

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2014
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a complaint investigation survey on 06/16/14. It was determined the facility had provided substandard quality of care at the Immediate Jeopardy level. A partial extended survey was conducted on 06/18/14 and an exit conference was held with the facility on 06/18/14. The Immediate Jeopardy began on 06/08/14 and was removed on 06/18/14.	F 000			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		7/11/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/03/2014

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 157	<p>Continued From page 1</p> <p>resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and facility staff, nurse practitioner and physician interviews, the facility failed to notify the resident ' s physician of recurrent low blood sugars (BS); and failed to immediately notify the resident ' s physician of an acute episode of unresponsiveness associated with low blood sugars for 1 of 4 sampled residents diagnosed with diabetes (Resident #1).</p> <p>Immediate jeopardy began on 6/8/14. On 6/8/14, Resident #1 was found to be unresponsive and identified as having a low blood sugar. The resident ' s physician was not immediately notified of the hypoglycemic (low blood sugar) event in accordance with the facility ' s Diabetic Protocols in the Standing Orders. The evidence revealed that the acute hypoglycemic episode of 6/8/14 had been preceded by 4 of the last 35 days where the resident experienced low blood sugars and the physician was not notified per the facility ' s Diabetic Protocols in the Standing Orders or as indicated by the physician ' s orders. Immediate Jeopardy was removed on 6/18/14 at 9:40 PM. The facility remained out of compliance at a lower scope and severity of (D), isolated with potential for more than minimal harm, while the facility completes the staff training required. The facility was in the process of monitoring the</p>	F 157	<p>Corrective Action for affected patient</p> <p>Resident #1 was discharged from the facility on 6/9/2014.</p> <p>Corrective Action for Potentially Affected Patients</p> <p>All residents with physician orders for anti-glycemic meds could be potentially affected. On 6/18/2014 the nurse consultant checked orders for all patients to identify those on insulin and /or oral medications. Those patients were then checked to ensure that all patients on these medications had orders for glucometer checks. One patient was identified who did not have a routine blood glucose checked order. On 6/18/2014 the MD for this patient was contacted by the Unit Manager and an order for blood glucose checks were ordered. All patients who have physician orders for glucometer checks have the potential to be affected by the alleged deficient practice. All current patients who have physician orders for glucometers checks (regardless of frequency) were reviewed</p>		

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F 157	<p>Continued From page 2 implementation of their corrective action.</p> <p>The findings included:</p> <p>A review of the facility ' s " Episodic Charting Policy " dated 10/2001 and revised on 6/2010 read, in part: " If an incident (Ex., fall, resident becomes ill, elevated temperature, on antibiotics, UTI ' s (urinary tract infections), emotional/behavioral problems, newly combative resident, resident wanders out of Facility, etc.) occurs on your shift you are responsible for: #2 (of 9): Calling MD (Medical Doctor) of an emergency, at the time of event, or #3 (of 9): Fax info to MD next day if problem not urgent and/or after hours. #5 (of 9): If MD is called, it shall be noted in Electronic Nurses Notes by the nurse making the call, as well as response received from MD. #6 (of 9): If info is faxed, it shall be noted in Electronic Nurses Notes by the nurse who sent the fax, as well as response received from MD. "</p> <p>A review of the facility ' s Admitting and Standing Orders included a section entitled, " Diabetic Protocols. " The Diabetic Protocols read as follows: " BS < (less than) 40 Responsive Resident: Give 120 cc (cubic centimeter, a measure of liquid equivalent to a milliliter) of Resource. Hold Insulin or hypoglycemic and notify MD (Medical Doctor) and recheck in one hour. Monitor closely. BS < 40 Unresponsive Resident: Administer 1 unit dose of Glucagon (an injectable antidote for hypoglycemia or low blood sugar) IM (intramuscularly). Hold insulin or hypoglycemic. Notify MD immediately. Recheck BS in 1 hour and monitor closely.</p>	F 157	<p>by the unit managers or directors of nursing on 6/17/14 and 06/18/14. For these patients the blood glucose results documented on the medication administration record for the past 30 days were reviewed. 0 patients were identified with results less than or equal to 40 over the past 30 days. 24 patients were identified with results greater than or equal to 41 and less than 80 in the last 30 days. The physicians were notified of the low blood sugar results. This notification was completed by the Unit Manager and Director of Nursing on 06/18/14 and this notification was documented in the medical record for that patient by the Unit Manager and Director of Nursing on 06/18/14. MDs were notified of the BS and current diabetic medication was listed.</p> <p>Systematic Changes</p> <p>See below diabetic protocol. All current nurses (registered nurses and licensed practical nurses) who are currently employed on a full time, part time or as needed basis will receive education on the proper notification of physicians/physician extenders when a patient experiences low blood sugars provided by the Staff Development Coordinator. There are two agency nurses that may provide staffing coverage if needed. On 6/18/2014, the director of nursing contacted both of these nurses and provided them with the education. Education began on 06/18/14 and will continue until all employees have received</p>		

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F 157	<p>Continued From page 3</p> <p>BS < 80 > (greater than) 40: Hold insulin or hypoglycemic. Offer 120 cc Resource. Recheck in 1 hour. If BS remains < 80, call MD. If BS >80, give medications and continue to monitor. BS > 400: call MD immediately. Monitor closely.</p> <p>"</p> <p>Resident #1 was admitted to the facility on 11/6/13 from an acute care hospital. Her cumulative diagnoses included Type 2 diabetes, hyperlipidemia, hypertension, heart failure, and possible chronic kidney disease estimated upon admission as stage 1- 3 (kidney disease is frequently classified by 5 stages, with stage 1 indicative of mild kidney disease and stage 5 indicative of end stage renal disease).</p> <p>A review of Resident #1 ' s May 2014 Physician Orders revealed the following medications were used in the treatment of diabetes: 5 milligrams (mg) glipizide (an oral antidiabetic agent which is classified as a sulfonylurea medication) given as one tablet by mouth one time a day; and Humalog insulin 100 units/milliliter (a rapid acting insulin) injected subcutaneously (under the skin) two times a day as sliding scale insulin (SSI). SSI coverage indicated that the dose of insulin administered was dependent on the resident's BS result. Blood sugars were checked twice daily at 9 AM and 5 PM.</p> <p>A review of the Nursing Progress Notes revealed that on the morning of 5/3/14, Resident #1 ' s BS was 46 and she was described as, " unresponsive and wet with sweat. " The resident was administered one dose of glucagon, the physician was contacted, and the resident was sent to the hospital. Resident #1 was admitted to the hospital on 5/3/14 and discharged back to the</p>	F 157	<p>the in-service. Any employee not in-serviced by 06/18/14 will not be allowed to work until they have been in-serviced. This included the following details: Update: On 07/11/14, all current nurses (registered nurses and licensed practical nurses) who are currently employed on a full time, part time or as needed basis will receive education on the updated hypoglycemia protocol provided by the Staff Development Coordinator and Director of Nursing. Any employee not in-serviced by 07/11/14 will not be allowed to work until they have been in-serviced. This education will continue until all nurses are in-serviced and will be completed by 07/16/14.</p> <p>1. The current hypoglycemic protocol includes: Diabetic Protocols All diabetic patients should have blood glucose monitoring orders based on their individual needs. If orders are not received on admission then the charge nurse should contact the MD for orders or reason why orders for blood sugar checks are not required. Blood sugar less than 40 Responsive Resident: Give 120cc of Med Pass 2.0 PO. 120 cc of Med Pass 2.0 has 28 grams of carbohydrate. This is not a change. 2.0 was left off in the plan of correction but is the brand the facility uses. Hold Insulin or hypoglycemic and notify MD immediately. Re-check blood glucose every 15 minutes until blood glucose is above 80. Blood sugar less than 40 Unresponsive Resident: Administer 1 unit dose of</p>		

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F 157	<p>Continued From page 4 facility on 5/4/14.</p> <p>A review of Resident #1 ' s medical record revealed that on 5/5/14, the Nurse Practitioner (NP) wrote new orders for the resident at the facility. The orders included: " Decrease glipizide to 2.5 mg po (by mouth) qd (every day); Change C/S (an abbreviation for chemstrips, which referred to the BS checks) to TID (three times daily) 6AM-no SSI; 9AM with SSI and 5PM with SSI (same scale, no changes-flag to reevaluate if BS <70 or >150); staff to assist with meals. "</p> <p>An interview conducted with the Director of Nursing (DON) on 6/17/14 at 9:47 AM clarified that a " flag " was an indication to the nursing staff that a resident ' s chart should be set aside at the nursing station as a means to call the NP ' s attention to it. The system was designed so that the NP would be alerted of a situation or resident needing to be reviewed. The DON reported the NP came in every weekday, Monday through Friday.</p> <p>A review of the resident ' s May 2014 Medication Administration Record (MAR) revealed her BS were checked at 6AM, 9AM and 5PM beginning on 5/6/14. A note on the MAR was handwritten and read in part, " flag to re-eval if BS<70 or >150. "</p> <p>A review of Resident #1 ' s quarterly MDS (Minimum Data Set) assessment dated 5/9/14 revealed the resident had severely impaired cognitive skills for daily decision making. She required extensive assist with bed mobility, locomotion on/off unit; dressing; toilet use; and</p>	F 157	<p>Glucagon IM. Hold insulin or hypoglycemic. Notify MD immediately. Someone should stay with the patient until the blood sugar is above 80. Recheck blood glucose every 15 minutes x 2 or until blood glucose is above 80 and the patient is responsive, or if remains below 80, notify MD or order to send to ER for evaluation. 911 should be called if the patient does not respond to treatment and has been unresponsive for more than 30 minutes.</p> <p>Blood sugar less than 80 but greater than or equal to 41 responsive resident: hold insulin or hypoglycemic. Offer 120cc Med Pass 2.0. Recheck in 15 minutes. If blood sugar remains less than 80 or if the patient is symptomatic, call MD immediately. If blood sugar is greater than 80, give medications and either call physician or fax physician if after normal business hours. Resident assessment will be performed and documented.</p> <p>Blood sugar less than 80 but greater than or equal to 41 unresponsive resident: hold insulin or hypoglycemic. Administer 1 unit dose of Glucagon IM. Notify MD immediately. Someone should stay with the patient until the resident becomes responsive. Recheck blood glucose every 15 minutes x 2 or until the patient is responsive, or if remains unresponsive, notify MD or order to send to ER for evaluation. 911 should be called if the patient does not respond to treatment and has been unresponsive for more than 30 minutes.</p> <p>If you cannot reach the attending physician the patient's blood sugar is not</p>		

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F 157	<p>Continued From page 5</p> <p>personal hygiene. The resident required supervision with eating. The MDS assessment indicated Resident #1 received insulin injections on 4/7 days during the assessment period. No care plan was included in the resident ' s medical record.</p> <p>On 5/22/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s May 2014 MAR revealed that on 5/22/14 the resident ' s BS at 5 PM was 58 with a rechecked BS (no time noted) of 63.</p> <p>There were no notations made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70.</p> <p>A telephone interview was conducted with Nurse #1 on 6/18/14 at 3:28 PM. Nurse #1 was the 2nd shift nurse assigned to care for Resident #1 on 5/22/14. During the interview, Nurse #1 reported that she could not recall this particular situation. When asked if she would have notified the physician of the low blood sugar, Nurse #1 stated that if the resident had not responded or her blood sugars had not come up, " then yes. " The nurse reported that if she did notify the physician, this would have been noted in the Nurse ' s notes or on the MAR.</p> <p>On 5/23/14, Resident #1 was noted to have a low BS on three occasions. A review of Resident #1 ' s May 2014 MAR revealed that on 5/23/14 the resident ' s BS at 6 AM was 57; on 5/23/14 at 9 AM BS was 61; and on 5/23/14 at 5 PM BS was 67. There were no notations made in the resident ' s medical record (including the Nurse ' s Notes</p>	F 157	<p>responding to the actions or if the patient is unresponsive then call 911 and initiate transfer to the emergency room. If the patient's blood sugar is improving and the signs and symptoms of hypoglycemia are improving then contact the on call administrative nurse who will call the medical director.</p> <p>Some patients may have more specific parameters for contacting the physicians. This will be documented in a physician order and will be listed on the medication administration record. You must contact the physician anytime the patient's condition meets the criteria identified in the order.</p> <p>2. The physician must be notified any time the protocol is implemented.</p> <p>3. Some patients may have more specific parameters for contacting the physicians. This will be documented in a physician order and will be listed on the medication administration record. You must contact the physician anytime the patient's condition meets the criteria identified in the order.</p> <p>4. Document all communication with the physician in the nursing notes. Include times of calls/pages and time when the physician responded to the call. Initiated telephone orders for any new orders received.</p> <p>As of 6/18/14 employees who have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all</p>		

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F 157	<p>Continued From page 6 and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70.</p> <p>A telephone interview was conducted with Nurse #2 on 6/18/14 at 4:26 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on 5/23/14. During the interview, Nurse #2 reported that she could not recall this particular situation. Upon inquiry, Nurse #2 reported that she did not report any of Resident #1 ' s low blood sugars to the physician or NP at any point in time.</p> <p>A telephone interview was conducted with Nurse #1 on 6/18/14 at 3:28 PM. Nurse #1 was the 2nd shift nurse assigned to care for Resident #1 on 5/23/14. During the interview, Nurse #1 reported that she could not recall this particular situation. The nurse reported that if the resident had not been responding under these circumstances, she would have contacted the physician.</p> <p>On 5/31/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s May 2014 MAR revealed that on 5/31/14 the resident ' s BS at 6 AM was 68; on 5/31/14 at 9 AM no BS result was documented; and on 5/31/14 at 5 PM her BS was 71. There were no notations made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70.</p> <p>A telephone interview was conducted with Nurse #2 on 6/18/14 at 4:26 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on 5/23/14. When asked if she could recall this</p>	F 157	<p>general orientation programs that is completed started 6/18/14.</p> <p>Quality Assurance</p> <p>A Quality Assurance audit will be completed by the Unit Manager or the Director of Nursing in their absence and will review all patients on glucose monitoring daily times 14 days then at least 10 patients weekly x three months. The patient's medication administration records will be reviewed (last seven days of glucose monitoring) to ensure that the physician was notified according to the protocol. These items will be reviewed weekly times three months or until resolved by QOL/QA committee and will begin on 6/20/2014. Reports of the audit will be given by the Director of Nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly.</p>		

