receive it prior to working the next scheduled shift. The Director of Nursing will track the training to ensure all staff are educated.

Newly hired licensed staff will receive training during orientation by Director of Nursing.

The facility alleged immediate jeopardy removal 1/8/25.

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F 684	Continued From page 16 The immediate jeopardy removal date of 1/8/25 was validated on 1/8/25. Review of staff education materials and sign-in sheets for the education were reviewed to determine that education was provided to Nurse #1. The facility staff nurses and NAs were interviewed and demonstrated they had been trained on the topics of Diabetic protocol, Change in Condition with physician notification, facility policy on hypoglycemia and hyperglycemia, Review of resident medication administration record and diagnosis list to determine residents with diabetes mellitus. Review of the facility documents revealed audits were done per the facility ' s plan of correction. The immediate jeopardy was removed on 1/8/25.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(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;	F 842		1/29/25

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F 842	Continued From page 17 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained 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(h)(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	F 842		

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F 842	Continued From page 18 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 maintain a complete and accurate medical record by failing to document a resident ' s change in condition requiring Emergency Medical Services interventions for 1 of 4 residents reviewed for accuracy of medical records. (Resident #22) The findings included: Resident #22 was admitted to the facility on 12/3/24 with diagnoses that included Diabetes Mellitus Type 2. Review of the Emergency Medical Services (EMS) patient care record report dated 12/15/24 revealed they were contacted at 8:51 AM for a male patient with a possible stroke. The EMS report revealed they arrived on scene at 8:58 AM and to Resident #22 ' s bedside at 8:59 AM. Resident #22 ' s blood glucose was obtained, and he had a blood glucose of 46. Resident #22 was administered dextrose 10% 100 milliliters via IV (intravenous). At 9:06 AM Resident #22 became alert and started to speak. Resident #22 refused to be transported to the Emergency Room (ER). Review of the medical record revealed no documentation in the nurses notes of Resident	F 842	1.Resident #22 was discharged from the facility on 12/19/24. 2. On 1/20/2025 The Regional Clinical Director performed a 14 day look back of the 24-hour report and the change in condition evaluation of current residents to ensure any change in condition requiring Emergency Medical Services intervention was documented in the resident medical record. No issues were identified during the look back. 3.1/20/2025 the Director of Nursing/designee began education to licensed nurses on the E Interact Change in condition evaluation in the Electronic Medical Record (EMR), the expectation that any resident with a change in condition must have the evaluation completed at the time the change was identified. The education included the process regarding notification and required documentation to the Director of Nursing and/or Administrator if resident identified with acute change requiring Emergency Medical Services Intervention. This education is to be completed by 1/29/25 for Licensed Nurse including agency staff that cannot be reached within	

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F 842	Continued From page 19 #22 having a critically low blood glucose (normal blood glucose level is 70-100 milligrams per deciliter [mg/dL]) or notification of EMS for treatment on 12/15/24. An interview was conducted with Nurse #1 on 1/8/25 at 6:15 AM. Nurse #1 stated she was the primary nurse on the East Hall where Resident #22 resided on 12/15/24. Nurse #1 stated she was called to Resident #22 ' s room and observed he had a change in his level of consciousness. Nurse #1 stated she called 911. Nurse #1 stated she did not document the incident in the electronic medical record because she got sidetracked and forgot. An interview was conducted with the Director of Nursing on 1/8/25 at 9:46 AM. The Director of Nursing reviewed the nurse progress notes for 12/15/24. The DON confirmed there was no documentation for the 7:00 AM to 3:00 PM shift on 12/15/24. The DON stated Nurse #1 should have documented in the nurse progress notes that Resident #22 had a low blood glucose and EMS was called for intervention.	F 842	the initial education time frame will not take an assignment until they have received this education by the Director of Nursing/designee. Newly hired nurses, including agency nurses, will receive this education during their orientation period. 4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor the 24-hour report and the Change in Condition Evaluation in the Electronic Medical Record (EMR) to ensure proper documentation was completed on any resident who has a change in condition or identified with need for Emergency Medical Services Intervention Monitoring will be done 5x weekly for 12 weeks. The Center Administrator held a Quality Assurance Performance Improvement meeting on 1/21/2025 with the Interdisciplinary Team (IDT) including the Director of Nursing, Social Services, MDS Coordinator, Business Office Manager, Activities Director, Admissions Director, and Unit Manger with focusing on the area of F842 Resident Records. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring or as it is amended by the committee.	