STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505528	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEA HILL REHABILITATION AND CARE CENTER	32049 109TH PL SE AUBURN, WA 98092

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure responsible parties were notified when there was a change in medications for one (#1) of one residents reviewed. This failure potentially placed the residents at risk for complications related to deviations from the resident's medication regime. Findings included . Refer to CFR 483.21(b)(3)(i), F-658, Services Provided Meet Professional Standards FACILITY POLICY According to the facility policy on Change in a Resident's Condition or Status dated May 2017, Our facility shall promplty notify the reisdent, his or her Attending Physician, and respresentative (sponsor) of changes in the resident's medical/metnal condition and /or status (e.g., changes in level of care .) . Resident #1 admitted to the facility on [DATE] and according to the 03/06/2020 Admission Miniumum Data Set (MDS- an assessment tool), the resident was assessed with [REDACTED]. According to this assessment, staff determined Resident #1 as cognitively intact and required a daily injection of insulin. In an interview on 08/26/2020 at 9:15 AM, Resident #1's responsible party stated that her father had been on insulin for eight years and that when she met with the facility physician prior to her father's discharge home in June of 2020, she discovered the resident was no longer on insulin. The family member stated, Why would they take him off the insulin? The doctor was concerned and he (the doctor) wasn't there before and he started him back up on insulin immediately (after being informed the resident was on insulin at the time of admission). The family member stated, He (Staff A, Director of Nursing) said that the hospital took him off the insulin. Why was he not put on insulin when he came back, why wasn't it addressed? They never told me that he didn't have insulin or that they discontnued it . According to February and March 2020 Medication Administration Records (MARs), the resident recieved two oral hypoglycemic agents ([MEDICATION NAME] and Repaglinide) and required 35 units of [MEDICATION NAME] daily and had blood sugars (BS) checked four times a day with sliding scale (SS) coverage (the resident recieved varying amounts of insulin based on the BS levels). From March 1-16, the resident's SS BSs ranged from 81-258 and the resident recieved coverage on 18 of 64 occasions. The resident discharged to the hospital on [DATE] for non-diabetic related issues and readmitted to the facility on [DATE] (48 hours). Upon readmission to the facility, there were no physician orders for insulin, nor were there directions from the hospital to facility staff to monitor the resident's blood sugars. There was no indication facility staff assessed or clarified why the resident no longer required insulin or monitoring of blood sugars. In an interview on 08/31/2020 at 11:20 AM, Staff A stated, We are under no obligation to notifiy the family that the insulin was discontinued, it was the hospital that discontinued it, they are responsible. A pharmacy recommendation dated 04/14/2020 identified the resident, frequently requires insulin per sliding scale despite receiving Repaglinide (oral hypoglycemic medication) .and [MEDICATION NAME] (oral hypoglycemic medication) . The resident's [MEDICATION NAME] was decreased and the Replinade was increased subsequent to the pharmacy recommendations. There was no documentation in the record at this time that staff notified the resident's responsible party. Progress notes dated 05/24/2020 showed, Residents blood sugar has been running high according to records from the past week. He is currently on [MEDICATION NAME] 500 mg and 750 mg, morning/evening. MD was notified and he has issued new orders to increase the dose to 1000 mg BID and to continue to check BS and report changes. Order has been carried out. Another note on 05/24/2020 showed, on alert for increased blood glucose readings- res not on insulin therapy but complies with new order increased [MEDICATION NAME] . Record review showed no indication facility staff notified Resident #1's responsible party of these medication changes or the noted increase in blood sugars. The facility failure to immediately inform the resident and notify the resident representative when there is a need to alter treatment significantly (a need to discontinue insulin) caused a delay in the responsible party's ability to advocate for the consistent administration of insulin. REFERENCE: WAC 388-97-0320. .