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F 157	<p>Continued From page 7</p> <p>particular situation, Nurse #2 stated, " not really. " Upon inquiry, Nurse #2 reported that she did not report any of Resident #1 ' s low blood sugars to the physician or NP at any point in time.</p> <p>A review of the June 2014 MAR revealed the resident ' s BS were checked at 6AM, 9AM and 5PM. A note on the MAR was handwritten and read in part, " flag to re-eval if BS<70 or >150. "</p> <p>On 6/1/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/1/14 the resident ' s BS at 6 AM was 62 (on 6/1/14 at 9 AM her BS was 86; and on 6/1/14 at 5 PM BS was 185). There were no notations made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70.</p> <p>A telephone interview was conducted with Nurse #3 on 6/18/14 at 3:57 PM. Nurse #3 was the 3rd shift nurse assigned to care for Resident #1 on 6/1/14. During the interview, Nurse #3 recalled the situation encountered with Resident #1 at 6 AM on that date. The nurse indicated that the resident was alert, oriented and responded to her at that time. Upon inquiry, Nurse #3 indicated she did not notify the resident ' s physician of the low BS. She stated there was, " no reason because her BS came up and she was alert and oriented and responded to me. "</p> <p>On 6/8/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14 the resident refused a BS check at 6 AM; on 6/8/14 at 9 AM her BS was 60.</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>There were no notations made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for the 9AM BS result being less than 70.</p> <p>An interview was conducted with Nurse #4 on 6/16/14 at 2:51 PM. Nurse #4 was the 1st shift nurse assigned to care for Resident #1 on 6/8/14. During the interview, Nurse #4 recalled that the outgoing 3rd shift nurse reported the resident ' s refusal to have her BS checked at 6 AM and that the resident was alert and verbal. At 9 AM on 6/8/14, Resident #1 ' s BS was 60. Nurse #4 reported that she gave the resident 120cc Med Pass and that the resident was fine. The nurse stated that she rechecked the BS after the Med Pass was consumed and her breakfast was served. She was not sure how much breakfast the resident ate. Nurse #4 stated she did not document the result of the resident ' s BS recheck, but thought it was in the 90 ' s. The nurse reported that the resident appeared, " fine " the rest of the morning but noted she did talk with herself that morning. She noted this was a usual behavior for the resident. Nurse #4 indicated that she did not report the low BS results to the resident ' s physician or NP. The nurse stated she did make a report of the 9 AM BS result to the oncoming nurse but that there was nothing else out of the ordinary to share.</p> <p>On 6/8/14, Resident #1 was noted to have a second low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14 the resident ' s BS at 5 PM was 42. A Nursing Progress note dated 6/8/14 at 5:00 PM read:</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>" Pt (patient) unresponsive bs (blood sugar) 42 VS (Vital Signs) 96.4 (temperature); 64 (heart rate); 18 (respiration rate); 120/74 (blood pressure); glucagon given bs (blood sugar) came up to 71 pt alert responsive sweating pt drank glucerna refused supper will monitor. "</p> <p>A notation was made on the back of the resident ' s MAR dated 6/8/14 at 5:00 PM which indicated the resident ' s BS was 42; she was unresponsive; glucagon was given; and the results of a BS recheck (no time provided) was 71. There were no notations made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70.</p> <p>An interview was conducted with Nurse #5 on 6/16/14 at 3:19 PM. Nurse #5 was the 2nd shift nurse assigned to care for Resident #1 on 6/8/14. During the interview, the nurse reported the resident was asleep that day when they made rounds at 3PM. She indicated that was not unusual for Resident #1. The nurse stated that when she went to check the resident around 4:30 PM (to do the 5PM BS check), the resident would not wake up. The resident ' s BS at that time was 42. The nurse stated that she had the NA take the resident ' s vital signs while she went to get a glucagon shot for her. After the glucagon shot was given, the nurse had the NA stay with the resident. The resident woke up after about 20 minutes and was reported to be alert but confused at that time. The nurse indicated the resident was usually disoriented. When the resident was awake, the nurse rechecked her BS again and found that it had come up to 71. Nurse #5 stated that she gave the resident some</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>Glucerna at that time (around 5:00 PM). The nurse reported that the resident seemed her " normal self " after consuming this Glucerna. Nurse #5 stated that she did check the resident ' s BS again after the supper trays came out, but didn ' t document the result. The nurse thought that BS result when rechecked was, " either 100 or 148. " Nurse #5 stated that Resident #1 wouldn ' t eat her supper that evening, which was not unusual for her. The nurse also reported that at around 8:30PM the resident drank another can of Glucerna. The nurse reported that she checked on her 2-3 more times that shift. She stated that her checks, " just involved verbal stimuli " and that the resident would wake up and talk with her. At the end of the shift, the nurse reported that Resident #1 was sleeping (like she usually would have at that time of night). Nurse #5 stated that she faxed the resident ' s physician the evening of 6/8/14 to inform him that Resident #1 ' s BS had been low and that glucagon was given. Upon inquiry, the nurse indicated that she would have called the physician if the resident would have remained unresponsive. The nurse noted that she told the oncoming nurse in report that she had given glucagon to the resident, Resident #1 was refusing her meals, and to watch her BS.</p> <p>On 6/9/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/9/14 the resident ' s BS at 6 AM was 41. A notation dated 6/9/14 at 6 AM was made on the back of the June 2014 MAR. The notation reported Resident #1 ' s BS was 41; 2 packs of sugar were given under her tongue; and BS recheck at 7 AM was 57.</p> <p>A telephone interview was conducted with Nurse</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>#2 on 6/16/14 at 4:35 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on the evening of 6/8/14 to the morning of 6/9/14. During this interview, the nurse recalled there was nothing unusual noted for Resident #1 that night. The nurse reported that Resident #1 would sometimes wake up around 3 AM - 4 AM, but did not recall whether or not she woke up that night. The nurse reported that when she took the resident ' s BS between 6AM and 6:30AM, she found it was low and the resident was unresponsive. The nurse stated that she went to the Stat Box (referring to the Stat Medication Box, an emergency supply of medications kept in the Medication Room), " to see if we had glucagon, " but there wasn ' t any. Nurse #2 reported she then went to a second unit ' s medication room and there wasn ' t ' any glucagon there either. At that time, the nurse reported she went and got sugar (2-3 packets) and put it under the resident ' s tongue. After that, she called to the 3rd and final unit in the facility to see if they had any glucagon and found that they did not. Nurse #2 stated that she rechecked the resident ' s sugar more than once but only documented the results of the last recheck when her BS had gone up to around 57. She recalled that the resident was moaning at about that time (approximately 7:00 AM). Nurse #2 stated that it was also about 7:00 AM when she gave report to the on-coming nurse. When asked why she did not initiate any further interventions or call the resident ' s physician, Nurse #4 stated, " I thought her sugar was coming up and the situation was resolving. "</p> <p>A telephone interview was conducted with NA #1 on 6/16/14 at 6:31 PM. NA #1 was the 3rd shift NA assigned to care for Resident #1 on the evening of 6/8/14 to the morning of 6/9/14. The</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>NA recalled that around 2:00 AM she told the nurse that the resident was in deep sleep and snoring. She recalled that at about 4:00 AM she reported the same to the hall nurse. NA #1 stated that at 6:00 AM (on her last round) she couldn ' t wake the resident up. She told Nurse #2 (the hall nurse), and the nurse said she was aware of it and was trying to find the glucagon to bring her sugar up. The NA stated the nurse wasn ' t able to find any glucagon. She recalled that the nurse then gave the resident some sugar under her tongue. The NA stated that the resident did not respond while she was in the room.</p> <p>A Nursing Progress note written for 6/9/14 at 7:15 AM (created as a late entry on 6/16/14 at 11:40 AM) read: " In rsdt (resident ' s) room this shift. Rsdtd noted unresponsive, BS checked 51. Glucagon shot given at 7:15 AM. Back in rsdt room at 7:45 am. BS increase to 113 rsdt remained unresponsive. Sat (oxygen saturation) 93% ra (on room air). V/S (Vital Signs) 97.5 (temperature), 130/60 (blood pressure), 18 (respiration rate); 80 (heart rate). White foam substance noted coming from mouth. Called [name of hospital] to get MD on call for [name of resident ' s physician], [name of on-call physician] called right back, informed him of status change. Order given to send to [name of hospital] for eval. 911 called for transport of rsdt to [name of hospital]. RP [family member] called informed of status change and order to send to [name of hospital], was appreciative. "</p> <p>An interview was conducted with Nurse #6 on 6/16/14 at 2:33 PM. Nurse #6 was the 1st shift nurse who came on duty at 7:00 AM on 6/9/14. Nurse #6 stated that when she got to the facility that morning, the resident was unresponsive and</p>	F 157			

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F 157	<p>Continued From page 13</p> <p>she was told the resident ' s sugar was low. Nurse #6 stated, " I think I was told (her BS was) 51. " Nurse #6 reported the BS was rechecked and it was still low (no value was given). The nurse reported she went and got a glucagon shot from the neighboring facility and administered it to the resident at 7:15 AM. The nurse indicated that she waited 15-30 minutes to see if the resident would respond. When the nurse went back at 7:45 AM, her BS was 113 but she wasn ' t responding. Nurse #6 stated she did a sternal rub and the resident was still nonresponsive. She obtained the vital signs, phoned the on-call physician, and received orders to send her out to the Emergency Department. The nurse reported that was her second time having to give the resident a shot of glucagon---the first was in the beginning of May. The nurse stated that back in May the resident did become responsive once her sugar went up. " That ' s why this time I knew it was different. "</p> <p>A review of Resident #1 ' s medical record revealed a Physician ' s Telephone Order was received on 6/9/14 at 8:25 AM to send the resident to [name of hospital] to be evaluated. A review of the Emergency Department records revealed Resident #1 was transported by air to another hospital on 6/9/14 at 1:07 PM for specialty care/treatment. The diagnoses at the time of the transfer included AMS (altered mental status), NSTEMI (non-ST-elevation myocardial infarction or heart attack), suspected CVA (cerebrovascular accident or stroke), renal (kidney) insufficiency, and ECG changes (an ECG or electrocardiogram is a test that evaluates the rhythm and electrical activity of the heart).</p>	F 157			

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F 157	<p>Continued From page 14</p> <p>Interviews were conducted with the Director of Nursing (DON) on 6/16/14 at 4:05 PM and 6/17/14 at 9:47 AM. During the interviews, the DON was asked what she would have expected to be done as follow-up on 5/22/14, 5/23/14, 5/31/14, and 6/1/14 when Resident ' s #1 ' s blood sugars were noted to be less than 70. The DON indicated that the resident ' s chart should have been flagged for the NP to review when she came in. When asked what the DON ' s expectations would have been after the glucagon injection was given to Resident #1 on the evening of 6/8/14, the DON stated that the protocol was to notify the physician. However, she indicated that the timing of the physician notification would have depended on the BS result and the resident ' s response to the glucagon. The DON stated that the resident ' s response would have been " key " in regards to MD notification. She reported that if glucagon was given and the resident got back to her baseline, the nursing staff may not have called the physician. Instead, the nurse may have told the NP of the situation the next day when she came into the facility.</p> <p>An interview was conducted on 6/17/14 at 11:33 AM with the NP. During this interview, the order written on 5/5/14 for Resident #1 was discussed. This order included the phrase, "flag to reevaluate if BS <70 or >150. " The NP stated that the facility would sometimes " flag " a chart, which meant the nurses would pull a resident ' s chart at the Nurses ' Station to let her know that she needed to review the resident. The NP described the procedure as, " a tickler system. " After reviewing the May 2014 and June 2014 MAR for Resident #1, the NP stated she had not been made aware of any of the resident ' s low BS results from May 2014 or June 2014. The NP</p>	F 157			

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F 157	<p>Continued From page 15</p> <p>indicated she would have wanted to know about each of the low BS results that were less than 70. The NP reported that if the resident ' s BS were outside of the parameters and the resident was symptomatic, then she would have wanted to be notified of the situation by telephone. If the resident was not symptomatic, flagging the chart for her to see the resident the next day would have been acceptable. The NP noted that she was in the facility every weekday, Monday through Friday. Additionally, she had been on call the weekends of 5/31/14 -6/1/14 and 6/7/14-6/8/14 from 7 AM until 7 PM. Upon review of the resident ' s low blood sugar results from May 2014 and June 2014, the NP stated, " This could have been taken care of. "</p> <p>An interview was conducted on 6/17/14 at 12:50 PM with Resident #1 ' s physician. Resident #1 ' s May 2014 and June 2014 MARs were reviewed (noting the low BS results of 5/22/14, 5/23/14, 5/31/14, and 6/1/14) along with the 5/5/14 order written to "flag to reevaluate if BS <70 or >150 " for Resident #1. Upon inquiry, the physician stated that he " would have expected someone to be contacted...a provider, on-call physician or NP, especially if parameters were written. " The physician indicated he had not been notified. Upon review of the situation encountered on the evening of 6/8/14, the physician stated, " The physician has got to be notified in that situation ...there are always different ways to manage a patient with hypoglycemia. A fax is not immediate notification. I would expect if you have an unresponsive resident, even if the resident becomes responsive that provider should be notified. I think that ' s a standard. A physician needs to help guide them. " He stated, " The problem is the MD was not contactedThey</p>	F 157			

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F 157	<p>Continued From page 16 should have contacted the physician from the get-go. "</p> <p>The facility ' s Administrator was notified of the Immediate Jeopardy on 6/17/14 at 6:45 PM. A credible allegation of compliance was received on 6/18/14 at 8:45 PM as follows:</p> <p>Physician Notification 157</p> <p>Corrective Action for affected patient Resident #1was discharged from the facility on 6/9/2014.</p> <p>Corrective Action for Potentially Affected Patients All residents with physician orders for anti-glycemic meds could be potentially affected. On 6/18/2014 the nurse consultant checked orders for all patients to identify those on insulin and /or oral medications. Those patients were then checked to ensure that all patients on these medications had orders for glucometer checks. One patient was identified who did not have a routine blood glucose checked order. On 6/18/2014 the MD for this patient was contacted by the Unit Manager and an order for blood glucose checks were ordered.</p> <p>All patients who have physician orders for glucometer checks have the potential to be affected by the alleged deficient practice. All current patients who have physician orders for glucometers checks (regardless of frequency) were reviewed by the unit managers or directors of nursing on 6/17/14 at 21:00. For these patients the blood glucose results documented on the medication administration record for the past 30 days were reviewed. 0 patients were identified</p>	F 157			

