STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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 -** Immediate jeopardy **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 staff interviews, record review, staff statement review, and review of facility policy titled Condition Change Notification, the facility failed to ensure that the physician was notified in a timely manner of a critical change in condition for one resident (R) (#1) from a total sample of nine residents. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: R#1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings include: The facility had a Condition Change Notification policy dated 3/1/12. The policy documented that upon a change in a resident's condition, the facility would immediately inform the physician if there was a significant change in the resident's physical, mental, or psychosocial status such as a deterioration in status in either life-threatening conditions or clinical complications. The policy included that it would be the responsibility of the Licensed Nurse to notify the physician when a condition change warrants notification. R#1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The resident had a plan of care that included to watch for signs of hypo/[MEDICAL CONDITION] and to be alert for signs of ketoacidosis such as [MEDICATION NAME] breath, dehydration, and rapid, weak pulse. Licensed nursing staff were also to report any significant observations to the Physician. R#1 had physician's orders [REDACTED]. Review of the October 2019 MAR indicated [REDACTED]. A subsequent entry on the MAR indicated [REDACTED]. A 10/31/19 untimed Nurse's Note entry documented that on initial morning rounds, the FSBS was HI and 14 units (of insulin) was administered, the FSBS was rechecked and remained HI, the Physician was notified, and new orders were received to send R#1 to the emergency room . The resident left the facility at 10:40 a.m. via ambulance service transportation. Licensed nursing staff failed to report significant observations and/or changes related to [MEDICAL CONDITION] and ketoacidosis to the physician in a timely manner on 10/31/19. A review of a written statement provided by Licensed Practical Nurse (LPN) CC revealed that on 10/31/19 after the HI FSBS reading at 8:00 a.m. (and [MEDICATION NAME] R insulin coverage) and HI reading again 9:00 a.m., a third check of the blood glucose level was obtained at 9:40 a.m. and continued to read HI on the glucometer. The Physician was notified, and a new order was received to send the resident to the emergency room . A review of text messages that occurred between LPN CC and the Physician on 10/31/19 confirmed that the Physician was not notified of the repeated HI glucometer readings and vomiting until 9:44 a.m., with the Physician responding at 10:08 a.m. A review of hospital documentation revealed that the resident was admitted to the hospital with [REDACTED]. The physician stated that with the vomiting (which was occurring at 8:00 a.m.), the resident needed fluids at that point. Cross refer to F684
F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and staff statement review, the facility failed to report significant observations related to [MEDICAL CONDITION], as care planned for one resident (R) (#1), and failed to administer medications and/or treatment related to the management of diabetes and risk for hyper/[DIAGNOSES REDACTED] as care planned for four residents (#1, #2, #3 and #6), from a total sample of nine residents. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: R#1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings include: Review of the policy titled Care Planning initiated 11/15/16 documented the procedure for administering the care plan conference program of the facility includes, but is not limited to the following: 12. DON, Registered Nurse (RN) supervisor, and Licensed Charge Nurses are responsible for assuring provision of care in accordance with the care plan. 1. R#1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A care

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
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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 0656 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) plan was developed that included that R#1 was at risk for hypo/[MEDICAL CONDITION] and other complications related to the [DIAGNOSES REDACTED]. The care plan also included an intervention for licensed nursing staff to report any significant observations to the Physician. However, licensed nursing staff failed to report significant observations related to [MEDICAL CONDITION] and ketoacidosis to the Physician in a timely manner on 10/31/19, as care planned. Review of the clinical record revealed that on 10/31/19 at 8:00 a.m., R#1 was vomiting and had a finger stick blood sugar (FSBS) reading of HI. LPN CC administered 14 units of [MEDICATION NAME] R. The FSBS was rechecked and remained HI. A review of text messages that occurred between LPN CC and the Physician on 10/31/19 confirmed that the Physician was not notified of the repeated HI glucometer readings and vomiting until 9:44 a.m., with the Physician responding at 10:08 a.m. A review of hospital documentation revealed that the resident was admitted to the hospital with [REDACTED].#1 was in ketoacidosis, that he could smell a fruity smell, and that the resident was vomiting up until the time he was sent to the emergency room . In addition, R#1 also had a care plan intervention for licensed nursing staff to administer diabetic medications as ordered. The Physician's Insulin Protocol revealed an order for [REDACTED]. If greater than 450 on the third recheck, notify the Physician. However, review of the MAR's revealed that licensed nursing staff failed to consistently recheck the FSBS, per the Physician Ordered Protocol for R#1, after an initial reading of greater than 450, for 12 times in October 2019, 12 times in November 2019, 23 times in December 2019, 11 times in January 2020 and nine times in February 2020. Additionally, licensed nursing staff failed to consistently administer the correct amount of insulin, as ordered and as care planned, for FSBS readings greater than 450 for five times in January 2020. Cross refer to F684 2. R#2 had a care plan, developed 7/8/19, for being at risk for hypo/[MEDICAL CONDITION] and other complications related to a [DIAGNOSES REDACTED]. Review of the clinical record revealed an 11/22/19 Physician's Order to obtain FSBS readings before meals and at bedtime (four times daily) and administer insulin ([MEDICATION NAME] R) per a sliding scale. Licensed nursing staff failed to obtain the blood glucose levels as frequently as ordered by the Physician, to determine how much [MEDICATION NAME] R insulin to administer as ordered, as care planned, for the month of December 2019. A review of the clinical record, including the December 2019 MAR's revealed that R#2's blood glucose level was only obtained once