STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

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 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 Physician Assistant (PA) interview, staff interview, and record review the facility failed to follow standing orders and meet the expectations of the PA and Director of Nursing (DON) regarding management of a low blood sugar level for 1 of 1 sampled residents (Resident #1) who experienced a blood sugar level below 50. Findings included: The facility's Physicians Standing Orders, signed off on by the attending physician on 01/01/20, documented, .For CBG (capillary blood glucose) below 50, the blood sugar will be immediately rechecked and documented. If the resident is able to safely take oral treatment, the resident will be offered at least one of the following: sweetened drink (juice, soda, supplement, etc), sugared candy, other food/snack/drink that the resident is known to respond to. If the resident is unable to safely take oral treatment, the resident will be treated with [MEDICATION NAME] 1 mg (milligram) IM (intramuscularly). The resident's blood sugar be be checked again 15 - 30 minutes after treatment. If the CBG remains below 50 and the resident continues to be asymptomatic, the resident will be offered one of the above treatments again. The resident's blood sugar will be checked again 15 - 30 minutes after second treatment. If the CBG remains below 50, the MD/Provider will be notified for further orders. If at any time the resident's condition declines or if the resident becomes non-responsive, the MD/Provider will be notified immediately. Record review revealed Resident #1 was admitted to the facility from the hospital on [DATE]. Her documented [DIAGNOSES REDACTED]. The resident was admitted to the facility on [DATE] with continuation of the following medications received during her hospitalization : [MEDICATION NAME] (oral hypoglycemic agent) 10 mg twice daily, humalog sliding scale insulin, [MEDICATION NAME] 15 mg daily with breakfast for arthritis, [MEDICATION NAME] (antibiotic) 500 mg BID x 12 days, and [MEDICATION NAME] (antibiotic) 1,000 mg BID x 24 days. The resident's [MEDICATION NAME] was discontinued in the hospital, but restarted upon her admission to the nursing home, [MEDICATION NAME] hcl ER 500 mg BID. The resident was also admitted to the facility on [DATE] on a low concentrated sweets (LCS) diet, and a physician order [REDACTED]. A 03/06/20 2:16 PM Admission Note documented, Resident Arrival Date and Time: 03/06/20 3:00 PM. Resident Admitting From: ___ (name of hospital). Reason for Admission: Fever. Code Status: Full Code. Residents discharge goal is to return to the community. Cognitive Status/Orientation: oriented x 4. Skin impairment observed Resident has ADL limitations Cooperative and pleasant. 2-person + assistance needed to transfer from chair to bed. Pt c/o (patient complains of) extreme pain to bilateral knees with any contact or movement. States unable to bear weight on right leg. Use mechanical lift for safety. admitted for fever/h.pylori . Resident #1's March 2020 electronic medical record (e-MAR) documented her blood sugar was 261 at 5:00 PM on 03/06/20, and 4 units of sliding scale humalog insulin were administered per physician order. The e-MAR documented the resident's blood sugar was 313 at 8:00 PM on 03/06/20, and 6 units of sliding scale humalog insulin were administered per physician order. On 03/07/20 Nurse #1 documented on the March 2020 e-MAR that Resident #1's blood sugar was 43 at 8:00 AM, was 50 at 12 noon, and was 49 at 5:00 PM. Record review revealed Nurse #1 did not document any interventions that were put in place when the resident's blood sugar fell below 50. A 03/07/20 2:16 PM Daily Skilled Nursing Note documented, Resident is alert. Resident is oriented to person. Resident is oriented to place. Resident is oriented to time. Resident is oriented to situation Pleasant Cooperative .Skin is warm and dry Resident unable to ambulate .Resident's heart rate is regular [MEDICAL CONDITION] is present: +2 BUE (bilateral upper extremity, +2 BLE (bilateral lower extremity). No complaints of chest pain Lung sounds normal/clear in all fields Medications administered whole without difficulty. Therapy to evaluate and treat. Staff max assist. On 03/07/20 Resident #1's care plan identified Resident is at risk for unstable blood glucose related to diabetes as a problem. Interventions for this problem included Administer oral hypoglycemic and/or insulin as directed by the physician. Assess blood glucose levels as ordered and PRN. Monitor labs as directed by the physician. Monitor/educate resident s/sx (signs and symptoms) of [DIAGNOSES REDACTED] like: [MEDICAL CONDITION] dizziness, sweating, headache, fatigue, and visual changes. On 03/08/20 Nurse #1 documented on the March 2020 e-MAR that Resident #1's blood sugar was 26 at 8:00 AM. A 03/08/20 8:38 AM Nursing Note documented, Glucose gel administered. Will recheck. A 03/08/20 9:00 AM Nursing Note documented, BS (blood sugar) 70 upon recheck post glucose gel. Record review revealed documentation that Resident #1 ate 75% of her breakfast on 03/08/20. In a 03/08/20 11:03 AM Nursing Note Late Entry Nurse #1 documented, This nurse checked residents BS prior to breakfast. BS 26. Glucose gel administered. Upon recheck 10 minutes later BS 33. Rechecked BS again another 10 minutes later and BS 70. 