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F 157	<p>Continued From page 17</p> <p>with results less than or equal to 40 over the past 30 days. 6 patients were identified with results greater than or equal to 41 and less than 80 in the last 30 days. The physicians were notified of the low blood sugar results for 6 patients who were identified as having a blood glucose of less than 80 in the last 30 days. This notification was completed by the unit manager and director of nursing on 6/18/2014 and this notification was documented in the medical record for that patient by the unit manager and director of nursing on 6/18/14. MD 's were notified of the BS and current diabetic medication was listed.</p> <p>Systematic Changes See below diabetic protocol.</p> <p>All current nurses (registered nurses and licensed practical nurses) who are currently employed on a full time, part time or as needed basis will receive education on the proper notification of physicians/physician extenders when a patient experiences low blood sugars provided by the Staff Development Coordinator. There are two agency nurses that may provide staffing coverage if needed. On 6/18/2014, the director of nursing contacted both of these nurses and provided them with the education. This included the following details:</p> <p>1. The current hypoglycemic protocol includes:</p> <p>Diabetic Protocols All diabetic patients should have blood glucose monitoring orders based on their individual needs. If orders are not received on admission then the charge nurse should contact the MD for orders or reason why orders for blood sugar checks are not required.</p>	F 157			

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F 157	Continued From page 18 Blood sugar less than 40 Responsive Resident: Give 120cc of Med Pass PO (by mouth). Hold Insulin or hypoglycemic and notify MD immediately. Re-check blood glucose in 15 minutes and every 30 minutes until blood glucose is above 80. Blood sugar less than 40 Unresponsive Resident: Administer 1 unit dose of Glucagon IM. Hold insulin or hypoglycemic. Notify MD immediately. Someone should stay with the patient until the blood sugar is above 80. Recheck blood glucose every 15 minutes x 2 until blood glucose is above 80 and the patient is responsive, or if remains below 80 notify MD or order to send to ER for evaluation. 911 should be called if the patient does not respond to treatment and has been unresponsive for more than 30 minutes. Blood sugar less than 80 but greater than or equal to 41: hold insulin or hypoglycemic. Offer 120cc Med Pass. Recheck in 30 minutes. If blood sugar remains less than 80 or if the patient is symptomatic, call MD immediately. If blood sugar is greater than 80, give medications and either call physician or fax physician if after normal business hours. Resident assessment will be performed and documented. If you cannot reach the attending physician the patient ' s blood sugar is not responding to the actions or if the patient is unresponsive then call 911 and initiate transfer to the emergency room. If the patient ' s blood sugar is improving and the signs and symptoms of hypoglycemia are improving then contact the on call administrative nurse who will call the medical director.	F 157			

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F 157	<p>Continued From page 19</p> <p>Some patients may have more specific parameters for contacting the physicians. This will be documented in a physician order and will be listed on the medication administration record. You must contact the physician anytime the patient ' s condition meets the criteria identified in the order.</p> <p>2. The physician must be notified any time the protocol is implemented.</p> <p>3. Some patients may have more specific parameters for contacting the physicians. This will be documented in a physician order and will be listed on the medication administration record. You must contact the physician anytime the patient ' s condition meets the criteria identified in the order.</p> <p>4. Document all communication with the physician in the nursing notes. Include times of calls/pages and time when the physician responded to the call. Initiate telephone orders for any new orders received.</p> <p>As of 6/18/14 employees who have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed started 6/18/14.</p> <p>Completion Date 6/18/14.</p> <p>On 6/18/14 at 9:40 PM, the credible allegation of compliance was validated. The surveyor confirmed that the facility implemented the</p>	F 157			

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F 157	Continued From page 20 following: Nursing staff interviews confirmed each nurse had been in-serviced on the current hypoglycemic protocol (revised on 6/18/14), including documentation and communication with the physician.	F 157			
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a care plan based on the results of the Minimum Data Set Assessments for 1 of 3 sampled residents (Resident #1).	F 279	Corrective Action for Affected Patient For the affected resident a comprehensive care plan was developed by the interdisciplinary team including the MDS Coordinator, Dietary, Social Services, and	7/11/14	

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F 279	<p>Continued From page 21</p> <p>Immediate jeopardy began on 6/8/14. On 6/8/14, Resident #1 was found to be unresponsive and identified as having a low blood sugar, preceded by 4 of the last 35 days where the resident experienced low blood sugar(s). Resident #1 did not have an individualized plan of care in place which addressed the management of diabetes and risk of complications from it. Immediate Jeopardy was removed on 6/18/14 at 9:40 PM. The facility remained out of compliance at a lower scope and severity of (D), isolated with potential for more than minimal harm. The facility was in the process of full implementation and monitoring of their corrective action.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 11/6/13 from an acute care hospital. Her cumulative diagnoses included Type 2 diabetes, hyperlipidemia, hypertension, heart failure, and possible chronic kidney disease estimated upon admission as stage 1- 3 (kidney disease is frequently classified by 5 stages, with stage 1 indicative of mild kidney disease and stage 5 indicative of end stage renal disease).</p> <p>A review of the Nursing Progress Notes revealed that on the morning of 5/3/14, Resident #1 ' s BS was 46 and she was described as, " unresponsive and wet with sweat. " The resident was administered one dose of glucagon, the physician was contacted, and the resident was sent to the hospital. Resident #1 was admitted to the hospital on 5/3/14 and discharged back to the facility on 5/4/14.</p> <p>A review of Resident #1 ' s quarterly MDS (Minimum Data Set) assessment dated 5/9/14</p>	F 279	<p>Activities. The care plan included a focus on Diabetes, Communication, Pain, Pressure ulcer risk, Dehydration risk, Falls risk and ADL performance. This was completed on 06/16/14 by the MDS Nurse.</p> <p>Potentially Affected Patients</p> <p>All residents could be potentially affected. On 6/17/2014 an audit was conducted by the MDS Nurse Consultant of all current residents to ensure a comprehensive care plan was in place. The audit revealed 1 out of 136 residents did not have a comprehensive care plan in place. The affected resident was discharged on 06/17/14 at 14:20.</p> <p>Systematic Changes</p> <p>The MDS Coordinator was educated on 06/17/14 by the MDS Nurse Consultant for failure to complete a comprehensive care plan for the residents identified. Topics included completing an interim care plane that includes individual risks, needs or problems in a resident centered format on admission. Interim care plans should be completed within 48 hours of admission. The interim care plan should also be updated after the admission comprehensive MDS assessment is completed. All care plans will be reviewed and updated at a minimum of quarterly and annual basis. In addition to this, care plans will be reviewed by the interdisciplinary team with any significant change in condition to ensure that the</p>		

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F 279	<p>Continued From page 22</p> <p>revealed the resident had severely impaired cognitive skills for daily decision making. She required extensive assist with bed mobility, locomotion on/off unit; dressing; toilet use; and personal hygiene. The resident required supervision with eating. The MDS assessment also indicated the resident received pain medications (scheduled and as needed) for almost constant pain (rated as a 7 on a pain rating scale of 0-10). Resident #1 received a therapeutic diet. Her medications included insulin injections (on 4 out of the 7 days during the assessment period), an antipsychotic medication (on 7 out of the 7 days), an antibiotic (on 7 out of the 7 days), and a diuretic (on 7 out of the 7 days).</p> <p>A review of Resident #1 ' s medical record revealed there was no care plan included in either the resident ' s paper chart or electronic chart.</p> <p>On 5/22/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s May 2014 MAR revealed that on 5/22/14 the resident ' s BS at 5 PM was 58 with a rechecked BS (no time noted) of 63.</p> <p>On 5/23/14, Resident #1 was noted to have a low BS on three occasions. A review of Resident #1 ' s May 2014 MAR revealed that on 5/23/14 the resident ' s BS at 6 AM was 57; on 5/23/14 at 9 AM BS was 61; and on 5/23/14 at 5 PM BS was 67.</p> <p>On 5/31/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s May 2014 MAR revealed that on 5/31/14 the resident ' s BS at 6 AM was 68; on 5/31/14 at 9 AM no BS result was documented; and on 5/31/14 at 5 PM her BS was</p>	F 279	<p>care plan currently reflects any individualized approaches in order to provide the highest practical level of well-being for each resident. Residents admitted on the weekend will have an interim care plan developed by the MDS Nurse within 48 hours of admission. In the MDS Nurses absence, the DON will develop the interim care plan.</p> <p>Daily Monday thru Friday in the Daily QOL meeting, attended by the Director of Nursing, Administrator, Unit Managers, Support Nurse, and MDS Nurse, (unless they are off from work that day), all new admissions will be reviewed by this committee to ensure interim care plans are developed within 48 hours of admission. The care plans will be check to ensure that they include individual risks, needs or problems in a resident centered format. This review began on 06/18/14. This committee is led by the Director of Nursing (DON) and the DON is responsible for ensuring the interim care plan is initiated within 48 hours of admission. In the MDS Nurse's absence, the DON will initiate the interim care plan. Education was provided to the DON by the MDS Nurse Consultant on 06/18/14. This training was incorporated into the general orientation program for all newly hired MDS Nurses starting 6/18/2014.</p> <p>Quality Assurance</p> <p>A Quality Assurance audit has been completed by the MDS Nurse to verify that all residents admitted since 06/16/14 has</p>		

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F 279	<p>Continued From page 23 71.</p> <p>On 6/1/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/1/14 the resident ' s BS at 6 AM was 62 (on 6/1/14 at 9 AM her BS was 86; and on 6/1/14 at 5 PM BS was 185).</p> <p>On 6/8/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14 the resident refused a BS check at 6 AM; on 6/8/14 at 9 AM her BS was 60. On 6/8/14, Resident #1 was noted to have a second low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14 the resident ' s BS at 5 PM was 42. A notation was made on the back of the resident ' s MAR dated 6/8/14 at 5:00 PM which indicated the resident ' s BS was 42; she was unresponsive; glucagon was given; and the results of a BS recheck (no time provided) was 71.</p> <p>On 6/9/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/9/14 the resident ' s BS at 6 AM was 41. A notation dated 6/9/14 at 6 AM was made on the back of the June 2014 MAR. The notation reported Resident #1 ' s BS was 41; 2 packs of sugar were given under her tongue; and BS recheck at 7 AM was 57. A Nursing Progress note written for 6/9/14 at 7:15 AM (created as a late entry on 6/16/14 at 11:40 AM) read: " In rsdt (resident ' s) room this shift. Rsdt noted unresponsive, BS checked 51. Glucagon shot given at 7:15 AM. Back in rsdt room at 7:45 am. BS increase to 113 rsdt remained unresponsive. Sat (oxygen saturation) 93% ra (on room air). V/S (Vital Signs) 97.5 (temperature), 130/60 (blood pressure), 18 (respiration rate); 80 (heart</p>	F 279	a care plan developed within 48 hours of admission. This audit will continue daily Monday thru Friday times three months. Weekly since 06/18/14, the MDS Nurse consultant has audited all current residents to ensure they had a care plan developed. This will continue weekly times 3 months. Reports of the audit will be given by the Director of Nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly.		

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F 279	<p>Continued From page 24</p> <p>rate). White foam substance noted coming from mouth. Called [name of hospital] to get MD on call for [name of resident ' s physician], [name of on-call physician] called right back, informed him of status change. Order given to send to [name of hospital] for eval. 911 called for transport of rsdt to [name of hospital]. RP [family member] called informed of status change and order to send to [name of hospital], was appreciative. "</p> <p>A review of Resident #1 ' s medical record revealed a Physician ' s Telephone Order was received on 6/9/14 at 8:25 AM to send the resident to [name of hospital] to be evaluated. A review of the Emergency Department records revealed Resident #1 was transported by air to another hospital on 6/9/14 at 1:07 PM for specialty care/treatment. The diagnoses at the time of the transfer included AMS (altered mental status), NSTEMI (non-ST-elevation myocardial infarction or heart attack), suspected CVA (cerebrovascular accident or stroke), renal (kidney) insufficiency, and ECG changes (an ECG or electrocardiogram is a test that evaluates the rhythm and electrical activity of the heart).</p> <p>On 6/16/14 at 12:20 PM, an interview was conducted with the facility ' s Administrator (upon his request). The Administrator reported that no care plan had been developed for Resident #1 since her admission to the facility on 11/6/13. He reported a care plan was put into the resident ' s electronic chart on this date (6/16/14) by Nurse #7 after the facility realized she did not have an existing care plan on record.</p> <p>An interview was conducted with Nurse #8 on 6/16/14 at 1:44 PM. Nurse #8 reported that she</p>	F 279			

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F 279	<p>Continued From page 25</p> <p>assumed responsibility for assisting with MDS assessments and putting the data into the computer. The nurse indicated that Nurse #7 assumed responsibility for creating the care plans for each of the facility ' s residents.</p> <p>A telephone interview was conducted with Nurse #7 on 6/16/14 at 4:00 PM. Nurse #7 confirmed that she assumed responsibility for developing a care plan for each of the facility ' s residents. In regards to Resident #1, the nurse stated, " There was no care plan. It just got missed. "</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/16/14 at 4:05 PM. Upon inquiry, the DON stated " My expectation is for the care plan to be done on admission and updated per MDS schedule. "</p> <p>The facility ' s Administrator was notified of the Immediate Jeopardy for F279 on 6/26/14 at 6:47 PM.</p> <p>The facility provided the following credible allegation of compliance on 6/27/14 at 12:29 PM.</p> <p>F 279--Care Plan Tag</p> <p>Corrective Action for Affected Patient For the affected resident a comprehensive care plan was developed by the interdisciplinary team including the MDS Coordinator, Dietary, Social Services, and Activities. The care plan included a focus on Diabetes, Communication, Pain, Pressure ulcer risk, Dehydration risk, Falls risk and ADL performance. This was completed on 06/16/14 by the MDS Nurse.</p> <p>Potentially Affected Patients</p>	F 279			

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F 279	<p>Continued From page 26</p> <p>All residents could be potentially affected. On 6/17/2014 an audit was conducted by the MDS Nurse Consultant of all current residents to ensure a comprehensive care plan was in place. The audit revealed 1 out of 136 residents did not have a comprehensive care plan in place. The affected resident was discharged on 06/17/14 at 14:20.</p> <p>Systematic Changes The MDS Coordinator was educated on 06/17/14 by the MDS Nurse Consultant for failure to complete a comprehensive care plan for the residents identified. Topics included completing an interim care plane that includes individual risks, needs or problems in a resident centered format on admission. Interim care plans should be completed within 48 hours of admission. The interim care plan should also be updated after the admission comprehensive MDS assessment is completed. All care plans will be reviewed and updated at a minimum of quarterly and annual basis. In addition to this, care plans will be reviewed by the interdisciplinary team with any significant change in condition to ensure that the care plan currently reflects any individualized approaches in order to provide the highest practical level of well-being for each resident.</p> <p>Daily Monday thru Friday in the Daily QOL meeting, attended by the Director of Nursing, Administrator, Unit Managers, Support Nurse, and MDS Nurse, (unless they are off from work that day), all new admissions will be reviewed by this committee to ensure interim care plans are developed within 48 hours of admission. The care plans will be check to ensure that they include individual risks, needs or problems in a resident centered format. This review began on 06/18/14.</p>	F 279			