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met professional standards of practice for one (#1) of one residents reviewed. Failure of nursing staff to clarify admission orders [REDACTED]. Findings included . Refer to CFR 483.10(g)(14)(i)-(iv)(15), F-580, Notification of Changes Resident #1 admitted to the facility on [DATE] and according to the 03/06/2020 Admission Minimum Data Set (MDS- an assessment tool), the resident was assessed with [REDACTED]. According to this assessment, staff determined Resident #1 as cognitively intact and required a daily injection of insulin. In an interview on 08/26/2020 at 9:15 AM, Resident #1's responsible party (family member) stated that Resident #1 was on insulin for eight years and that when meeting with the facility physician prior to Resident #1's discharge to home, in June 2020, it was discovered the resident was no longer on insulin. The family member stated, Why would they take him off the insulin? . He (physician) started him back up on insulin immediately (after being informed the resident was on insulin at the time of admission). The family member stated, He (Staff A, Director of Nursing) said that the hospital took him off the insulin. Why was he not put on insulin when he came back, why wasn't it addressed? According to February and March 2020 Medication Administration Records (MARs), the resident received two oral hypoglycemic agents ([MEDICATION NAME] 1500 mg every morning and 1000 mg each evening and Repaglinide 0.5 mg each morning). In addition, Resident #1 required 35 units of [MEDICATION NAME] daily, and had his blood sugars (BS) checked four times a day with sliding scale (SS) coverage (the resident received varying amounts of insulin based on the BS levels). From March 1-16, the resident's BSs ranged from 81-258 and the resident received insulin coverage on 18 of 64 occasions. hospitalization on [DATE] The resident discharged to the hospital on [DATE] for non-diabetic related issues and readmitted to the facility on [DATE]. Upon readmission to the facility, there were no physician orders for regularly scheduled insulin. While there was a nursing order to check blood sugars four times a day, there was no insulin ordered to cover any elevated BSs. There was no indication nursing staff attempted to clarify with either the discharging hospital why a resident who previously received daily insulin, now no longer required it. In an interview on 08/31/2020 at 11:50 AM, when asked if it made sense that a resident who required 35 units of insulin and sliding scale coverage four times a day, would readmit to the facility and no longer require insulin, Staff B, Pharmacist, stated, It doesn't make sense (that the resident would no longer require insulin) and it makes sense to question not being on it (insulin). hospitalization on [DATE] Record review showed the resident discharged to the hospital on [DATE] for non-diabetic related issues and readmitted to the facility on [DATE]. Upon readmission, the resident continued to receive the same doses of the [MEDICATION NAME] and Repaglinide and now had hospital ordered BS checks four times a day with SS coverage. There was no indication nursing staff identified or attempted to clarify why the resident no longer received the regularly scheduled insulin. According to the April 2020 MARs, nursing staff failed to obtain SS BSs on 04/03/2020 (9:00 PM), twice on 04/04/2020 (4:00 PM and 9:00 PM), 04/07/2020 (4:00 PM), 04/11/2020 (4:00 PM) and 04/12/2020 (4:00 PM). The BSs from 04/03/2020 through 04/21/2020 ranged from 85 to 296 and the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident received SS coverage on 50 of 60 opportunities. Record review showed no indication nursing staff assessed the reason behind the increased blood sugars and increased use of SS insulin. A pharmacy recommendation dated 04/14/2020 identified the resident, frequently requires insulin per sliding scale despite receiving Repaglinide .and [MEDICATION NAME] . The pharmacist recommended discontinuing the sliding scale insulin as it is not recommended as it often results in wide variations in blood glucose . The resident's [MEDICATION NAME] was decreased and the Replinade was increased subsequent to the pharmacy recommendations. There was no documentation in the record at this time that staff identified or questioned why the resident no longer received regularly scheduled insulin. hospitalization on [DATE] Record review showed Resident #1 was discharged to