15 minutes later resident's (family member) called this nurse into room due to resident becoming lethargic, leaning to right side, and having garbled speech. (Family member) requested for resident to be sent to hospital. EMS (emergency medical services) contacted and upon arrival found BS to be 30 and took her to ED (emergency department). Resident #1's 03/08/20 5-day Medicare minimum data set (MDS) documented her cognition had not been assessed, she exhibited no behaviors including resistance to care, she required extensive staff assistance with bed mobility/transfers/toileting., she required moderate staff assistance with dressing and hygiene, she required minimal staff assistance with eating, she was dependent on staff for bathing, she was always continent of bowel and bladder, she was 63 inches tall and weighed 194 pounds, her weight was stable, she was on a therapeutic diet, and she received prn insulin injections. The facility completed a 03/08/20 discharge MDS which documented Resident #1 was being discharged to an acute care hospital with return not anticipated. Resident #1's 03/08/20 12:53 PM ED Encounter note documented, .presents to the emergency department for evaluation of altered mental status EMS was called out for possible stroke-like symptoms. But turned out patient's blood sugar was 20. She states she takes [MEDICATION NAME] EMS give patient D50 and something to eat her blood glucose came up to 70 then went back down to 30 she remains alert oriented she denies any other complaints. She has chronic bilateral leg pain which is why she was admitted to the hospital and rehab facility. She complained of continued leg pain they gave her some pain medicine she is alert oriented here. Three attempts at various times on various dates were made to reach Nurse #1 who on longer worked in the facility. These attempts were unsuccessful. During a 06/15/20 4:36 PM telephone interview with Nursing Assistant (NA) #1, who cared for Resident #1 on first shift 03/08/20, she stated she remembered the resident eating about 75% of her breakfast on 03/08/20, drinking all of the fluids on her meal tray, and asking for more beverage. She reported she and a family member noticed Resident #1 seemed weak on one side of her body with her eye and mouth drooping. According to NA #1, she and the family member both thought the resident had a stroke. She commented she cleaned the resident up quickly before emergency medical services (EMS) got there on 03/08/20, and she did not remember the resident being clammy or sweaty. The NA stated the resident was talking a lot on 03/08/20 , but could not remember if the conversation made sense or not. However, she commented the family member definitely stated the resident was not acting normal. During an interview with the Director of Nursing (DON) on 06/15/20 at 3:11 PM she stated her expectation was when a resident blood sugar was below 50 or 60 that the nurse should notify the physician or PA to keep them in the loop. She reported she was made aware of Resident #1's low blood sugar of 26 on 03/08/20, but had not been informed of the resident's blood sugars being 50 and below on 03/07/20. She commented Nurse #1 did not document that she put any interventions in place or contacted a physician or PA when Resident #1's blood sugar was 43, 49, and 50 on 03/07/20. According to the DON, it was a good idea to involve the physician or PA so a medication review and review of food intake could be coordinated. The DON reported she thought a family member ended up

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA HEALTH & REHAB CENTER	**3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) taking care of Resident #1 at home, and the resident was doing well in that environment. During an interview with PA #1 on 06/15/20 at 3:28 PM she stated this facility was her dedicated building, and she did not recall being contacted about Resident #1's blood sugar being below 50. She reported she definitely expected direct care staff to involve her when residents began to experience blood sugar levels below 60. She commented at that point she liked to review the resident's food intake, fluid intake, medications (especially antibiotics and steroids), and review recent medication changes. The PA stated Nurse #1 should have followed the standing orders when Resident #1 first experienced a blood sugar below 50. During a 06/15/20 3:39 PM telephone interview with Nurse #2 she stated she notified a physician or PA every time a resident's blood sugar dropped below 60, and referred to the standing orders in the e-MAR or the standing orders notebook for guidance about the interventions that needed to be put in place and the timing of blood sugar re-checks. During a 06/17/20 10:50 AM telephone interview with NA #2, who cared for Resident #1 on 03/07/20 first shift, she stated she could not remember the resident. During a 06/17/20 10:53 AM telephone interview with NA #3, who cared for Resident #1 on 03/07/20 second shift, she stated she could not remember the resident.