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F 279	Continued From page 27 This training was incorporated into the general orientation program for all newly hired MDS Nurses starting 6/18/2014. Completion Date 6/18/14 On 6/18/14 at 9:40 PM, verification of the credible allegation of compliance was evidenced by record review. The surveyor confirmed that the facility implemented the following: A care plan was developed for Resident #1 on 6/16/14, which included a focus area related to the management of diabetes and risk for complications related to the diabetes; Care plans had been developed for sample residents diagnosed with diabetes, and each care plan included a focus area related to the management of the diabetes and risk for complications from it.	F 279			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, hospital record review, and facility staff, nurse practitioner and physician interviews, the facility failed to provide immediate assessment, intervention, and monitoring for 1 of 4 sampled residents	F 309	Corrective Action for Affected Patient Resident #1 was discharged from the facility on 6/9/2014	7/11/14	

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F 309	<p>Continued From page 28</p> <p>diagnosed with diabetes (Resident #1) presenting with low blood sugars (BS) and recurrent acute episodes of unresponsiveness associated with low blood sugars.</p> <p>Immediate jeopardy began on 6/8/14. Resident #1 was found to be unresponsive and identified as having a low blood sugar on 6/8/14, preceded by 4 of the last 35 days where the resident experienced low blood sugar(s). The evidence revealed the facility did not follow their Diabetic Protocols in the Standing Orders to ensure corrective interventions were put into place, follow-up monitoring was provided, and physician guidance was obtained when needed. Immediate Jeopardy was removed on 6/18/14 at 9:40 PM. The facility remained out of compliance at a lower scope and severity of (D), isolated with potential for more than minimal harm, while the facility completes the staff training required. The facility was in the process of monitoring the implementation of their corrective action.</p> <p>The findings included:</p> <p>A review of the facility 's Admitting and Standing Orders included a section entitled, " Diabetic Protocols. " The Diabetic Protocols read as follows: " BS < (less than) 40 Responsive Resident: Give 120 cc (cubic centimeter, a measure of liquid equivalent to a milliliter) of Resource (a liquid nutritional supplement high in calories and protein). Hold Insulin or hypoglycemic (a medication that lowers blood sugar) and notify MD (Medical Doctor) and recheck in one hour. Monitor closely. BS < 40 Unresponsive Resident: Administer 1 unit dose of Glucagon (an injectable antidote for</p>	F 309	<p>Potentially Affected Patients</p> <p>All residents with physician orders for anti-glycemic meds could be potentially affected. On 6/18/2014 the nurse consultant checked orders for all patients to identify those on insulin and /or oral medications. Those patients were then checked to ensure that all patients on these medications had orders for glucose monitoring per MD order. One patient was identified who did not have routine blood glucose check orders. On 6/18/2014 the MD for this patient were contacted by Unit Manager and order for blood glucose check were ordered. All current patients who have physician orders for anti-glycemic medications were reviewed by the unit managers or directors of nursing on 6/17-18/14. For these patients the blood glucose results documented on the medication administration record for the past 30 days were reviewed. 0 patients were identified with results less than or equal to 40. 24 patients were identified with results greater than or equal to 41 and less than 80. On 06/17/14 when the auditing process began, 6 residents were identified with a blood sugar result greater than or equal to 41 and less than 80. On 06/18/14 18 additional residents were noted with blood sugar result greater than or equal to 41 and less than 80. This was due to an auditing error. On 6/17 and 6/18, the one patient identified as being on diabetic medications but not having blood glucose check orders and the 24 patients</p>		

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F 309	<p>Continued From page 29</p> <p>hypoglycemia or low blood sugar) IM (intramuscularly). Hold insulin or hypoglycemic. Notify MD immediately. Recheck BS in 1 hour and monitor closely.</p> <p>BS < 80 > (greater than) 40: Hold insulin or hypoglycemic. Offer 120 cc Resource. Recheck in 1 hour. If BS remains < 80, call MD. If BS >80, give medications and continue to monitor. BS > 400: call MD immediately. Monitor closely.</p> <p>"</p> <p>According to LexiComp, a comprehensive medication database, the appropriate indication for glucagon is insulin or sulfonylurea overdose. Additionally, under the heading of " Other warnings/ precautions, " LexiComp includes a notation that patients with hypoglycemia should immediately be treated with dextrose (sugar). If IV (intravenous) access cannot be established or if dextrose is not available, glucagon may be considered as alternative acute treatment until dextrose can be administered. Other precautions include: Monitor blood glucose levels closely. Supplemental carbohydrates should be given to patients who respond to glucagon for severe hypoglycemia to prevent secondary hypoglycemia.</p> <p>Resident #1 was admitted to the facility on 11/6/13 from an acute care hospital. Her cumulative diagnoses included Type 2 diabetes, hyperlipidemia, hypertension, heart failure, and possible chronic kidney disease estimated upon admission as stage 1- 3 (kidney disease is frequently classified by 5 stages, with stage 1 indicative of mild kidney disease and stage 5 indicative of end stage renal disease).</p> <p>A review of Resident #1 ' s May 2014 Physician</p>	F 309	<p>identified as having blood sugars less than 80 during the last 30 days were then assessed by the unit managers or director of nursing to ensure that they were not currently experiencing signs or symptoms of hypoglycemia (such as shakiness, nervousness or anxiety, sweating, chills and clamminess, irritability or impatience, confusion, including delirium, rapid/fast heartbeat, lightheadedness or dizziness, hunger and nausea, sleepiness, blurred/impaired vision, tingling or numbness in the lips or tongue, headaches, weakness or fatigue, anger, stubbornness, or sadness, lack of coordination, nightmares or crying out during sleep, seizures, or unconsciousness).</p> <p>On 6/17/2014 the 6 patients identified with blood sugar results greater than or equal to 41 and less than 80 had their blood glucose levels assessed according to the facilities policy which states that blood glucose levels can be obtained by the nurses if hypoglycemia needs to be ruled out. Documentation of this evaluation was completed in the progress notes. None of these 6 residents <input type="checkbox"/> required MD notification of blood sugars less than 80.</p> <p>On 6/18/2014 the remainder of the patients identified (18 patients) were checked by the unit managers and or the Director of Nursing to ensure that they had a blood glucose level checked in the past 24 hours. No problems were identified.</p> <p>On 6/18/2014, meal documentation was reviewed for all 24 diabetic residents and assessed by the Director of Nursing.</p>		

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F 309	<p>Continued From page 30</p> <p>Orders revealed the following medications were used in the treatment of diabetes: 5 milligrams (mg) glipizide (an oral medication used to lower blood glucose in patients with Type 2 diabetes) given as one tablet by mouth one time a day and scheduled for 9:00 AM; and Humalog insulin 100 units/milliliter (a rapid acting insulin) injected subcutaneously (under the skin) two times a day as sliding scale insulin (SSI). SSI coverage indicated that the dose of insulin administered was dependent on the resident's BS result. Blood sugars were checked twice daily at 9 AM and 5 PM. The SSI ordered utilized the following parameters:</p> <p style="padding-left: 40px;">If BS 150-200, give 2 units insulin; If BS 201-250, give 3 units insulin; If BS 251-300, give 4 units insulin; If BS 301-350, give 5 units insulin; If BS 351-400, give 6 units insulin; If BS 401 or greater, give 7 units insulin.</p> <p>A review of the Nursing Progress notes for Resident #1 revealed the following notation was made on 5/3/14 at 8:45 AM: " In rsdt (resident ' s) room to check bs (blood sugar) and bs (blood sugar) 46 and resident was unresponsive and wet with sweat. Glucagon shot given IM at 8:15 AM. Called [name of hospital] to get MD on call for [name of resident ' s physician]. [Name of resident ' s physician] called right back. Informed him of bs (blood sugar) and rsdt (resident) unresponsive. Ordered given to send to [name of hospital]. Called to arrange transport. 911 in at 8:45 am to transport rsdt (resident) to ER (Emergency Room). Called rp (Responsible Party) in r/t (relation to) being sent to [name of hospital], called all three no (numbers). No answer. "</p>	F 309	<p>There was no missing meal documentation breakfast and lunch on 6/18, 19 of the 24 had meal intakes greater than 50 %. 1 resident was NPO on 6/18/14 for a test. 1 resident who ate less than 25%-50% was interviewed by Administrator who informed him she often eats snacks from his room in lieu of eating a facility meal. Another resident the evening of 6/17/2014 was NPO for a test. The variation of the resident's blood glucose levels could not be tied to anti-glycemic medication. Of the 24 residents reviewed none of the variations were related to medication administration times.</p> <p>Systematic Changes</p> <p>These changes were discussed with the Medical Director on 6/18/2014 by the Director of Nursing.</p> <p>All current nurses (registered nurses and licensed practical nurses) and nursing assistants who are currently employed on a full time, part time or as needed basis will receive education on the hypoglycemia protocol provided by the Staff Development Coordinator on 6/18/2014. There are two agency nurses that may provide staffing coverage if needed. On 6/18/2014, the director of nursing contacted both of these nurses and provided them with the education. This in-service includes the Diabetic Protocol below which also includes signs and symptoms of hypoglycemia (see below). Education began on 06/18/14 and will continue until all employees have</p>		

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F 309	<p>Continued From page 31</p> <p>A review of the hospital ' s Discharge Summary dated 5/4/14 revealed Resident #1 was admitted to the hospital on 5/3/14 and discharged back to the facility on 5/4/14. The discharge diagnoses included UTI (urinary tract infection); and transient hypoglycemia (low blood sugar). The Discharge Summary included information titled, " Hospital Course " , which read, in part: " This [age of resident] woman was hospitalized after she was found unresponsive at the Mary Gran Nursing Home with hypoglycemia. Her initial blood sugar was as low as 44. She also had recently been diagnosed with a urinary tract infection and had been started on Bactrim (an antibiotic) for this. Following admission, the patient was treated with IV dextrose (sugar) infusions, until her sugar stabilized. When the infusion was stopped, her BS remained stable in the low 100s ... "</p> <p>A review of Resident #1 ' s medical record revealed that on 5/5/14, the Nurse Practitioner wrote new orders for the resident at the facility. The orders included: " Decrease glipizide to 2.5 mg po (by mouth) qd (every day); Change C/S (an abbreviation for chemstrips, which referred to the BS checks) to TID (three times daily) 6AM-no SSI; 9AM with SSI and 5PM with SSI (same scale, no changes-flag to reevaluate if BS <70 or >150); staff to assist with meals. "</p> <p>A review of the resident ' s May 2014 Medication Administration Record (MAR) revealed her BS were checked at 6AM, 9AM and 5PM beginning on 5/6/14. A note on the MAR was handwritten and read in part, " flag to re-eval if BS<70 or >150. "</p>	F 309	<p>received the in-service. Any employee not in-serviced by 06/18/14 will not be allowed to work until they have been in-serviced. Topics included: the hypoglycemia protocol, provided by the Staff Development Coordinator. On 07/11/14, all current nurses (registered nurses and licensed practical nurses) who are currently employed on a full time, part time or as needed basis will receive education on the updated hypoglycemia protocol provided by the Staff Development Coordinator and Director of Nursing. Any employee not in-serviced by 07/11/14 will not be allowed to work until they have been in-serviced. This education will continue until all nurses are in-serviced and will be completed by 07/16/14.</p> <p>1. The current hypoglycemic protocol which was updated on 6/18/14 and again on 07/11/14 includes: Diabetic Protocols All diabetic patients should have blood glucose monitoring orders based on their individual needs. If orders are not received on admission then the charge nurse should contact the MD for orders or reason why orders for blood sugar checks are not required. Blood sugar less than 40 Responsive Resident: Give 120cc of Med Pass 2.0 PO. 120 cc of Med Pass 2.0 has 28 grams of carbohydrate. This is not a change. 2.0 was left off in the plan of correction but is the brand the facility uses. Hold Insulin or hypoglycemic and notify MD immediately. Re-check blood glucose every 15 minutes until blood</p>		

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	<p>Continued From page 32</p> <p>A review of Resident #1 ' s quarterly MDS (Minimum Data Set) assessment dated 5/9/14 revealed the resident had severely impaired cognitive skills for daily decision making. She required extensive assist with bed mobility, locomotion on/off unit; dressing; toilet use; and personal hygiene. The resident required supervision with eating. The MDS assessment indicated Resident #1 received insulin injections on 4/7 days during the assessment period. No care plan was included in the resident ' s medical record.</p> <p>On 5/22/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s May 2014 MAR revealed that on 5/22/14 the resident ' s BS at 5 PM was 58 with a rechecked BS (no time noted) of 63. There was no record of a Nursing Progress note written on this date; no notations were made regarding interventions initiated in response to the resident ' s low BS per the Diabetic Protocols in the Standing Orders; no notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70. The May 2014 MAR noted the resident ' s glipizide (antidiabetic medication) had been given as scheduled at 9 AM on 5/22/14; no insulin was given to the resident on this date. A review of Resident #1 ' s Meal Intake records from 5/22/14 indicated she had consumed 51-75% of her breakfast meal; and 51-75% of her mid-day meal. No intake record was available for the evening meal. No intake record was available to document the resident ' s acceptance of a bedtime snack on 5/22/14.</p>		<p>glucose is above 80. Blood sugar less than 40 Unresponsive Resident: Administer 1 unit dose of Glucagon IM. Hold insulin or hypoglycemic. Notify MD immediately. Someone should stay with the patient until the blood sugar is above 80. Recheck blood glucose every 15 minutes x 2 or until blood glucose is above 80 and the patient is responsive, or if remains below 80, notify MD or order to send to ER for evaluation. 911 should be called if the patient does not respond to treatment and has been unresponsive for more than 30 minutes.</p> <p>Blood sugar less than 80 but greater than or equal to 41 responsive resident: hold insulin or hypoglycemic. Offer 120cc Med Pass 2.0. Recheck in 15 minutes. If blood sugar remains less than 80 or if the patient is symptomatic, call MD immediately. If blood sugar is greater than 80, give medications and either call physician or fax physician if after normal business hours. Resident assessment will be performed and documented.</p> <p>Blood sugar less than 80 but greater than or equal to 41 unresponsive resident: hold insulin or hypoglycemic. Administer 1 unit dose of Glucagon IM. Notify MD immediately. Someone should stay with the patient until the resident becomes responsive. Recheck blood glucose every 15 minutes x 2 or until the patient is responsive, or if remains unresponsive, notify MD or order to send to ER for evaluation. 911 should be called if the patient does not respond to treatment and has been unresponsive for more than 30</p>		