the hospital for non-diabetic issues on 04/23/2020 and readmitted to the facility on [DATE]. A review of MARs dated 04/26/2020 showed there were no directions to staff regarding insulin or the monitoring of blood sugars until a nursing order dated 04/30/2020 which read, Blood sugar checks two times day: report to physician if blood sugar is less than 60 or greater than 400. Facility staff recorded 11 BSs from 05/01/2020 through 05/06/2020 with a range of 157-383. hospitalization on [DATE] Record review showed the resident was hospitalized for [REDACTED]. Review of the May 2020 MARs and diabetic flow sheets showed no monitoring of the resident's blood sugars from the time of readmission on 05/07/2020 until 05/21/2020 when staff documented, Check Blood sugars every morning and evening. after 7 days report results to MD for further orders. Staff documented blood sugars twice a day that ranged from 304 to 441 from 05/21/2020 through 05/24/2020. Progress notes dated 05/24/2020 showed, Residents blood sugar has been running high according to records from the past week. He is currently on [MEDICATION NAME] 500 mg and 750 mg, morning/evening. MD was notified and he has issued new orders to increase the dose to 1000 mg BID and to continue to check BS and report changes. Order has been carried out. Another note on 05/24/2020 showed, on alert for increased blood glucose readings- res not on insulin therapy but complies with new order increased [MEDICATION NAME] . According to MAR indicated [REDACTED]. The resident continued to demonstrate elevated BSs from 05/28/2020 through 06/06/2020 which ranged from 316 to 395. There was no indication in the record nursing staff notified the MD of BS results after seven days as directed. RD notes dated 06/03/2020 indicated, discussed intake r/t elevated (BS) levels (BS) levels typically range from 300-400 mg/dL. Staff documented BSs twice a day, with results ranging from 250 to 441, from 05/28/2020 through 06/15/2020. A physician note dated 06/15/2020 revealed, We also noticed that starting right around April 22, his blood sugars have been universally elevated. He reports he used to be on [MEDICATION NAME] ([MEDICATION NAME]) but I cannot find it on his medication list in March or April. He is okay to restart insulin and that thet resident's diabetes was, Chronic medical condition which is poorly controlled at this point. Adding daily [MEDICATION NAME] ([MEDICATION NAME]) to his regimen and titrate until morning sugars are routinely between 120 and 180. At that point he may need mealtime insulin as well. The resident was subsequently started on 5 units of [MEDICATION NAME] on 06/15/2020. Physician notes dated 06/19/2020 showed, Patient continues on [MEDICATION NAME] 5 units daily I had a conversation with his daughter about patient's symptoms .I then related how he has been off of insulin until just this week and his blood sugars have been persistently elevated, often above 300 .His daughter was shocked to learn that [MEDICATION NAME] ([MEDICATION NAME]) was stopped during his hospital stay and was not given to him during his stay here . His home dose of [MEDICATION NAME] ([MEDICATION NAME]) was 30 units nightly. I will initiate 25 units nightly and we can adjust the insulin over the weekend to make him ready for discharge on Monday. The resident was discharged home with 24 hour care on 06/26/2020. In an interview on 08/31/2020 at 11:20 AM when asked if nursing staff should have questioned the cessation of insulin treatment in the absence of clinical rationale, Staff A indicated, I think we should follow the Physician Orders. When asked if the hospital could have made an error in omitting the insulin or sliding scale insulin coverage on discharge on 03/19/2020, Staff A stated, That's possible. When asked if nursing staff should have clarified with the primary physician that the resident discharged to the hospital with orders for 35 units of insulin and sliding scale insulin coverage but readmitted to the facility with no insulin orders, Staff A stated, Probably. We reported to the physician in May that he had elevated blood sugars. When asked why the insulin was discontinued, in an interview on 08/31/2020 at 1:11 PM, Staff A replied, I don't know why it was discontinued. When asked why it would be important to determine why the insulin wasn't on the discharge orders from the hospital, Staff A replied, I would do things differently next time. REFERENCE: WAC [PHONE NUMBER]20(2)(b)(i)(ii); (6)(b)(i). .