daily from 12/1/19 through 12/31/19. Cross refer to F684 3. R#3 had a care plan, dated 9/25/19, for being at risk for hypo/[MEDICAL CONDITION] and other complications related to a [DIAGNOSES REDACTED]. R#3 had Physician's Orders in place that included for licensed nursing staff to complete FSBS checks before meals and at bedtime and administer [MEDICATION NAME] R insulin via a sliding scale with the FSBS checks. For a FSBS reading greater than 450, licensed nursing staff were to recheck every hour for three hours administering insulin as needed. However, licensed nursing staff failed to consistently recheck the FSBS, per the Physician Ordered Protocol, after an initial result of greater than 450 for the following dates, times and FSBS results: A) Once in December 2019: 12/11 at 11:30 a.m. for a FSBS of 492. B) Three times in February 2020: 2/8 at 6:30 a.m. for FSBS of 478, 2/10 at 11:30 a.m. for FSBS of 463 and on 2/19/20 at 9:00 p.m. for a FSBS of 461. Cross refer to F684 4. R#6 had a current care plan for being at risk for hypo/[MEDICAL CONDITION] and other complications related to [DIAGNOSES REDACTED]. Review of the January 2020 Physician's Orders form revealed the resident had a Physician's Order since 6/28/18 for [MEDICATION NAME] 10 units subcutaneous at bedtime every day. Review of the January 2020 MAR indicated [REDACTED]. In addition, there was documentation on the January 2020 MAR indicated [REDACTED]. However, there were no Physician's Orders with parameters to hold the scheduled [MEDICATION NAME]. During a post survey interview on 3/24/2020 at 10:15 a.m., the DON revealed that care plans are located in the resident's charts. She stated nurses should know when a resident is on a diabetic medication, that there is a care plan and it should be reviewed and followed. Care plans are discussed in PAR (patient at risk) meetings and that information is communicated to the nurses. The DON stated that she knows nurses are reviewing the care plan because they have to make nurses notes which have to reflect their diagnosis, and they get that information from the care plan. Cross refer to F684
F 0658 **Level of harm** - Immediate jeopardy **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 staff interviews, record review, review of the Charge Nurse job description, and review of the Georgia Board of Nursing Rule 410-10-.02 Standards of Practice for Licensed Practical Nurses, licensed nursing staff failed to utilize appropriate nursing standards and notify the physician, in a timely manner, of signs of [MEDICAL CONDITION] for one resident (R) (#1), from a total sample of nine residents. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: R#1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings include: A review of the Charge Nurse job description for Registered Nurse (RN) and Licensed Practical Nurse (LPN) charge nurses revealed that one of the primary purposes of the position was to provide direct nursing care to the residents. Review of the Georgia Board of Nursing Rule 410-10-.02: Standards of Practice for Licensed Practical Nurses revealed the practice of license practical nursing means the provision of care for compensation, under the supervision of a physician [MEDICATION NAME] medicine, a dentist [MEDICATION NAME] dentistry, a podiatrist [MEDICATION NAME] podiatry, or a registered nurse [MEDICATION NAME] nursing in accordance with applicable provisions of law. Such care shall relate to the promotion of health, the prevention of illness and injury, and the restoration and maintenance of physical and mental health through acts authorized by the board, which shall include, but not limited to the following: A. Participating in the assessment, planning, implementation, and evaluation of the delivery of health care services and other specialized tasks when appropriately trained and consistent with board rules and regulations; B. Providing direct personal patient observation, care, and assistance in hospitals, clinics, nursing homes The facility utilized (name) glucometers for obtaining FSBS results. A review of the (name) Blood Glucose Monitoring System User Instruction Manual revealed that the glucometer displays results between 20-600 mg/dL. A reading of HI appears when the blood glucose level is greater than 600mg/dL and indicates severe [MEDICAL CONDITION]. The manual also included that if HI is displayed again upon retesting, to contact the patient's healthcare provider immediately. However, licensed nursing staff failed to report significant observations and/or changes related to [MEDICAL CONDITION] and ketoacidosis to the physician in a timely manner on 10/31/19 for R#1. R#1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A care plan was developed that included that R#1 was at risk for hypo/[MEDICAL CONDITION] and other complications related to the [DIAGNOSES REDACTED]. The care plan also included an intervention for licensed nursing staff to report any significant observations to the Physician. Review of the October 2019 MAR indicated [REDACTED]. A subsequent entry on the MAR indicated [REDACTED]. A 10/31/19 untimed Nurse's Note entry documented that on initial morning rounds, the FSBS was HI and 14 units (of insulin) was given, the FSBS was rechecked and remained HI, the Physician was notified, and new orders were received to send R#1 to the emergency room . A 10/31/19 10:30 a.m. Nurse's Note entry documented that the ambulance service was notified for transportation and a 10:40 a.m. Nurse's Note entry noted that the resident was out of the facility via ambulance service transportation. A review of a written statement provided by Licensed Practical Nurse (LPN) CC revealed that on 10/31/19 after the HI FSBS reading at 8:00 a.m. (and [MEDICATION NAME] R insulin coverage) and HI reading again 9:00 a.m., a third check of the blood glucose level was obtained at 9:40 a.m. and continued to read HI on the glucometer. The Physician was notified, and a new order was received to send the resident to the emergency room . A review of text messages that occurred between LPN CC and the Physician on 10/31/19 confirmed that the Physician was not notified of the repeated HI glucometer readings and vomiting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) until 9:44 a.m., with the Physician responding at 10:08 a.m. A review of hospital documentation revealed that the resident was admitted to the hospital with [REDACTED]. During an interview on 3/3/2020 at 12:20 p.m., LPN CC stated that R#1 was in ketoacidosis, that he could smell a fruity smell, and that the resident was vomiting up until the time he was sent to the emergency room . He stated he was concerned about the resident's condition and called the Physician after he sent the text. During an interview on 3/2/2020 at 1:02 p.m., Physician FF stated that the 40-minute gap in time (from the second reading of HI at 9:00 a.m. and of him being notified at 9:44 a.m.) was a problem and that he should have been notified sooner. The Physician stated that with the vomiting, the resident needed fluids at that point, not just insulin coverage, that administering only insulin with DKA can be dangerous.