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F 309	<p>Continued From page 33</p> <p>A telephone interview was conducted with Nurse #1 on 6/18/14 at 3:28 PM. Nurse #1 was the 2nd shift nurse assigned to care for Resident #1 on 5/22/14. During the interview, Nurse #1 reported that she could not recall this particular situation. However, she stated that in this type of circumstance she would have typically given the resident Med Pass (a liquid nutritional supplement high in calories, protein, and fat) and gone back in 1 hour to recheck her blood sugar. When asked what she would typically have done next, Nurse #1 reported that if the resident was acting fine, eating and responding appropriately, she would, "just let it be." However, she noted that if the resident was sluggish or not responding, she would notify the physician. When asked if she would have notified the physician of the low blood sugar, Nurse #1 stated that if the resident had not responded or her blood sugars had not come up, "then yes." The nurse reported that if she did notify the physician, this would have been noted in the Nurse ' s notes or on the MAR.</p> <p>On 5/23/14, Resident #1 was noted to have a low BS on three occasions. A review of Resident #1 ' s May 2014 MAR revealed that on 5/23/14 the resident ' s BS at 6 AM was 57; on 5/23/14 at 9 AM BS was 61; and on 5/23/14 at 5 PM BS was 67. The May 2014 MAR noted the resident ' s glipizide (antidiabetic medication) was given as scheduled on 5/23/14 at 9 AM. There was no record of a Nursing Progress note on this date; no notations were made regarding interventions initiated in response to the resident ' s low BS per the Diabetic Protocols in the Standing Orders; no notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to</p>	F 309	<p>minutes.</p> <p>If you cannot reach the attending physician the patient's blood sugar is not responding to the actions or if the patient is unresponsive then call 911 and initiate transfer to the emergency room. If the patient's blood sugar is improving and the signs and symptoms of hypoglycemia are improving then contact the on call administrative nurse who will call the medical director.</p> <p>Some patients may have more specific parameters for contacting the physicians. This will be documented in a physician order and will be listed on the medication administration record. You must contact the physician anytime the patient's condition meets the criteria identified in the order.</p> <p>2. Documentation should be completed in the nursing notes any time this protocol is implemented. This documentation should be in the electronic health record. Documentation must include the following: blood glucose results, signs and symptoms of hypoglycemia (such as shakiness, nervousness or anxiety, sweating, chills and clamminess, irritability or impatience, confusion, including delirium, rapid/fast heartbeat, lightheadedness or dizziness, hunger and nausea, sleepiness, blurred/impaired vision, tingling or numbness in the lips or tongue, headaches, weakness or fatigue, anger, stubbornness, or sadness, lack of coordination, nightmares or crying out</p>		

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F 309	<p>Continued From page 34</p> <p>indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70. No insulin was given to the resident on 5/23/14. A review of Resident #1 ' s Meal Intake records from 5/23/14 revealed there were no intake records available for the breakfast or mid-day meals; the records indicated Resident #1 had consumed 0-25% of her evening meal. A notation, " Not Applicable, " was made on the resident ' s bedtime snack intake record for 5/23/14.</p> <p>A telephone interview was conducted with Nurse #2 on 6/18/14 at 4:26 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on 5/23/14. During the interview, Nurse #2 reported that she could not recall this particular situation. When asked what she would have typically done under similar circumstances, Nurse #2 reported she would have given the resident 120 cc of Med Pass for the low BS. When asked if she would have rechecked the resident ' s BS, Nurse #2 stated, " I know I ' m supposed to recheck it, but sometimes I haven ' t. " The nurse indicated that if she did recheck the resident ' s BS it should be noted on the back of the MAR. She acknowledged that if the results of a BS recheck were not on the back of the MAR, the BS was not re-checked. Nurse #2 added that if the BS was not rechecked and it was less than 1 hour before she went off of her shift, she would, " probably report it to the oncoming nurse. " Upon inquiry, Nurse #2 reported that she did not report any of Resident #1 ' s low blood sugars to the physician or NP at any point in time.</p> <p>A telephone interview was conducted with Nurse #1 on 6/18/14 at 3:28 PM. Nurse #1 was the 2nd</p>	F 309	<p>during sleep, seizures, or unconsciousness), actions taken to improve the blood glucose levels such as Med Pass 2.0 consumption or glucagon injection, time these actions were taken, resident response to actions taken, and results of the blood glucose recheck including what time it was measured.</p> <p>3. Documenting the times when actions and rechecks are taken are important to ensure that proper protocols were followed.</p> <p>4. It is also important that the nursing assistants document meal intake. If a nursing assistant is unable to document food intake in point click care they are to notify you. You can then document in the point of care part of Point Click Care. Or you can document the meal intake in the nursing notes. If a nursing assistant is unable to complete their documentation please notify the Director of Nursing by leaving a note under her door.</p> <p>5. Nursing assistants should notify you if a diabetic patient refuses a meal or if they eat less than 25 %. Make sure to offer the patient an alternative and assess the cause of the loss of appetite.</p> <p>6. If a resident is diabetic and does not have a blood sugar check order and becomes symptomatic a blood sugar check will be performed and the diabetic protocol will be followed.</p> <p>As of 6/18/2014 any employees that have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation</p>		

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F 309	<p>Continued From page 35</p> <p>shift nurse assigned to care for Resident #1 on 5/23/14. During the interview, Nurse #1 reported that she could not recall this particular situation. When asked what she would have typically done for Resident #1 when her BS result was 67, the nurse stated that if she was not responding she would have called the physician. However, Nurse #1 also stated that if the resident was, " acting her norm, " she would have kept a check on her and given her Med Pass. Nurse #1 stated that if she didn ' t do a re-check, she probably didn ' t give her Med Pass. But, she added that was hard to say and depended on the situation. Nurse #1 stated, " I try really hard to document BS lows and Med Pass given at such and such a time (in the Nurses ' Notes or on the back of the MAR). "</p> <p>On 5/28/14, an order was initiated for Resident #1 to receive Glucerna (a liquid nutritional product designed for people with diabetes) three times daily based on the facility ' s consultant Dietitian ' s recommendation due to a low oral intake. Each serving of Glucerna, if consumed, provided 190 calories, 23 grams of carbohydrate, 10 grams of protein and 7 grams of fat. Resident #1 received Glucerna between meals at 10 AM, 3 PM, and at HS (bedtime).</p> <p>The meal and bedtime snack intake records from 5/30/14 were reviewed. There was no record of Resident #1 ' s intake available for either her meals or snack. A review of Resident #1 ' s May 2014 MAR revealed that on 5/30/14 Resident #1 ' s 10 AM Glucerna was refused; the 3 PM Glucerna was refused; and, there was no documentation of the resident ' s acceptance of the 8 PM Glucerna. Resident #1 received 4 units of insulin in accordance with her SSI regimen on</p>	F 309	<p>program and will be discussed during all general orientation programs that is completed after 6/18/2014.</p> <p>All current nursing assistants who are currently employed on a full time, part time or as needed basis will receive education on documenting meal intake at all three meals. This was provided by the Staff Development Coordinator.</p> <p>Education began on 06/18/14 and will continue until all employees have received the in-service. Any employee not in-serviced by 06/18/14 will not be allowed to work until they have been in-serviced. This included:</p> <ol style="list-style-type: none"> 1. Meal intake must be documented prior to the end of your shift. 2. This documentation must be documented in point click care. 3. If for any reason you are unable to complete this documentation you must notify your charge nurse. 4. If a patient refuses a meal or eats less than 25 % make sure to offer them the alternative meal. If they continue to refuse or still do not eat then notify the charge nurse immediately. <p>As of 6/18/2014 employees that have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all general orientation programs starting 6/18/2014.</p> <p>Quality Assurance</p>		

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F 309	<p>Continued From page 36 5/30/14 at 5 PM for a BS of 251.</p> <p>On 5/31/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s May 2014 MAR revealed that on 5/31/14 the resident ' s BS at 6 AM was 68; on 5/31/14 at 9 AM no BS result was documented; and on 5/31/14 at 5 PM her BS was 71. The May 2014 MAR noted the resident ' s glipizide (antidiabetic medication) was given as scheduled on 5/31/14 at 9 AM. There was no record of a Nursing Progress note written on this date; no notations were made regarding interventions initiated in response to the resident ' s low BS at 6 AM per the Diabetic Protocols in the Standing Orders; no notations were made documenting the reason why no BS result was recorded at 9 AM; and no notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70. No insulin was documented to have been given on 5/31/14. A review of Resident #1 ' s Meal Intake records from 5/31/14 revealed there were no intake records available for the resident ' s breakfast or mid-day meals. The records indicated Resident #1 consumed 51-75% of her evening meal. The May 2014 MAR revealed Resident #1 ' s acceptance of the Glucerna was not recorded at 10AM, and noted as 0% at 3PM and 0% at bedtime. A notation, " Accepted, " was made on the resident ' s bedtime snack intake record for 5/31/14.</p> <p>A telephone interview was conducted with Nurse #2 on 6/18/14 at 4:26 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on 5/23/14. When asked if she could recall this</p>	F 309	<p>A Quality Assurance audit will be completed by the Unit Manger or Director of Nursing in their absence and will review all patients on glucose monitoring daily times 14 days then at least 10 patients weekly x three months. The patient's medication administration records will be reviewed (last seven days of glucose monitoring) to ensure to ensure that blood glucose levels are recorded as ordered and that results are above 80. If the patient has a recorded blood glucose level less than 80 then their chart will be reviewed to ensure that the diabetic protocol was initiated appropriately, that the physician was notified according to the protocol and that the documentation includes actions taken and times for these actions and blood glucose checks. These items will be reviewed weekly times three months or until resolved by QOL/QA committee and will begin on 6/20/2014. Reports of the audit will be given by the Director of Nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly. The medical director will be given minutes of the meeting by the Administrator.</p>		

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F 309	<p>Continued From page 37</p> <p>particular situation, Nurse #2 stated, " not really. " Upon inquiry, Nurse #2 reported that she typically would have given the resident Med Pass with the resident ' s Prilosec (a medication indicated for the treatment of gastroesophageal reflux) scheduled for 6:30 AM if she had a low blood sugar. When asked if she would have rechecked the resident ' s BS, Nurse #2 stated, " probably not ...I just report it to the oncoming nurse. " Upon inquiry, Nurse #2 reported that she did not report any of Resident #1 ' s low blood sugars to the physician or NP at any point in time.</p> <p>A review of the June 2014 MAR revealed the resident ' s BS were checked at 6AM, 9AM and 5PM. A note on the MAR was handwritten and read in part, " flag to re-eval if BS<70 or >150. "</p> <p>On 6/1/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/1/14 the resident ' s BS at 6 AM was 62 (on 6/1/14 at 9 AM her BS was 86; and on 6/1/14 at 5 PM BS was 185). The June 2014 MAR noted the resident ' s glipizide (antidiabetic medication) was given as scheduled on 6/1/14 at 9 AM. There was no record of a Nursing Progress note on this date; a notation was made on the back of the resident ' s MAR dated 6/1/14 at 6:00 AM which indicated 120 cc of Med Pass were given to the resident in response to the resident ' s low BS at 6 AM, along with the results of a BS recheck of 74 (the time of the re-check was not noted). No notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that either the physician or NP was notified of a low BS as indicated by the physician orders or in accordance with the Diabetic Protocols in the</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>Standing Orders. A review of Resident #1 ' s Meal Intake records from 6/1/14 revealed there was no documentation available for the resident ' s breakfast or mid-day meals. The records indicated Resident #1 consumed 76-100% of the evening meal on 6/1/14. The June 2014 MAR noted that two units of insulin were given to the resident at 5 PM on 6/1/14 in accordance with the SSI regimen (for a BS of 185). The June 2014 MAR also revealed Resident #1 accepted 25% of the Glucerna at 10 AM, none of the Glucerna at 3PM; and 50% of the Glucerna at bedtime. A notation, " Accepted, " was made on the resident ' s bedtime snack intake record for 6/1/14.</p> <p>A telephone interview was conducted with Nurse #3 on 6/18/14 at 3:57 PM. Nurse #3 was the 3rd shift nurse assigned to care for Resident #1 on 6/1/14. During the interview, Nurse #3 recalled the situation encountered with Resident #1 at 6 AM on that date. The nurse indicated that the resident was alert, oriented and responded to her at that time. Nurse #3 stated that she gave the resident 120cc Med Pass and then rechecked her BS approximately 30-45 minutes later. She recalled that the BS had come up and that she reported this to the oncoming nurse. The nurse reported that she recorded the BS recheck results on the back of the MAR. Upon inquiry, Nurse #3 indicated she did not notify the resident ' s physician of the low BS. She stated there was, " no reason because her BS came up and she was alert and oriented and responded to me. "</p> <p>A review of the June 2014 MAR revealed the resident refused her 8 AM and 9 AM medications on 6/3/14 and 6/4/14. The refused medications included glipizide scheduled for 9 AM</p>	F 309			