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled Medication Administration General Guidelines, the facility failed to follow the physician ordered protocol for abnormal blood glucose reading interventions for three residents (R) (#1, #3 and #7), failed to administer the correct amount of insulin as ordered for one resident (#1), failed to obtain blood glucose readings as ordered for one resident (#2), failed to obtain diabetic medication as ordered for one resident (#3), and failed to administer insulin via a sliding scale or routine dose as ordered for two residents (#4 and #6) from a total sample of nine residents. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: R#1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings include: The facility's policy titled Medication Administration General Guidelines updated July 2012 included that the intent of the guideline was that medications were administered as prescribed, in accordance with good nursing principles. However licensed nursing staff failed to consistently implement medication administration general guidelines to administer medications as prescribed for R#1, R#2, R#3, R#4, R#6, and R#7. R#4 was under the care of Physician FF and all other residents were under the care Physician EE. Both Physicians used the same Physician Insulin Protocol. There was a total of 19 residents classified as insulin dependent on 3/2/2020. The facility utilized (name) glucometers for obtaining FSBS results. A review of the (name) Blood Glucose Monitoring System User Instruction Manual revealed that the glucometer displays results between 20-600 mg/dL. A reading of HI appears when the blood glucose level is greater than 600mg/dL and indicates severe [MEDICAL CONDITION]. 1. R#1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#1 had Physician's Orders in place that included for licensed nursing staff to complete finger stick blood sugar (FSBS) checks before meals and at bedtime. Further review of the clinical record, including the Medication Administration Records (MARs), revealed that the FSBS checks were scheduled at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9:00 p.m. R#1 also had orders for [MEDICATION NAME] R insulin to be administered based on a sliding scale along with the FSBS checks. A review of the Physician's Insulin Protocol, that accompanied the resident's [MEDICATION NAME] R insulin sliding scale order, revealed that licensed nursing staff were to administer a specific dose of insulin based on the FSBS reading obtained. The sliding scale insulin usage started at a FSBS reading of 150. For a FSBS reading greater than 450, licensed nursing staff were to administer 14 units of insulin. Additionally, licensed nursing staff were to repeat the FSBS in one hour and give insulin again according to the result and the sliding scale. Then, two hours after the first reading (of greater than 450), the FSBS was to be checked again and insulin again administered per the sliding scale. Three hours after the first FSBS reading (that was greater than 450), the FSBS was to be checked again and insulin administered per the sliding scale. If the FSBS reading remained above 450 on the third check, the Physician was to be notified. However, licensed nursing staff failed to consistently monitor R#1 and recheck the FSBS three times and administer insulin as needed, per the Physician Ordered Protocol, after an initial FSBS reading of greater than 450 was obtained and an insulin dose administered. During an interview on 3/2/2020 at 4:45 p.m. with the Administrator and Director of Nursing (DON), and a subsequent interview on 3/3/2020 at 10:00 a.m. with the DON, they both stated that they felt licensed nursing staff had been misinterpreting the Physician's Insulin Protocol regarding continuing to recheck blood glucose readings and administer insulin according to the sliding scale, for initial results greater than 450. They stated that the misinterpretation was that the blood glucose was to continue being rechecked only if it remained above 450 when rechecked. However, there was no evidence in the clinical records, that after the initial result of greater than 450 and a dose of insulin was administered, that nursing staff consistently completed a recheck to see if the blood sugar remained above 450. Licensed nursing staff failed to follow the protocol for the following dates, times and FSBS readings for R#1: A) 12 times in October 2019: 10/1 at 6:30 a.m. for a FSBS of 555, 10/5 at 6:30 a.m. for a FSBS of 476, 10/9 at 6:30 a.m. for FSBS of HI, 10/10 at 6:30 a.m. for FSBS of HI, 10/13 at 6:30 a.m. for FSBS of 505, 10/16 at 6:30 a.m. for FSBS of 490 and at 11:30 a.m. for FSBS of 575, 10/22 at 6:30 a.m. for FSBS of 548, 10/24 at 6:30 a.m. for FSBS of HI, 10/26 at 4:30 p.m. for FSBS of 465, 10/27 at 6:30 a.m. for FSBS of 480, and on 10/30/19 at 11:30 a.m. for a FSBS of HI. B) 12 times in November 2019: 11/5 at 11:30 a.m. for FSBS of 525, 11/6 at 9:00 p.m. for FSBS of 511, 11/9 at 6:30 a.m. for FSBS of 473, 11/10 at 6:30 a.m. for FSBS 575, 11/11 at 6:30 a.m. for FSBS of 600, 11/12 at 6:30 a.m. for FSBS of 596, 11/17 at 6:30 a.m. for FSBS of 474, 11/19 at 6:30 a.m. for FSBS of 495, 11/22 at 6:30 a.m. for FSBS of HI, 11/23 at 6:30 a.m. for FSBS of 492, 11/26 at 6:30 a.m. for FSBS of HI, and on 11/27/19 at 6:30 a.m. for FSBS of 493. C) 23 times in December 2019: 12/3 at 6:30 a.m. for FSBS of 578, 12/4 at 4:30 p.m. for FSBS of 502, 12/6 at 6:30 a.m. for FSBS of 519 and at 4:30 p.m. for FSBS of 452, 12/7 at 4:30 p.m. for FSBS of 502, 12/8 at 4:30 p.m. for FSBS of HI, 12/9 at 6:30 a.m. for FSBS of 500, 12/11 at 6:30 a.m. for FSBS of 482 and at 4:30 p.m. for FSBS of 528, 12/12 at 4:30 p.m. for FSBS of 456, 12/13 at 6:30 a.m. for FSBS of 597 and at 4:30 p.m. for FSBS of HI, 12/15 at 6:30 a.m. for FSBS of 567, 12/16 at 4:30 p.m. for FSBS of 528, 12/22 at 6:30 a.m. for FSBS of 509, 12/23 at 11:30 a.m. for FSBS of 590, 12/24 at 6:30 a.m. for FSBS of 529, 12/25 at 6:30 a.m. for FSBS of 560, 12/26 at 4:30 p.m. for FSBS of 483, 12/27 at 6:30 a.m. for FSBS of 495, and on 12/28/19 at 6:30 a.m. for FSBS of 485. D) 11 times in January 2020: 1/10 at 4:30 p.m. for FSBS of 502, 1/11 at 4:30 p.m. for FSBS of 502, 1/14 at 6:30 a.m. for FSBS of 570 and at 9:00 p.m. for FSBS of HI, 1/16 at 6:30 a.m. for FSBS of HI, 1/19 at 6:30 a.m. for FSBS of 486, 1/22 at 6:30 a.m. for FSBS of 500, 1/23 at 6:30 a.m. for FSBS at 508, 1/24 at 6:30 a.m. for FSBS at 519, 1/25 at 6:30 a.m. for FSBS at 462, and on 1/30 at 6:30 a.m. for FSBS of 575. E) nine times in February 2020: 2/6 at 11:30 a.m. for FSBS of 518, 2/13 at 11:30 a.m. for FSBS of 514, 2/14 at 6:30 a.m. for FSBS of 455, 2/15 at 11:30 a.m. for FSBS of 500, 2/17 at 5:30 a.m. for FSBS of 500, 2/23 at 5:30 a.m. for FSBS of 530, 2/25 at 5:30 a.m. for FSBS of 538, and on 2/26 at 9:00 p.m. for FSBS of 