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F 309	<p>Continued From page 39</p> <p>administration on each of these dates. No notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of the medication refusal on 6/3/14 and 6/4/14.</p> <p>On 6/8/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14 the resident refused a BS check at 6 AM; on 6/8/14 at 9 AM her BS was 60. The June 2014 MAR noted the resident ' s glipizide (antidiabetic medication) was given as scheduled on 6/8/14 at 9 AM. There was no record of a Nursing Progress note having been written on 6/8/14 in reference to the 9 AM low blood sugar; no notations were made regarding interventions initiated in response to the resident ' s low BS at 9 AM per the Diabetic Protocols in the Standing Orders; no notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70. No insulin was given to the resident on 6/8/14. A review of Resident #1 ' s Meal Intake records from 6/8/14 revealed there was no documentation available for the resident ' s breakfast or mid-day meals. The June 2014 MAR revealed Resident #1 accepted 0% of the Glucerna at 10 AM; no documentation was made regarding her acceptance of the Glucerna at 3PM.</p> <p>A telephone interview was conducted with Nurse #2 on 6/16/14 at 4:35 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on the evening of 6/7/14 to the morning of 6/8/14. Upon inquiry, the nurse indicated the resident</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>was very agitated the morning of 6/8/14 and she would not allow the BS to be checked. The nurse also reported that sometimes the resident would get agitated and refuse the BS checks. Nurse #2 reported that she was, " yelling out and wouldn ' t let me stick her finger. "</p> <p>A telephone interview was conducted with Nursing Assistant (NA) #1 on 6/16/14 at 6:31 PM. NA #1 was the 3rd shift NA assigned to care for Resident #1 on the evening of 6/7/14 to the morning of 6/8/14. The NA reported the resident slept all night that evening. NA #1 stated that she would go into the resident ' s room every 2-3 hours during rounds to check on her. The NA reported she would check to be sure the resident was breathing, if she was wet, or had other needs. NA #1 indicated the resident liked to ring her call bell if she needed help. Upon inquiry, NA recalled that Resident #1 was very agitated the morning of 6/8/14 and noted, " at times she would be like that. "</p> <p>An interview was conducted with Nurse #4 on 6/16/14 at 2:51 PM. Nurse #4 was the 1st shift nurse assigned to care for Resident #1 on 6/8/14. During the interview, Nurse #4 recalled that the outgoing 3rd shift nurse reported the resident ' s refusal to have her BS checked at 6 AM and that the resident was alert and verbal. At 9 AM on 6/8/14, Resident #1 ' s BS was 60. Nurse #4 reported that she gave the resident 120cc Med Pass and that the resident was fine. The nurse stated that she rechecked the BS after the Med Pass was consumed and her breakfast was served. She was not sure how much breakfast the resident ate. Nurse #4 stated she did not document what the result of the resident ' s BS recheck was, but thought it was in the 90 ' s. The</p>	F 309			

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F 309	<p>Continued From page 41</p> <p>nurse reported that the resident appeared, " fine " the rest of the morning but noted she did talk with herself that morning. She noted this was a usual behavior for the resident. Nurse #4 indicated that she did not report the low BS results to the resident ' s physician or NP. The nurse stated she did make a report of the 9 AM BS result to the oncoming nurse but that there was nothing else out of the ordinary to share.</p> <p>A telephone interview was conducted with Nursing Assistant (NA) #2 on 6/16/14 at 3:43 PM. NA #2 was the 1st shift NA assigned to care for Resident #1 on 6/8/14. The NA recalled that the resident was, " talking a little off for a while " that morning, but that this wasn ' t unusual for her. NA #2 reported the resident drank a little of her juice but would not eat her breakfast that morning. Upon inquiry, NA #2 stated that she set up the meal for the resident and then she ate it on her own. She recalled that the resident drank her sweet tea at lunchtime and kept something off of her tray to eat at a later time, but the NA was not sure what that item was or whether or not the resident actually consumed it later that day.</p> <p>On 6/8/14, Resident #1 was noted to have a second low BS result. A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14 the resident ' s BS at 5 PM was 42. A Nursing Progress note dated 6/8/14 at 5:00 PM read: " Pt (patient) unresponsive bs (blood sugar) 42 VS (Vital Signs) 96.4 (temperature); 64 (heart rate); 18 (respiration rate); 120/74 (blood pressure); glucagon given bs (blood sugar) came up to 71 pt alert responsive sweating pt drank glucerna refused supper will monitor. " A notation was made on the back of the resident ' s MAR dated 6/8/14 at 5:00 PM which indicated</p>	F 309			

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F 309	<p>Continued From page 42</p> <p>the resident ' s BS was 42; she was unresponsive; glucagon was given; and the results of a BS recheck (no time provided) was 71. No notations were made in the resident ' s medical record (including the Nurse ' s Notes and MAR) to indicate that the NP or physician was notified of a low BS per the Diabetic Protocols in the Standing Orders or as indicated by the physician orders for a BS less than 70. A review of Resident #1 ' s Meal Intake records from 6/8/14 indicated Resident #1 consumed 26-50% of the evening meal on 6/8/14. No documentation of the resident ' s acceptance of Glucerna at bedtime was recorded on the MAR. A notation, " Accepted, " was made on the resident ' s bedtime snack intake record for 6/8/14.</p> <p>An interview was conducted with Nurse #5 on 6/16/14 at 3:19 PM. Nurse #5 was the 2nd shift nurse assigned to care for Resident #1 on 6/8/14. During the interview, the nurse reported the resident was asleep that day when they made rounds at 3PM. She indicated that was not unusual for Resident #1. The nurse stated that when she went to check the resident around 4:30 PM (to do the 5PM BS check), the resident would not wake up. The resident ' s BS at that time was 42. The nurse stated that she had the NA take the resident ' s vital signs while she went to get a glucagon shot for her. After the glucagon shot was given, the nurse had the NA stay with the resident. The resident woke up after about 20 minutes and was reported to be alert but confused at that time. The nurse indicated the resident was usually disoriented. When the resident was awake, the nurse rechecked her BS again and found that it had come up to 71. Nurse #5 stated that she gave the resident some</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>Glucerna at that time (around 5:00 PM). The nurse reported that the resident seemed her " normal self " after consuming this Glucerna. Nurse #5 stated that she did check the resident ' s BS again after the supper trays came out, but didn ' t document the result. The nurse thought that BS result when rechecked was, " either 100 or 148. " Nurse #5 stated that Resident #1 wouldn ' t eat her supper that evening, which was not unusual for her. The nurse also reported that at around 8:30PM the resident drank another can of Glucerna. The nurse reported that she checked on her 2-3 more times that shift. She stated that her checks, " just involved verbal stimuli " and that the resident would wake up and talk with her. At the end of the shift, the nurse reported that Resident #1 was sleeping (like she usually would have at that time of night). Nurse #5 stated that she faxed the resident ' s physician the evening of 6/8/14 to inform him that Resident #1 ' s BS had been low and that glucagon was given. Upon inquiry, the nurse indicated that she would have called the physician if the resident would have remained unresponsive. The nurse noted that she told the oncoming nurse in report that she had given glucagon to the resident, Resident #1 was refusing her meals, and to watch her BS.</p> <p>An interview was conducted with NA #3 on 6/16/14 at 3:08 PM. NA #3 worked the 2nd shift on 6/8/14 and recalled the situation with Resident #1 on that date. NA #3 reported that when Nurse #5 told her she couldn ' t get Resident #1 awake, she went into the room and also tried to awaken her without success. The NA reported the nurse checked her BS, left to get the glucagon, then returned and administered it to her. NA #3 reported that she and a co-worker (another NA)</p>	F 309			

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F 309	<p>Continued From page 44</p> <p>stayed with the resident " the entire time " until she woke up. Upon awakening, the resident was described as disoriented and very sweaty. The NA stated that the resident drank a whole can of Glucerna but wouldn ' t eat her supper.</p> <p>An interview was conducted with NA #4 on 6/17/14 at 9:26 AM. NA #4 worked as a NA during the 2nd shift on 6/8/14 and recalled the events that occurred with Resident #1 on that date. NA #4 recalled that she was working with another resident when the resident ' s sugar had dropped. The NA reported that she assisted the resident with drinking a can of Glucerna at around 5PM. The NA reported that the resident was, " talking and everything and seemed like she was getting okay ...she said she was cold. " The NA indicated she went in and checked on the resident about every 30 minutes and noted that she was, " sleeping sometimes and sometimes awake. " NA #4 reported that around 8:00 PM or so she assisted the resident with drinking another can of Glucerna, which she finished. The NA stated, " I just did it because I knew she didn ' t eat her food. " Upon inquiry, the NA stated that the last time she checked on the resident was probably around 10:30 PM on 6/8/14. The resident was noted to be sleeping at that time.</p> <p>On 6/9/14, Resident #1 was noted to have a low BS. A review of Resident #1 ' s June 2014 MAR revealed that on 6/9/14 the resident ' s BS at 6 AM was 41. A notation dated 6/9/14 at 6 AM was made on the back of the June 2014 MAR. The notation reported Resident #1 ' s BS was 41; 2 packs of sugar were given under her tongue; and BS recheck at 7 AM was 57.</p> <p>A telephone interview was conducted with Nurse</p>	F 309			

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F 309	<p>Continued From page 45</p> <p>#2 on 6/16/14 at 4:35 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on the evening of 6/8/14 to the morning of 6/9/14. During this interview, the nurse recalled there was nothing unusual noted for Resident #1 that night. The nurse reported that Resident #1 would sometimes wake up around 3 AM - 4 AM, but did not recall whether or not she woke up that night. The nurse reported that when she took the resident ' s BS between 6AM and 6:30AM, she found it was low and the resident was unresponsive. The nurse stated that she went to the Stat Box (referring to the Stat Medication Box, an emergency supply of medications kept in the Medication Room), " to see if we had glucagon, " but there wasn ' t any. Nurse #2 reported she then went to a second unit ' s medication room and there wasn ' t ' any glucagon there either. At that time, the nurse reported she went and got sugar (2-3 packets) and put it under the resident ' s tongue. After that, she called to the 3rd and final unit in the facility to see if they had any glucagon and found that they did not. Nurse #2 stated that she rechecked the resident ' s sugar more than once but only documented the results of the last recheck when her BS had gone up to around 57. She recalled that the resident was moaning at about that time (approximately 7:00 AM). Nurse #2 stated that it was also about 7:00 AM when she gave report to the on-coming nurse. When asked why she did not initiate any further interventions or call the resident ' s physician, Nurse #4 stated, " I thought her sugar was coming up and the situation was resolving. "</p> <p>A telephone interview was conducted with NA #1 on 6/16/14 at 6:31 PM. NA #1 was the 3rd shift NA assigned to care for Resident #1 on the evening of 6/8/14 to the morning of 6/9/14. The</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>NA recalled that around 2:00 AM she told the nurse that the resident was in deep sleep and snoring. She recalled that at about 4:00 AM she reported the same to the hall nurse. NA #1 stated that at 6:00 AM (on her last round) she couldn ' t wake the resident up. She told Nurse #2 (the hall nurse), and the nurse said she was aware of it and was trying to find the glucagon to bring her sugar up. The NA stated the nurse wasn ' t able to find any glucagon. She recalled that the nurse then gave the resident some sugar under her tongue. The NA stated that the resident did not respond while she was in the room.</p> <p>A Nursing Progress note written for 6/9/14 at 7:15 AM (created as a late entry on 6/16/14 at 11:40 AM) read: " In rsdt (resident ' s) room this shift. Rsdtd noted unresponsive, BS checked 51. Glucagon shot given at 7:15 AM. Back in rsdt room at 7:45 am. BS increase to 113 rsdt remained unresponsive. Sat (oxygen saturation) 93% ra (on room air). V/S (Vital Signs) 97.5 (temperature), 130/60 (blood pressure), 18 (respiration rate); 80 (heart rate). White foam substance noted coming from mouth. Called [name of hospital] to get MD on call for [name of resident ' s physician], [name of on-call physician] called right back, informed him of status change. Order given to send to [name of hospital] for eval. 911 called for transport of rsdt to [name of hospital]. RP [family member] called informed of status change and order to send to [name of hospital], was appreciative. "</p> <p>An interview was conducted with Nurse #6 on 6/16/14 at 2:33 PM. Nurse #6 was the 1st shift nurse who came on duty at 7:00 AM on 6/9/14. Nurse #6 stated that when she got to the facility that morning, the resident was unresponsive and</p>	F 309			

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F 309	<p>Continued From page 47</p> <p>she was told the resident ' s sugar was low. Nurse #6 stated, " I think I was told (her BS was) 51. " Nurse #6 reported the BS was rechecked and it was still low (no value was given). The nurse reported she went and got a glucagon shot from the neighboring facility and administered it to the resident at 7:15 AM. The nurse indicated that she waited 15-30 minutes to see if the resident would respond. When the nurse went back at 7:45 AM, her BS was 113 but she wasn ' t responding. Nurse #6 stated she did a sternal rub and the resident was still nonresponsive. She obtained the vital signs, phoned the on-call physician, and received orders to send her out to the Emergency Department. The nurse reported that was her second time having to give the resident a shot of glucagon---the first was in the beginning of May. The nurse stated that back in May the resident did become responsive once her sugar went up. " That ' s why this time I knew it was different. "</p> <p>A review of Resident #1 ' s medical record revealed a Physician ' s Telephone Order was received on 6/9/14 at 8:25 AM to send the resident to [name of hospital] to be evaluated. A review of the hospital Emergency Department records revealed Resident #1 was transported by air to another hospital on 6/9/14 at 1:07 PM for specialty care/treatment. The diagnoses at the time of the transfer included AMS (altered mental status), NSTEMI (non-ST-elevation myocardial infarction or heart attack), suspected CVA (cerebrovascular accident or stroke), renal (kidney) insufficiency, and ECG changes (an ECG or electrocardiogram is a test that evaluates the rhythm and electrical activity of the heart).</p>	F 309			

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F 309	Continued From page 48 Interviews were conducted with the Director of Nursing (DON) on 6/16/14 at 4:05 PM and 6/17/14 at 9:47 AM. During the interviews, the DON was asked what she would have expected to be done as follow-up on 5/22/14, 5/23/14, 5/31/14, and 6/1/14 when Resident ' s #1 ' s blood sugars were noted to be less than 70. The DON indicated that the order received on 5/5/14 instructed the nursing staff to "flag to reevaluate if BS <70 or >150. " The DON indicated that such an order meant that the resident ' s chart should have been set aside at the nursing station to call the NP ' s attention to it. Then, Resident #1 would have been reviewed when the NP came in. The DON indicated the NP came in every weekday, Monday through Friday. When asked what the DON ' s expectations would have been after the glucagon injection was given to Resident #1 on the evening of 6/8/14, the DON stated that the protocol was to notify the physician. However, she indicated that the timing of the physician notification would depend on the BS result and that the resident ' s response to the glucagon would have also been key in determining this. The DON reported that if glucagon was given and the resident got back to baseline, the nursing staff may not call the physician. Instead, the nurse may tell the NP the next day. When asked what her expectations were in regard to monitoring the resident on the evening of 6/8/14, the DON indicated that the fact that the resident was okay when it was time to go to bed made this difficult to answer. The DON was then asked what she would have expected her nursing staff to do on the morning of 6/9/14 at 6:00 AM when the resident was found to be unresponsive. The DON stated, " My expectations would have been for her (the 3rd shift nurse) to give some glucagon from our sister	F 309			