553. Additionally, licensed nursing staff failed to consistently administer the correct amount of insulin, as ordered, for FSBS results greater than 450 for five times in January 2020. Twelve units of [MEDICATION NAME] R insulin was administered, instead of the ordered 14 units for a blood glucose results of 570 at 6:30 a.m. on 1/14/2020, a HI result at 6:30 a.m. on 1/16/2020, 486 result at 6:30 a.m. on 1/19/2020, 519 result at 6:30 a.m. on 1/24/2020, and a reading of 462 at 6:30 a.m. on 1/25/2020. R#1 was noncompliant at times with his diabetic management and has had six hospitalization s for diabetic ketoacidosis since 10/31/19. The hospitalization s were as follows: 10/31/19 through 11/4/19, 11/13/19 through 11/15/19, 11/28/19 through 11/29/19, 1/2/2020 through 1/3/2020, 1/5/2020 through 1/8/2020, and 1/26/2020 through 1/29/2020. All of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) hospitalization s were reviewed with a concern being identified for 10/31/19 and 1/5/2020. Review of the October 2019 MAR indicated [REDACTED]. A subsequent entry on the MAR indicated [REDACTED]. A 10/31/19 untimed Nurse's Note entry documented that on initial morning rounds, the FSBS was HI and 14 units (of insulin) was given, the FSBS was rechecked and remained HI, the Physician was notified, and new orders were received to send R#1 to the emergency room . A 10/31/19 10:30 a.m. Nurse's Note entry documented that the ambulance service was notified for transportation and a 10:40 a.m. Nurse's Note entry noted that the resident was out of the facility via ambulance service transportation. A review of a written statement provided by LPN CC revealed that on 10/31/19 after the HI FSBS reading at 8:00 a.m. (and [MEDICATION NAME] R insulin coverage) and HI reading again 9:00 a.m., a third check of the blood glucose level was obtained at 9:40 a.m. and continued to read HI on the glucometer. The Physician was notified, and a new order was received to send the resident to the emergency room . A review of text messages that occurred between LPN CC and the Physician on 10/31/19 confirmed that the Physician was not notified of the repeated HI glucometer readings and vomiting until 9:44 a.m., with the Physician responding at 10:08 a.m. A review of hospital documentation revealed that the resident was admitted to the hospital with [REDACTED]. Review of the clinical record revealed on 1/5/2020 R#1 received his regularly schedule Humalog insulin at 6:00 a.m. At 6:30 a.m. the blood sugar was documented, by night shift LPN HH, on the January 2020 MAR indicated [REDACTED]. However, on 1/5/2020 there was no active sliding scale with [MEDICATION NAME] R insulin coverage ordered because the [MEDICATION NAME] R insulin order had been discontinued on 1/3/2020 per review of the Physician's Orders. Therefore, the 14 units of insulin coverage (given in response to the HI reading) was given without a Physician's Order. After the initial reading of HI at 6:30 a.m. and the 14 units of insulin coverage, there is no evidence of further follow-up by licensed nursing staff on the night shift or oncoming day shift. LPN HH (night shift) documented in a written statement that report was always given to the oncoming nurse regarding (insulin) coverage. Day shift LPN GG documented in a written statement that he was not made aware of the HI reading and did not do a recheck of the blood sugar reading. Further review of LPN GG's written statement revealed that R#1 refused the scheduled blood sugar check at 11:30 a.m. At 12:47 p.m. the resident is documented in a 1/5/2020 Nurse's Note entry as being slumped over in bed, nauseated and vomiting coffee ground emesis, and lethargic. The Physician was notified, and the resident was sent to the emergency room . The Nurse's Note entry also includes a blood sugar of 447 just prior to leaving the facility. LPN GG's written statement included that the nursing supervisor had to talk the resident into allowing his blood sugar to be checked at that time. A review of the 1/5/2020 hospital History and Physical revealed that R#1 was admitted with diabetic ketoacidosis associated with type 2 diabetes mellitus. He returned to the facility on [DATE]. During an interview on 3/2/2020 at 1:02 p.m. Physician FF stated he expected the nurses to follow his orders and insulin protocol of rechecking the blood sugar three times following a result of greater than 450. 2. R#2 was admitted to the facility on [DATE] and had a [DIAGNOSES REDACTED]. On 12/27/19, the frequency of the FSBS monitoring was decreased from before meals and at bedtime to three times daily. Therefore, for the month of December 2019, R#2's blood glucose levels should have been obtained four times daily, until it was decreased to three times daily on 12/27/19. However, licensed nursing staff failed to obtain the blood glucose levels as frequently as ordered by the Physician, to determine how much [MEDICATION NAME] R insulin to administer as ordered for the month of December 2019. A review of the clinical record, including the December 2019 MAR's revealed that R#2's blood glucose level was only obtained once daily from 12/1/19 through 12/31/19. During an interview on 2/14/2020 at 9:30 a.m., the Administrator stated that they were unable to locate any additional information that the FSBS levels were obtained as ordered for December 2019. 3.R#3 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R#3 had Physician's Orders for licensed nursing staff to complete FSBS checks before meals and at bedtime and administer [MEDICATION NAME] R insulin via a sliding scale with the FSBS checks. A review of the Physician's Insulin Protocol, that accompanied the resident's [MEDICATION NAME] R insulin sliding scale order, revealed that licensed nursing staff were to administer a specific dose of [MEDICATION NAME] R insulin based on the FSBS result obtained. The sliding scale insulin usage started at a FSBS reading of 150. For a FSBS reading greater than 450, licensed nursing staff were to administer 14 units of insulin. Additionally, licensed nursing staff were to repeat the FSBS in one hour and give insulin again according to the result and the sliding scale. Then, two hours after the first reading, the FSBS was to be checked again and insulin again administered per the sliding scale. Three hours after the first FSBS reading greater than 450, the FSBS was to be checked again and insulin administered per the sliding scale. If the FSBS reading remained above 450 on the third check, the Physician was to be notified. However, licensed nursing staff failed to consistently recheck the FSBS, per the Physician Ordered Protocol, after an initial result of greater than 450 for the following dates, times and FSBS results: A) Once in December 2019: 12/11 at 11:30 a.m. for a FSBS of 492. B) Three times in February 2020: 2/8 at 6:30 a.m. for FSBS of 478, 2/10 at 11:30 a.m. for FSBS of 463 and on 2/19/20 at 9:00 p.m. for a FSBS of 461. Review of the clinical record and written timeline of communication between the facility and the pharmacy revealed the following information: R#3 had a Physician's Order since 10/18/17 for 2mg of Bydureon to be administered subcutaneously, weekly, for a [DIAGNOSES REDACTED]. However, the medication was changed from a vial to a penlet on 2/13/19 which required a new Prior Authorization. Despite repeated refill requests from the facility to the pharmacy (on 2/13/19, 2/20/19, 5/7/19, 5/10/19, 6/28/19 and 8/14/19) and pharmacy's repeated notification to the facility (on 2/13/19, 2/14/19, 2/16/19, 2/18/19, 2/19/19, 2/20/19, 2/21/19, 5/10/19 and on 10/7/19) that the medication required Prior Authorization before the prescription could be filled, there is no evidence that a Prior Authorization request was submitted by the facility, to the insurance company, for review until 2/26/2020, at which time it was denied. The Physician was notified, and the medication was discontinued. Therefore, R#3 had not received the Bydureon medication as ordered since 2/6/19, prior to the order being discontinued on 2/26/2020. Further review of the timeline of communication between the pharmacy and the facility revealed that prior to 2/26/2020, facility nursing staff notified the Physician of the medication not being available on 5/7/19 and 10/9/19 but there was no evidence of the Physician's response. In addition to the Bydureon medication order, R#3's diabetes was managed with [MEDICATION NAME] R insulin (routine dose and per sliding scale), [MEDICATION NAME], and FSBS before meals and at bedtime. His most recent hemoglobin A1C (average level of blood glucose over the past 2-3 months) was 11.1% (normal 4-5.6%) on 12/9/19. The Physician documented on the lab results noncompliant with Rx. Review of the clinical record revealed that R#3 was noncompliant with multiple aspects of his care including medications, labs, wound treatments, ADL care, etc. On 3/4/2020 at 11:00 a.m., Physician FF was interviewed regarding the Bydureon injection not being received and the Physician stated it had not impacted his health, that he had wanted the Bydureon because it was a weekly injection and he thought it might help with his compliance. He stated that the resident's compliance would make a difference. Physician FF stated he had been told about the resident needing prior authorization for the medication and he told the facility to keep trying for the approval. 4. R#4 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Physician's Orders revealed admission orders [REDACTED]. An order was included for FSBS results to be obtained before meals and at bedtime. A review of the Physician's Insulin Protocol, that accompanied the resident's [MEDICATION NAME] R insulin sliding scale order, revealed that licensed nursing staff were to administer a specific dose of insulin based on the FSBS reading obtained. The sliding scale insulin usage started at a FSBS reading of 150. However, a review of the December 2019 MAR's revealed that the sliding scale insulin protocol was not implemented after 12/10/19. Therefore, R#4 was did not receive any [MEDICATION NAME] R insulin coverage for FSBS results greater than 150 between 12/11/19 and 12/31/19. Further review of the documented FSBS results on the December 2019 MAR indicated [REDACTED]. The following is a list of the dates, times, FSBS reading and amount of insulin warranted for R#4 that was not administered: For the 6:30 a.m. FSBS on 12/12/19, 217, 4 units; 12/13/19, 210, 4 units; 12/14/19, 180, 2 units; 12/15/19, 240, 4 units; 12/16/19, 206, 4 units; 12/17/19, 221, 4 units; 12/18/19, 173, 2 units; 12/19/19, 175, 2 units; 12/20/19, 152, 2 units; 12/21/19, 182, 2 units; 12/22/19, 161, 2 units; 12/23/19, 181, 2 units; 12/24/19, 169, 2 units; 12/25/19, 158, 2 units; and 12/29/19, 192, 2 units. For the 11:30 a.m. FSBS on 12/11/19, 350, 8 units; 12/12/19, 313, 8 units; 12/13/19, 193, 2 units; 12/14/19, 324, 8 units; 12/15/19, 245, 4 units; 12/16/19, 324, 8 units; 12/17/19, 285, 6 units; 12/18/19, 243, 4 units; 12/19/19, 179, 2 units; 12/20/19, 241, 4 units; 12/22/19, 151, 2 units; 12/23/19, 180, 2 units; 12/27/19, 167, 2 units; 12/28/19, 158, 2 units; 12/30/19, 162, 2 units; and 12/31/19, 169, 2 units. For the 4:30 p.m. FSBS on 12/11/19, 360, 10 units; 12/12/19, 261, 6 units; 12/13/19, 280, 6 units; 12/14/19, 429, 12 units; 12/15/19, 217, 4 units; 12/16/19, 205, 4 units; 12/17/19, 273, 6 units; 12/18/19, 215, 4 units; 12/19/19, 216, 4 units; 12/20/19, 200, 2 units; 12/21/19, 245, 4 units; 12/22/19, 198, 2 units; 12/25/19, 261, 6 units; 12/26/19, 216, 4 units; 12/27/19, 155, 2 units; 12/28/19, 192, 2 units; 12/30/19, 169, 2 units; and 12/31/19, 222, 4 units. For the 9:00 p.m. FSBS on 12/12/19, 324, 8 units; 12/14/19, 350, 8 units; 12/15/19, 210, 4 units; 12/16/19, 193, 2 units; 12/17/19, 262, 6 units; 12/18/19, 200, 2 units; 12/19/19, 267, 6 units; 12/20/19, 206, 4 units; 12/21/19, 195, 2 units; 12/22/19, 176, 2 units; 12/23/19, 197, 2 units; 12/28/19, 155, 2 units; and 12/31/19, 199, 2 units. During an interview on 3/3/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) at 10:00 a.m. the DON stated that the insulin sliding scale order was discontinued in error in December (2019), that the nurse misunderstood the orders. During an interview on 3/3/2020 at 10:35 a.m., Unit Manager BB confirmed that it was her error regarding the sliding scale being discontinued for R#4 in December (2019), that she read the order incorrectly. She stated that the resident's Physician was notified of the error that morning (3/3/2020). During an interview on 3/4/2020 at 11:55 a.m. Physician EE confirmed that he was made aware on 3/3/2020 of the medication omission that occurred in December 2019. The Physician stated he did expect nursing staff to follow the Physician's Orders. 5. R#6 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the January 2020 Physician's Orders form revealed the resident had a Physician's Order since 6/28/18 for [MEDICATION NAME] 10 units subcutaneous at bedtime every day. Review of the January 2020 MAR indicated [REDACTED]. In addition, there was documentation on the January 2020 MAR indicated [REDACTED]. However, there were no Physician's Orders with parameters to hold the scheduled [MEDICATION NAME]. During an interview with the DON on 3/12/2020 at 9:50 a.m., she confirmed there were no orders to hold the [MEDICATION NAME]. She could not give an explanation why there was no documentation the medication had been administered for the eight of 31 days in January 2020. 6. R#7 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the December 2019 Physician's Orders form, and the Insulin Protocol revealed if the finger stick blood sugar is less than 70 mg/dl give glucose (Glucose= glucose gel, fruit juice, fruit juice with added sugar or [MEDICATION NAME] 50% in water intravenous - IV D50W). However, review of the December 2019 MAR indicated [REDACTED]. During an interview with the DON 3/12/2020 at 9:50 a.m., she stated the staff should have documented if the glucose was given.