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F 309	<p>Continued From page 49</p> <p>facility at 6:00 AM when the resident was unresponsive. " In regards to not giving the glucagon at 6:00 AM , the DON stated, " that ' s an issue. "</p> <p>An interview was conducted on 6/17/14 at 11:33 AM with the NP. The NP clarified what she intended to be done when she wrote the order, "flag to reevaluate if BS <70 or >150 " on 5/5/14 for Resident #1. The NP stated that the facility would sometimes " flag " a chart, which meant the nurses would pull a resident ' s chart to indicate he/she needed to be reviewed, and described the procedure as, " a tickler system. " After reviewing the May 2014 and June 2014 MAR for Resident #1, the NP stated she had not been made aware of any of the resident ' s low BS (BS less than 70) during the months of May or June. The NP indicated she would have wanted to know about all of the BS results that were outside of the parameters she had specified (less than 70 for a low). The NP indicated that if the resident ' s BS were outside of the parameters and the resident was symptomatic, that she would have wanted a phone call. If the resident was not symptomatic, flagging the chart for her to see the resident the next day would have been acceptable. The NP noted that she was in the building every weekday, Monday through Friday. Additionally, she had been on call the weekends of 5/31/14 -6/1/14 and 6/7/14-6/8/14 from 7 AM - 7 PM. When asked what follow-up should have been used when glucagon was administered to a resident, the NP stated that she would have wanted more monitoring done, including checks on the resident ' s BS at 20 minutes and one hour. In addition, the NP noted that nursing should have checked the BS at least 2-3 times in the night after administering the glucagon. When</p>	F 309			

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F 309	<p>Continued From page 50</p> <p>asked what her thoughts were in regards to the length of time which elapsed between when the resident was found unresponsive with a low blood sugar on 6/9/14 and when the glucagon was administered on that date, the NP stated this delay was, " not acceptable. "</p> <p>An interview was conducted on 6/17/14 at 12:50 PM with Resident #1 ' s physician. Resident #1 ' s May 2014 and June 2014 MARs were reviewed (noting the low BS results of 5/22/14, 5/23/14, 5/31/14, and 6/1/14) along with the 5/5/14 order written to "flag to reevaluate if BS <70 or >150 " for Resident #1. Upon inquiry, the physician stated that he, " would have expected someone to be contacted...a provider, on-call physician or NP, especially if parameters were written. " The physician indicated he had not been notified. Upon review of the situation encountered on the evening of 6/8/14, the physician stated, " The physician has got to be notified in that situation ...there are always different ways to manage a patient with hypoglycemia. A fax is not immediate notification. I would expect if you have an unresponsive resident, even if the resident becomes responsive that provider should be notified. I think that ' s a standard. A physician needs to help guide them. " The physician was asked what monitoring he would have ordered if he had been notified of the resident ' s low BS on the evening of 6/8/14. He stated that he would have expected a repeat BS but indicated that he couldn ' t tell from the notes as to when the follow-up BS (a result of 71) was obtained. The physician indicated his guidance for additional monitoring would have been dependent on this information. He stated that with a patient who was initially unresponsive, he would have wanted 1 more BS check within 30 minutes, then maybe</p>	F 309			

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F 309	<p>Continued From page 51</p> <p>every hour until the BS normalized for at least 3 readings. He stated, " The problem is the MD was not contactedThey should have contacted the physician from the get-go. " When asked what his thoughts were in regards to the length of time which elapsed between when the resident was found unresponsive with a low blood sugar the morning of 6/9/14 and when the glucagon was administered, the MD stated that amount of time was, " too long in an unresponsive patient. "</p> <p>The facility ' s Administrator was notified of the Immediate Jeopardy on 6/17/14 at 6:45 PM. A credible allegation of compliance was received on 6/18/14 at 8:45 PM as follows:</p> <p>F 309 Corrective Action for Affected Patient The patient remains at the hospital as of 6/18/2014.</p> <p>Potentially Affected Patients All residents with physician orders for anti-glycemic meds could be potentially affected. On 6/18/2014 the nurse consultant checked orders for all patients to identify those on insulin and /or oral medications. Those patients were then checked to ensure that all patients on these medications had orders for glucose monitoring per MD order. One patient was identified who did not have routine blood glucose check orders. On 6/18/2014 the MD for this patient were contacted by Unit Manager and order for blood glucose check were ordered.</p> <p>All current patients who have physician orders for anti-glycemic medications were reviewed by the unit managers or directors of nursing on 6/17-18/14. For these patients the blood glucose</p>	F 309			

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F 309	<p>Continued From page 52</p> <p>results documented on the medication administration record for the past 30 days were reviewed. 0 patients were identified with results less than or equal to 40. 21 patients were identified with results greater than or equal to 41 and less than 80.</p> <p>On 6/17 and 6/18, the one patient identified as being on diabetic medications but not having blood glucose check orders and the 21 patients identified as having blood sugars less than 80 during the last 30 days were then assessed by the unit managers or director of nursing to ensure that they were not currently experiencing signs or symptoms of hypoglycemia (such as shakiness, nervousness or anxiety, sweating, chills and clamminess, irritability or impatience, confusion, including delirium, rapid/fast heartbeat, lightheadedness or dizziness, hunger and nausea, sleepiness, blurred/impaired vision, tingling or numbness in the lips or tongue, headaches, weakness or fatigue, anger, stubbornness, or sadness, lack of coordination, nightmares or crying out during sleep, seizures, or unconsciousness). On 6/17/2014 there were 6 patients who had additional blood glucose levels according to the facilities policy which states that blood glucose levels can be obtained by the nurses if hypoglycemia needs to be ruled out. Documentation of this evaluation was completed in the progress notes. None of these 6 residents required MD notification of blood sugars less than 80. On 6/18/2014 the remainder of the patients identified (17 patients) were checked by the unit managers and or the Director of Nursing to ensure that they had a blood glucose level checked in the past 24 hours.</p> <p>On 6/18/2014, meal documentation was reviewed</p>	F 309			

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F 309	<p>Continued From page 53</p> <p>for all 21 diabetic residents assessed. There was no missing meal documentation for breakfast and lunch on 6/18. 19 of the 21 had meal intakes greater than 50 %. 1 resident was NPO on 6/18/14 for a test. 1 resident who ate less than 25%-50% was interviewed by Administrator who informed him she often eats snacks from his room in lieu of eating a facility meal. Another resident the evening of 6/17/2014 was NPO for a test. The variation of the resident ' s blood glucose levels could not be tied to anti-glycemic medication. Of the 21 residents reviewed none of the variations were related to medication administration times.</p> <p>Systematic Changes These changes were discussed with the Medical Director on 6/18/2014 by the Director of Nursing. All current nurses (registered nurses and licensed practical nurses) and nursing assistants who are currently employed on a full time, part time or as needed basis will receive education on the hypoglycemia protocol provided by the Staff Development Coordinator on 6/18/2014. There are two agency nurses that may provide staffing coverage if needed. On 6/18/2014, the director of nursing contacted both of these nurses and provided them with the education. This in-service includes the Diabetic Protocol below which also includes signs and symptoms of hypoglycemia (see below)</p> <p>1. The current hypoglycemic protocol which was updated on 6/18/14 includes: Diabetic Protocols All diabetic patients should have blood glucose monitoring orders based on their individual needs. If orders are not received on admission then the charge nurse should contact the MD for</p>	F 309			

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F 309	<p>Continued From page 54</p> <p>orders or reason why orders for blood sugar checks are not required.</p> <p>Blood sugar less than 40 Responsive Resident: Give 120cc of Med Pass PO (by mouth). Hold Insulin or hypoglycemic and notify MD immediately. Re-check blood glucose in 15 minutes and every 30 minutes until blood glucose is above 80.</p> <p>Blood sugar less than 40 Unresponsive Resident: Administer 1 unit dose of Glucagon IM. Hold insulin or hypoglycemic. Notify MD immediately. Someone should stay with the patient until the blood sugar is above 80. Recheck blood glucose every 15 minutes x 2 until blood glucose is above 80 and the patient is responsive, or if remains below 80 notify MD or order to send to ER for evaluation. 911 should be called if the patient does not respond to treatment and has been unresponsive for more than 30 minutes.</p> <p>Blood sugar less than 80 but greater than or equal to 41: hold insulin or hypoglycemic. Offer 120cc Med Pass. Recheck in 30 minutes. If blood sugar remains less than 80 or if the patient is symptomatic, call MD immediately. If blood sugar is greater than 80, give medications and either call physician or fax physician if after normal business hours. Resident assessment will be performed and documented.</p> <p>If you cannot reach the attending physician the patient ' s blood sugar is not responding to the actions or if the patient is unresponsive then call 911 and initiate transfer to the emergency room. If the patient ' s blood sugar is improving and the signs and symptoms of hypoglycemia are improving then contact the on call administrative</p>	F 309			

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F 309	<p>Continued From page 55 nurse who will call the medical director.</p> <p>Some patients may have more specific parameters for contacting the physicians. This will be documented in a physician order and will be listed on the medication administration record. You must contact the physician anytime the patient ' s condition meets the criteria identified in the order.</p> <p>2. Documentation should be completed in the nursing notes any time this protocol is implemented. This documentation should be in the electronic health record. Documentation must include the following: blood glucose results, signs and symptoms of hypoglycemia (such as shakiness, nervousness or anxiety, sweating, chills and clamminess, irritability or impatience, confusion, including delirium, rapid/fast heartbeat, lightheadedness or dizziness, hunger and nausea, sleepiness, blurred/impaired vision, tingling or numbness in the lips or tongue, headaches, weakness or fatigue, anger, stubbornness, or sadness, lack of coordination, nightmares or crying out during sleep, seizures, or unconsciousness), actions taken to improve the blood glucose levels such as resource consumption or glucagon injection, time these actions were taken, resident response to actions taken, and results of the blood glucose recheck including what time it was measured.</p> <p>3. Documenting the times when actions and rechecks are taken are important to ensure that proper protocols were followed.</p> <p>4. It is also important that the nursing assistants document meal intake. If a nursing assistant is unable to document food intake in point click care</p>	F 309			

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F 309	<p>Continued From page 56</p> <p>they are to notify you. You can then document in the point of care part of Point Click Care. Or you can document the meal intake in the nursing notes. If a nursing assistant is unable to complete their documentation please notify the Director of Nursing by leaving a note under her door.</p> <p>5. Nursing assistants should notify you if a diabetic patient refuses a meal or if they eat less than 25 %. Make sure to offer the patient an alternative and assess the cause of the loss of appetite.</p> <p>6. If a resident is diabetic and does not have a blood sugar check order and becomes symptomatic a blood sugar check will be performed and the diabetic protocol will be followed.</p> <p>As of 6/18/2014 any employees that have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed started -----6/18/2014.</p> <p>All current nursing assistants who are currently employed on a full time, part time or as needed basis will receive education on documenting meal intake at all three meals. This was provided by the Staff Development Coordinator. This included:</p> <ol style="list-style-type: none"> 1. Meal intake must be documented prior to the end of your shift. 2. This documentation must be documented in point click care. 	F 309			

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F 309	Continued From page 57 3. If for any reason you are unable to complete this documentation you must notify your charge nurse. 4. If a patient refuses a meal or eats less than 25 % make sure to offer them the alternative meal. If they continue to refuse or still do not eat then notify the charge nurse immediately. As of 6/18/2014 employees that have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all general orientation programs starting 6/18/2014. Completion Date 6/18/14. On 6/18/14 at 9:40 PM, the credible allegation of compliance was validated. The surveyor confirmed that the facility implemented the following: Nursing staff interviews confirmed each nurse had been in-serviced on the current hypoglycemic protocol (revised on 6/18/14) and documentation of the interventions. Facility staff interviews also confirmed each nursing assistant on duty had been in-serviced on the possible signs/symptoms exhibited by a resident who may be experiencing a low blood sugar, the importance of notifying a nurse immediately if a resident may be exhibiting possible signs/symptoms of a low blood sugar, and on the required documentation procedures for recording residents ' meal intakes.	F 309			
F 425 SS=J	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425		7/11/14	

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F 425	<p>Continued From page 58</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility staff and pharmacy staff interviews, the facility failed to maintain a supply of glucagon (an injectable medication used to treat severe hypoglycemia) in the emergency medication box for 1 of 1 sampled residents (Resident #1) presenting with an acute episode of unresponsiveness associated with low blood sugars.</p> <p>Immediate jeopardy began on 6/8/14. On 6/8/14, the facility used their last dose of glucagon and did not have any more doses available within the facility for use in an emergency. Immediate Jeopardy was removed on 6/18/14 at 9:40 PM. The facility remained out of compliance at a lower scope and severity of (D), isolated with potential</p>	F 425	<p>Corrective Action for Affected Patient</p> <p>Resident #1 was discharged from the facility on 6/9/2014.</p> <p>Corrective Action for Potentially Affected Patients</p> <p>Any patient who requires GlucaGen administration has the potential to be affected by the alleged deficient practice. On 6/17/2014 the Director of Nursing contacted the Director of Pharmacy services and requested that two doses of GlucaGen be included in each of the four emergency medication box. These doses</p>		

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F 425	<p>Continued From page 59</p> <p>for more than minimal harm, while the facility completes the staff training required. The facility was in the process of monitoring the implementation of their corrective action.</p> <p>The findings included:</p> <p>A review of the facility ' s Admitting and Standing Orders included a section entitled, " Diabetic Protocols. " The Diabetic Protocols included indications for the use of glucagon. The Diabetic Protocols read in part: BS < (less than) 40 Unresponsive Resident: Administer 1 unit dose of Glucagon IM (intramuscularly). Hold insulin or hypoglycemic. Notify MD (Medical Doctor) immediately. Recheck BS (blood sugar) in 1 hour and monitor closely.</p> <p>A review of the Emergency Drug Box Contents List for each of the facility ' s three Emergency Drug Kits (Stat Med Boxes) included the following: Drug: Glucagon Emergency 1 mg (milligram) Injection Quantity: 2 Location: Top Compartment</p> <p>A review of the facility ' s " Emergency Drug Kit, General Guidelines " policy dated 10/2001, read in part: " Purpose: 1. To obtain drugs on a prompt and timely basis. 2. Immediate availability of emergency drugs. Procedure: 8. (of 12) The pharmacy will be notified that the emergency supply has been used via the</p>	F 425	<p>were sent on 6/17/2014 and were verified as being in the emergency boxes by the Director of Nursing on 6/18/2014.</p> <p>Systematic Changes</p> <p>All current nurses (registered nurses and licensed practical nurses) who are currently employed on a full time, part time or as needed basis will receive education beginning on 06/18/14 and will continue until all employees have received the in-service. Any employee not in-serviced by 06/18/14 will not be allowed to work until they have been in-serviced. Topics included: the hypoglycemia protocol, provided by the Staff Development Coordinator. There are two agency nurses that may provide staffing coverage if needed. On 6/18/2014, the director of nursing contacted both of these nurses and provided them with the education. This included:</p> <ol style="list-style-type: none"> 1. When GlucaGen is used from the emergency stat box the nurse must complete an Emergency Kit Usage Form and fax to 1-888-522-4421. The charge nurse should keep the form with the 24 hour report and should report off to the next shift that the medication has been ordered. 2. The GlucaGen should be received from the pharmacy that night in the delivery totes. When the medication is checked in the charge nurse should put the medication in the emergency box and put the order form in the Director of Nursing box. 3. If the GlucaGen is not received the 		