F 0756 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, pharmacy consultant report review, and review of the Pharmacy Services Agreement and Consultant Pharmacist Retainer Agreement, the facility failed to ensure that irregularities were identified regarding the Physician Ordered Protocol for abnormal blood glucose reading interventions for two residents (R) (#1 and #3), administering the correct amount of insulin as ordered for one resident (#1), obtaining blood glucose readings as ordered for one resident (#2), and administering insulin via a sliding scale dose as ordered for one resident (#4); and failed to act on an irregularity that was identified regarding the unavailability of a diabetic medication for one resident (#3), from a total sample of nine residents. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: R#1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings include: The facility had a Pharmacy Services Agreement in place since 1/30/15. The facility also had a Consultant Pharmacist Retainer Agreement in place since 1/30/15. Responsibilities that were included in the consultant responsibilities included review of the drug regimen of each resident as required and report in writing any irregularities to the Administrator and DON, provide consultation on all aspects of the provision of pharmacy services and review and provide a continuing assessment of Nursing Center compliance with laws, rules and regulations as well as the facility's own pharmaceutical related policies and procedures. A review of the consultant pharmacist's medication regimen review reports revealed that residents' medication regimens were reviewed on a monthly basis. However, despite the monthly medication regimen reviews, irregularities concerning licensed nursing staff not following the physician ordered protocol for abnormal blood glucose results for R#1 and #3, administering the incorrect amount of insulin for R#1 , not obtaining blood glucose readings as ordered for R#2, and not administering insulin via a sliding scale dose as ordered for R#4 were not identified. During an interview on 3/10/2020 at 9:30 a.m., the Administrator stated that the facility also had a Registered Nurse (RN) pharmacy consultant come in and review medication regimens on 9/24/19 and 11/1/19. The RN pharmacy consultant identified an irregularity regarding the availability of a medication (Bydureon) for R#3, but the facility did not act on the irregularity. 1. R#1 had physician's orders [REDACTED]. R#1 also had orders for [MEDICATION NAME] R insulin to be administered based on a sliding scale along with the FSBS checks. A review of the Physician's Insulin Protocol, that accompanied the resident's [MEDICATION NAME] R insulin sliding scale order, revealed that licensed nursing staff were to administer a specific dose of insulin based on the FSBS reading obtained. The sliding scale insulin usage started at a FSBS reading of 150. For a FSBS reading greater than 450, licensed nursing staff were to administer 14 units of insulin. Additionally, licensed nursing staff were to repeat the FSBS in one hour and give insulin again according to the result and the sliding scale. Then, two hours after the first reading (of greater than 450), the FSBS was to be checked again and insulin again administered per the sliding scale. Three hours after the first FSBS reading (that was greater than 450), the FSBS was to be checked again and insulin administered per the sliding scale. If the FSBS reading remained above 450 on the third check, the Physician was to be notified. However, licensed nursing staff failed to consistently monitor the resident and recheck the FSBS three times and administer insulin as needed, per the physician ordered protocol, after an initial FSBS reading of greater than 450 was obtained and an insulin dose administered. Licensed nursing staff failed to follow the protocol for FSBS readings greater than 450: A) 12 times in October 2019. B) 12 times in November 2019. C) 23 times in December 2019. D) 11 times in January 2020. E) nine times in February 2020. Additionally, licensed nursing staff failed to consistently administer the correct amount of insulin, as ordered, for FSBS results greater than 450 for five times in January 2020. Twelve units of [MEDICATION NAME] R insulin was administered, instead of the ordered 14 units. A review of the Summary of Consultant Pharmacist's Medication Regimen Review and accompanying reports from November 2019 through February 2020 revealed that the consultant pharmacist had reviewed R#1's medication regimen between 11/1/19-11/27/19, 12/1/19-12/20/19, 1/1/2020-1/31/2020 and 2/1/2020-2/26/2020. However, there was no evidence that irregularities regarding the incorrect amount of insulin administered or the lack of follow up and monitoring of the repeatedly documented blood sugars greater than 450 was identified. 2. Review of the clinical record for R#2 revealed an 11/22/19 physician's orders [REDACTED]. On 12/27/19, the frequency of the FSBS monitoring was decreased from before meals and at bedtime to three times daily. Therefore, for the month of December 2019, R#2's blood glucose levels should have been obtained four times daily, until it was decreased to three times daily on 12/27/19. However, licensed nursing staff failed to obtain the blood glucose levels as frequently as ordered by the Physician, to determine how much [MEDICATION NAME] R insulin to administer as ordered for the month of December 2019. A review of the clinical record, including the December 2019 MAR's revealed that R#2's blood glucose level was only obtained once daily from 12/1/19 through 12/31/19. A review of the Summary of Consultant Pharmacist's Medication Regimen Review and accompanying reports from December 2019 and January 2020 revealed that the consultant pharmacist had reviewed R#2's medication regimen between 12/1/19 -12/20/19 and 1/1/2020-1/31/2020. However, there was no evidence that the irregularity regarding the frequency of FSBS monitoring for December 2019 was identified. 3. R#3 had physician's orders [REDACTED]. Protocol. However, licensed nursing staff failed to consistently recheck the FSBS, per the Physician Ordered Protocol, after an initial result of greater than 450 once in December 2019 and three times in February 2020. A review of the Summary of Consultant Pharmacist's Medication Regimen Review and accompanying reports from December 2019 through February 2020 revealed that the consultant pharmacist had reviewed R#3's medication regimen between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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 0756 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) 12/1/19-12/20/19, 1/1/2020-1/31/2020 and 2/1/2020-2/26/2020. However, there was no evidence that irregularities regarding the incorrect amount of insulin administered or the lack of follow up and monitoring of the documented blood sugars greater than 450 was identified. R#3 had a physician's orders [REDACTED]. There is no evidence that a Prior Authorization request was submitted by the facility, to the insurance company, for review until 2/26/2020. A review of the Summary of Consultant Pharmacist's Medication Regimen Review and accompanying reports from November 2019 through February 2020 revealed that the consultant pharmacist had reviewed R#3's medication regimen between 11/1/19 -11/27/19, 12/1/19 -12/20/19, 1/1/2020-1/31/2020 and 2/1/2020-2/26/2020. However, there was no evidence that irregularity regarding the unavailability of the Bydureon medication was identified. A review of the Summary of Nurse Consultant's MAR/Med Pass/Med Cart/Med Room Review reports from 9/24/19 and 11/1/19 revealed that irregularities concerning documentation of the administration of the Bydureon medication were identified on 9/24/19. The 11/1/19 report includes that the Bydureon medication required prior authorization. During an interview on 3/4/2020 at 11:00 a.m., Physician FF stated he had been told about the resident needing prior authorization for the medication and he told the facility to keep trying for the approval. During an interview on 3/10/2020 at 9:30 a.m. the Administrator stated that she and the DON get a copy of the consultant report and the DON breaks up the report between her and the Nurse Managers. She stated that she is unsure why they did not catch the breakdown in their system. 4. Review of R#4's physician's orders [REDACTED]. An order was included for FSBS results to be obtained before meals and at bedtime. Review of the December 2019 MAR's revealed that the sliding scale insulin protocol was not implemented after 12/10/19. Therefore, R#4 was did not receive any [MEDICATION NAME] R insulin coverage for FSBS results greater than 150 between 12/11/19 and 12/31/19. Further review of the documented FSBS results on the December 2019 MAR indicated [REDACTED]. The following is a list of the dates, times, FSBS reading and amount of insulin warranted for R#4 that was not administered: For the 6:30 a.m. FSBS on 12/12/19, 217, 4 units; 12/13/19, 210, 4 units; 12/14/19, 180, 2 units; 12/15/19, 240, 4 units; 12/16/19, 206, 4 units; 12/17/19, 221, 4 units; 12/18/19, 173, 2 units; 12/19/19, 175, 2 units; 12/20/19, 152, 2 units; 12/21/19, 182, 2 units; 12/22/19, 161, 2 units; 12/23/19, 181, 2 units; 12/24/19, 169, 2 units; 12/25/19, 158, 2 units; and 12/29/19, 192, 2 units. For the 11:30 a.m. FSBS on 12/11/19, 350, 8 units; 12/12/19, 313, 8 units; 12/13/19, 193, 2 units; 12/14/19, 324, 8 units; 12/15/19, 245, 4 units; 12/16/19, 324, 8 units; 12/17/19, 285, 6 units; 12/18/19, 243, 4 units; 12/19/19, 179, 2 units; 12/20/19, 241, 4 units; 12/22/19, 151, 2 units; 12/23/19, 180, 2 units; 12/27/19, 167, 2 units; 12/28/19, 158, 2 units; 12/30/19, 162, 2 units; and 12/31/19, 169, 2 units. For the 4:30 p.m. FSBS on 12/11/19, 360, 10 units; 12/12/19, 261, 6 units; 12/13/19, 280, 6 units; 12/14/19, 429, 12 units; 12/15/19, 217, 4 units; 12/16/19, 205, 4 units; 12/17/19, 273, 6 units; 12/18/19, 215, 4 units; 12/19/19, 216, 4 units; 12/20/19, 200, 2 units; 12/21/19, 245, 4 units; 12/22/19, 198, 2 units; 12/25/19, 261, 6 units; 12/26/19, 216, 4 units; 12/27/19, 155, 2 units; 12/28/19, 192, 2 units; 12/30/19, 169, 2 units; and 12/31/19, 222, 4 units. For the 9:00 p.m. FSBS on 12/12/19, 324, 8 units; 12/14/19, 350, 8 units; 12/15/19, 210, 4 units; 12/16/19, 193, 2 units; 12/17/19, 262, 6 units; 12/18/19, 200, 2 units; 12/19/19, 267, 6 units; 12/20/19, 206, 4 units; 12/21/19, 195, 2 units; 12/22/19, 176, 2 units; 12/23/19, 197, 2 units; 12/28/19, 155, 2 units; and 12/31/19, 199, 2 units. A review of the Summary of Consultant Pharmacist's Medication Regimen Review and accompanying reports from December 2019 and January 2020 revealed that the consultant pharmacist had reviewed R#4's medication regimen between 12/1/19-12/20/19 and 1/1/2020 -1/31/2020. However, there was no evidence that the irregularity regarding the discontinuation of the [MEDICATION NAME] R sliding scale for the month of December 2019 was identified.
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of Administrator and Director of Nursing job descriptions, the facility administration failed to ensure adequate management and monitoring of medications and/or treatment for [REDACTED]. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: Resident (R) #1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings Include: Review of the Administrator job description signed on 8/1/18 revealed: Summary - responsible for the overall management of a facility, plans, develops, directs, monitors and supports all operational, administrative, clinical . programs and services. Functions - directs and coordinates all functions of the facility. Responsibility - is responsible for efficient execution of the programs and services with highest possible standards. Ensures the quality and appropriateness of resident/ patient care meets or exceeds company and regulatory standards. A review of the Director of Nursing job description signed on 10/4/17 revealed that the primary purpose of the job position is to plan, organize, develop and direct the day to day functions of the Nursing Service Department to ensure that the highest degree of quality of care is maintained at all times. However, facility administrative and nursing administrative staff failed to provide effective supervision of licensed nursing staff and failed identify repeated issues concerning the care and management of diabetic residents R#1, R#2, R#3, R#4, R#6, and R#7. 1. Administration failed to ensure that the Physician was notified in a timely manner of a critical change in condition for R#1. Cross Refer to F580. 2. Administration failed to ensure that care plans were being followed related to reporting significant observations of [MEDICAL CONDITION] for R#1 and related to administering medications and/or treatments for the management of diabetes and risk for hyper/[DIAGNOSES REDACTED] for R#1, R#2, R#3 and R#6. Cross Refer to F656. 3. Administration failed to ensure that Physician ordered protocols were being followed for abnormal blood glucose reading interventions for R#1, R#3 and R#7, failed to ensure that correct amounts of insulin were being administered as ordered for R#1, failed to ensure blood glucose readings were being obtained as ordered for R#2, failed to obtain diabetic medication as ordered for R#3, and failed to ensure to ensure nursing staff administered insulin via a sliding scale or routine dose as ordered for R#4 and R#6. Cross refer to F684. 4. Administration failed to ensure appropriate nursing standards were utilized and physician notification, in a timely manner, of signs of [MEDICAL CONDITION] for R#1. Cross Refer to F658. 5. Administration failed to ensure that irregularities were identified regarding: Physician Ordered Protocol for abnormal blood glucose reading interventions for R#1 and R#3, administering the correct amount of insulin as ordered for R#1, obtaining blood glucose readings as ordered for R#2, and administering insulin via a sliding scale dose as ordered for R#4, and failed to act on an irregularity that was identified regarding the unavailability of a diabetic medication for R#3. Cross refer to F756. 6. Administration failed to have an effective Quality Assurance process that identified concerns related to the care and management of diabetic residents. Cross refer to F867. During an interview on 3/2/2020 at 4:45 p.m. with the Administrator and Director of Nursing (DON), and a subsequent interview on 3/3/2020 at 10:00 a.m. with the DON, they both stated that they felt licensed nursing staff had been misinterpreting the Physician's Insulin Protocol regarding continuing to recheck blood glucose readings and administer insulin according to the sliding scale, for initial results greater than 450. They stated that the misinterpretation was that the blood glucose was to continue being rechecked only if it remained above 450 when rechecked. During a post survey interview on 3/24/2020 at 10:00 a.m., the Administrator stated that she was not informed of the incident on 10/31/19 for R#1 and was not made aware until being questioned by the surveyor. The administrator revealed that she was unaware of the real issue related to the management of the diabetic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEA TRACE NURSING CENTER	910 TALBOTTON RD COLUMBUS, GA 31904

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) residents. She was delegating review of the consultant reports to the nurse managers and the nurse manager position had some turnover. Documentation issues were identified during those reviews but the fact that nursing staff were not following protocols was not identified. She stated that it is her responsibility to find issues and she was unable to see the errors with the insulin protocol being misinterpreted because it had been going on so long. She confirmed that when they did recently ask the Physician, he clarified the Physician's Insulin Protocol and it was not being followed.
F 0841 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.** Based on interview and Medical Director's Agreement review, the facility failed to have an active agreement in place that outlined the role and responsiblities of a Medical Director. The facility census was 83. A review of the Medical Director's Agreement which included the Medical Director's Responsibilities, Qualifications, Duration of Agreement, Financial Arrangement and Facility Responsibilities revealed a signature and date by Physician FF and the Administrator on 3/11/20. During an interview on 3/12/20 at 12:15 p.m. the Administrator stated that Physician FF had been the facility's Medical Director since 3/1/12, but that she was unable to locate the original contract, so the contract was updated the day prior, on 3/11/20.
F 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the Facility Assessment and Quality Assurance and Assessment (QAA) policy, the facility failed to have an effective Quality Assurance process that identified concerns related to the care and management of diabetic residents. The facility census was 83. On 3/10/2020 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing, Nurse Manager AA and Nurse Manager BB were informed of the Immediate Jeopardy on 3/10/2020 at 5:25 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/31/19. The Immediate Jeopardy is outlined as follows: Resident (R) #1 had a [DIAGNOSES REDACTED]. A review of the clinical record revealed that on 10/31/19 at 8:00 a.m. the resident was vomiting and had a glucometer reading of HI, which indicated a blood glucose level greater than 600 milligrams (mg) per deciliter (dL), indicating severe [MEDICAL CONDITION]. Licensed Practical Nurse (LPN) CC administered 14 units of [MEDICATION NAME] R insulin at that time. A recheck of the blood glucose level at 9:00 a.m. indicated that it remained at a level of HI. However, LPN CC failed to notify the Physician of the critical situation of the [MEDICAL CONDITION] and vomiting that had been occurring since 8:00 a.m., until 9:44 a.m. After Physician notification, R#1 was sent out to the hospital and admitted with diabetic ketoacidosis. Additional concerns regarding the management of diabetic residents was also identified. Further record review and interviews revealed concerns with following the Physician's protocol for monitoring and interventions for blood glucose readings less than 70 or greater than 450 for R#1, R#7, and R#3, administering the correct amount of insulin for R#1, obtaining finger stick blood sugar checks as frequently as ordered for R#2, obtaining a diabetic medication as ordered for R#3, administering insulin via a sliding scale as ordered by the Physician for R#4, and withholding insulin without an order for [REDACTED]. At the time of the exit on 3/12/2020, the Immediate Jeopardy remained ongoing. Findings include: The Facility assessment dated [DATE], documented that the facility's resident population included residents with diabetes. The facility had a Quality Assurance and Assessment (QAA) policy dated 8/13/12. The policy documented that the QAA policy was to identify quality deficiencies and develop and implement plans of action to correct the quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plan. The policy included that the committee would meet at least quarterly to identify issues with respect to which QAA activities were necessary. In the event that a deficiency was discovered, the facility would have a called QAA committee meeting to process a plan of action. A review of the Quality Assurance (QA) committee meeting sign in sheet revealed that the members of the committee included the Administrator, Physician, Director of Nursing, Care Plan Coordinators, Nurse Managers, Business Office Manager, Activities Director, Dietary Director, Environmental Services Director, Maintenance Director, Medical Records, Medical Supply, Social Services staff, Respiratory Care staff person and Restorative Nursing staff person. A review of the 10/23/19 QA meeting information for the 3rd quarter of 2019 revealed that it included information from the Registered Nurse (RN) Pharmacy Consultant. The Activities Monitored section included following insulin sliding scale as ordered by the Physician. The Opportunity for Improvement section included for nurses to identify and use the correct insulin type, for nurses to check insulin sliding scale dosage and draw insulin required coverage and record the injection site. Prior to the 10/23/19 QA meeting, a QA sub-committee meeting was conducted to address the RN pharmacy consultant identified concerns with an inservice initiated on 10/10/19 with licensed nursing staff. A review of the 1/20/2020 QA meeting information revealed that it also included review of the RN Pharmacy Consultant information, as from the 10/23/19 meeting notes. During an interview on 3/10/2020 at 9:30 a.m. the Administrator stated that the RN Pharmacy Consultant visited the facility on 9/24/19 and identified nursing issues for the facility to work on. The consultant returned on 11/1/19 and re-identified that some of the plans in place were not as successful as they wanted them to be and they provided additional inservices. The consultant returned on 2/17/2020, after surveyor entrance on 2/10/2020. Despite the QA meetings, QA sub-committee meetings and nursing concerns identified by the RN consultant, irregularities concerning licensed nursing staff not notifying the Physician timely of a critical change in condition for R#1, not following the physician ordered protocol for abnormal blood glucose results for R#1 and #3, administering the incorrect amount of insulin for R#1 , not obtaining blood glucose readings as ordered for R#2, and not administering insulin via a sliding scale dose as ordered for R#4 were not identified by the facility.