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F 425	<p>Continued From page 60</p> <p>faxing of the Emergency Usage Form at the time of usage and prior to the next scheduled delivery, but at least within 24 hours after the drug has been removed. The pharmacy will deliver a replacement. "</p> <p>A review of the facility ' s contract pharmacy Long Term Care Policy & Procedures included information titled, " Using the Emergency Kit " which read: " When a drug is used from the Emergency Drug Kit, an Emergency Drug Kit Usage Form should be filled out and faxed to [name of contract pharmacy] along with the new order. This will insure proper billing and proper restocking of the emergency drug kit. Failure to provide this form will result in the facility being charged for a medication when the Emergency Drug Kit becomes short of medications. "</p> <p>Resident #1 was admitted to the facility on 11/6/13 with cumulative diagnoses which included Type 2 diabetes.</p> <p>A review of Resident #1 ' s June 2014 MAR revealed that on 6/8/14, Resident #1 ' s BS at 5 PM was 42.</p> <p>A notation was made on the back of the resident ' s MAR dated 6/8/14 at 5:00 PM which indicated the resident ' s BS was 42; she was unresponsive; and glucagon was given.</p> <p>An interview was conducted with Nurse #5 on 6/16/14 at 3:19 PM. Nurse #5 was the 2nd shift nurse assigned to care for Resident #1 on 6/8/14. Nurse #5 reported that after using glucagon for Resident #1 on 6/8/14, she faxed the pharmacy to request replenishment of glucagon in the Stat Med Boxes. A review of the fax sent to the</p>	F 425	<p>Director of Nursing must be notified by leaving a note under her door.</p> <p>4. If you utilize GlucaGen and there is not another dose in the emergency box contact the on-call pharmacy at Clinton Drug 910-592-8444 to obtain the dose from the back up pharmacy. If the pharmacy says that the dose cannot be obtained contact the Director of Nursing at 910-305-6751.</p> <p>5. If GlucaGen is not available and resident meets the diabetic protocol to receive it, the MD will be called for order to send to ER for evaluation. When order is obtained 911 will be initiated. Unit Managers & MDS Nurse will check the stat box Monday through Friday and document. If items identified as used and not re-stocked they will initiate a form to pharmacy.</p> <p>As of 6/18/2014 employees who have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed 6/18/2014.</p> <p>Quality Assurance</p> <p>A Quality Assurance audit has been completed by the Director of Nursing to ensure that all three emergency medication boxes had two doses of glucagen in the boxes. Beginning 06/20/14 daily (Monday through Friday) the Unit Managers or Director of Nursing</p>		

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F 425	<p>Continued From page 61</p> <p>pharmacy revealed the following notation was written on the fax dated 6/8/14 at 10:29PM: " No Glucagon in any stat box. Please send for Unit 1, Unit 4, Unit 3. " During an interview conducted with the Director of Nursing (DON) on 6/17/14 at 10:15 AM, the DON reported that the pharmacy routinely delivered medications for the facility in the evenings (sometimes as late as 11 PM). The glucagon requested on the evening of 6/8/14 would have been scheduled for delivery on the evening of 6/9/14.</p> <p>A review of Resident #1 ' s June 2014 MAR revealed that on 6/9/14 the resident ' s BS at 6 AM was 41. A notation dated 6/9/14 at 6 AM was made on the back of the June 2014 MAR. The notation reported Resident #1 ' s BS was 41; 2 packs of sugar were given under her tongue; and BS recheck at 7 AM was 57.</p> <p>A telephone interview was conducted with Nurse #2 on 6/16/14 at 4:35 PM. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 on the evening of 6/8/14 to the morning of 6/9/14. The nurse reported that when she went to check the resident ' s BS between 6AM and 6:30AM on 6/9/14, the resident was unresponsive and her BS was low. The nurse stated that she went to the Stat Box (referring to the Stat Medication Box, an emergency supply of medications kept in the Medication Room), " to see if we had glucagon, " but there wasn ' t any. Nurse #2 reported she then went to a second unit ' s medication room and there wasn ' t ' any glucagon there either. At that time, the nurse reported she went and got sugar (2-3 packets) and put it under the resident ' s tongue. After that, she called to the 3rd and final unit in the facility to see if they had any glucagon and found that they did not. Nurse #2</p>	F 425	<p>in their absence will audit all three emergency boxes to ensure each has two doses of glucagen in the boxes. Reports of the audit will be given by the Director of Nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly.</p>		

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F 425	<p>Continued From page 62</p> <p>stated that it was about 7:00 AM when she gave report to the on-coming nurse.</p> <p>An interview was conducted with Nurse #6 on 6/16/14 at 2:33 PM. Nurse #6 was the 1st shift nurse who came on duty at 7:00 AM on 6/9/14. Nurse #6 stated that when she got to the facility that morning, the resident was unresponsive and she was told the resident ' s sugar was low. Nurse #6 stated, " I think I was told (her BS was) 51. " Nurse #6 reported the BS was rechecked and it was still low (no value was given). The nurse reported she went and got a glucagon shot from the neighboring facility and administered it to the resident at 7:15 AM. The nurse indicated that she waited 15-30 minutes to see if the resident would respond. When the nurse went back at 7:45 AM, her BS was 113 but she wasn ' t responding. Nurse #6 stated she did a sternal rub and the resident was still nonresponsive. She obtained the vital signs, telephoned the on-call physician, and received orders to send her out to the Emergency Department for evaluation.</p> <p>A review of Resident #1 ' s medical record revealed a Physician ' s Telephone Order was received on 6/9/14 at 8:25 AM to send the resident to [name of hospital] to be evaluated. A review of the Emergency Department records revealed Resident #1 was transported by air to another hospital on 6/9/14 at 1:07 PM for specialty care/treatment. The diagnoses at the time of the transfer included AMS (altered mental status), NSTEMI (non-ST-elevation myocardial infarction or heart attack), suspected CVA (cerebrovascular accident or stroke), renal (kidney) insufficiency, and ECG changes (an ECG or electrocardiogram is a test that evaluates the rhythm and</p>	F 425			

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F 425	<p>Continued From page 63 electrical activity of the heart).</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/17/14 at 9:47 AM. During the interview, the DON was asked to outline the facility ' s process of replenishing medications, specifically glucagon, in the three Stat Med Boxes kept at the facility. The DON stated that when a medication from the Stat Med Box was used, the nurse was supposed to send a fax to the contract pharmacy informing the pharmacy of this. The DON then stated that the pharmacy would send that medication out the next night with its regularly scheduled delivery. The DON noted that Nurse #5 did send a fax to the pharmacy on 6/8/14 at 10 PM which indicated the glucagon stock needed to be replenished. However, based on a review of the Emergency Drug Box Contents List, each of the facility ' s three Emergency Drug Kits (Stat Med Boxes) should have contained two doses of glucagon (for a total of six doses of glucagon kept in the facility at any one time). Upon inquiry, the DON stated that, " Obviously, the process wasn ' t effective. " She indicated that even with that obvious system problem, there was glucagon " on campus " (referring to the supply of glucagon at the sister facility located in a separate building approximately 200 feet away from her facility). During the interview, the DON acknowledged that her facility did not have control over the sister facility ' s system to ensure that glucagon would always be available there as a backup.</p> <p>An interview was conducted with the Staff Development Coordinator (SDC) on 6/17/14 at 10:45 AM. The SDC assumed responsibility for training the nursing staff. The SDC reported there were three Stat Med Boxes in the facility:</p>	F 425			

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F 425	<p>Continued From page 64</p> <p>Unit 1 and Unit 2 shared one box; Unit 3 had a box; and Unit 4 had a box. During this interview, the SDC outlined the process involved in ensuring the Stat Med Boxes were fully stocked. The SDC stated that if a nurse received an order for a medication not currently available for a resident, then the nurse would pull that medication from the Stat Med Box. The SDC reported the nurse who pulled the medication would complete an Emergency Drug Kit Usage Form. This form included information on the nurse opening the Stat Med Box, the resident receiving the medication, the name of the medication, dosage units used, and the facility ' s Unit borrowing the medication. The completed form would be faxed to the pharmacy to let them know the medication needed to be replaced. Depending on the time of day borrowed (noting that the cut-off time for same day delivery was around 4PM), the medication would be sent out to the facility with the next pharmacy delivery. The SDC stated that each time glucagon was used, the Emergency Drug Kit Usage Form should have been filled out and sent to the pharmacy. She speculated that if there were not two doses of glucagon in each of the facility ' s three Stat Med Boxes, then one of two things happened. Either the Emergency Drug Kit Usage Form didn ' t get faxed or the pharmacy didn ' t replace the medication after receiving the fax. The SDC reported that one of the two pieces would have failed if the glucagon was not in the Stat Med Boxes.</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 6/17/14 at 11:33 AM. The course of events surrounding Resident #1 on the morning of 6/9/14 was discussed. With regard to glucagon not being available within the facility on 6/9/14 when needed for Resident #1, the NP</p>	F 425			

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F 425	<p>Continued From page 65</p> <p>stated, " That needs to be corrected immediately and there needs to be a system where its checked and to ensure it is available at all times. "</p> <p>An interview was conducted with Resident #1 ' s physician on 6/17/14 at 12:50 PM. During the interview, the physician was asked if he felt that glucagon needed to be kept in stock at the facility at all times. The physician stated, " Absolutely glucagon needs to be in the building. "</p> <p>A telephone interview was conducted with the pharmacy manager for the facility ' s contract pharmacy on 6/17/14 at 1:25 PM. During this interview, the pharmacy manager reported that the facility ' s Stat Med Boxes were periodically replaced by the pharmacy to ensure all medications contained in the boxes were kept within their expiration dates. Upon inquiry, the pharmacy manager indicated that records were not kept of the date(s) the boxes were replaced. He reported that an inventory sheet was kept by the Stat Med Box to identify the contents of the box, including the name/dose of the medications and number of dosage units of each. The pharmacy manager stated that when a medication was taken out of a Stat Med Box, the nursing staff needed to fill out a usage sheet and fax it to the pharmacy. The Usage sheet provided information used for the billing purposes and for the replenishment of medications used from the Stat Med Box.</p> <p>A follow-up interview was conducted with the DON (in the presence of the facility ' s Nurse Consultant) on 6/17/14 at 5:15 PM. Inquiry was made as to who was responsible to check the facility ' s Stat Med Boxes and how often this was done to ensure they were fully stocked. The</p>	F 425			

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F 425	<p>Continued From page 66</p> <p>DON indicated that up until today (6/17/14), there was not a process for this. The DON stated that the process in place up to this point included a re-ordering/replenishment procedure via use of the Stat Medication Usage forms. In addition, she noted that the Stat Med Box did have an expiration date on the top of the box which indicated when the first medication in the box would expire. The DON reported that the consultant pharmacist was responsible to check/monitor this expiration date. When the box was nearing the expiration date, the DON stated that the pharmacy would pick up the Stat Med Box and send out a completely new box with a new expiration date. During this interview, the facility ' s Nurse Consultant reported that as of 6/17/14, a process had been developed to be sure the facility ' s Stat Med Boxes were stocked appropriately.</p> <p>A telephone interview was conducted with the facility ' s Consultant Pharmacist on 6/18/14 at 11:55 AM. The Consultant Pharmacist stated that she assumed responsibility to monitor the expiration date of the Stat Med Boxes and to initiate replacement of each box based on the earliest expiration date of the medications in the box. The Consultant Pharmacist confirmed that she was not assigned the responsibility to review the contents of the Stat Med Boxes or to ensure the boxes were fully stocked at all times.</p> <p>The facility ' s Administrator was notified of the Immediate Jeopardy on 6/17/14 at 6:45 PM. A credible allegation of compliance was received on 6/18/14 at 8:45 PM as follows:</p> <p>Medications not available F425</p>	F 425			

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F 425	<p>Continued From page 67</p> <p>Corrective Action for Affected Patient Resident #1 was discharged from the facility on 6/9/2014.</p> <p>Corrective Action for Potentially Affected Patients Any patient who requires glucagon administration has the potential to be affected by the alleged deficient practice. On 6/17/2014 the Director of Nursing contacted the Director of Pharmacy services and requested that two doses of glucagon be included in each of the three emergency medication boxes. These doses were sent on 6/17/2014 and were verified as being in the emergency boxes by the Director of Nursing on 6/18/2014.</p> <p>Systematic Changes All current nurses (registered nurses and licensed practical nurses) who are currently employed on a full time, part time or as needed basis will receive education on the hypoglycemia protocol provided by the Staff Development Coordinator. There are two agency nurses that may provide staffing coverage if needed. On 6/18/2014, the director of nursing contacted both of these nurses and provided them with the education. This included:</p> <ol style="list-style-type: none"> 1. When glucagon is used from the emergency stat box the nurse must complete an " Emergency Kit Usage Form " and fax to [fax number of pharmacy]. The charge nurse should keep the form with the 24 hour report and should report off to the next shift that the medication has been ordered. 2. The glucagon should be received from the pharmacy that night in the delivery totes. When the medication is checked in the charge nurse should put the medication in the emergency box and put the order form in the Director of Nursing box. 	F 425			

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F 425	<p>Continued From page 68</p> <p>3. If the glucagon is not received, the Director of Nursing must be notified by leaving a note under her door.</p> <p>4. If you utilize glucagon and there is not another dose in the emergency box contact the on-call pharmacy [name and phone number of pharmacy] to obtain the dose from the back up pharmacy. If the pharmacy says that the dose cannot be obtained contact the Director of Nursing [phone number].</p> <p>5. If glucagon is not available and resident meets the diabetic protocol to receive it, the MD will be called for an order to send to the ER (emergency room) for evaluation. When the order is obtained, 911 will be initiated.</p> <p>Unit Managers & MDS Nurse will check the stat box Monday through Friday and document. If items are identified as used and not re-stocked, they will initiate a form to pharmacy.</p> <p>As of 6/18/2014 employees who have not received this training will not be on the schedule to work and will not be allowed to work until the in-services are completed. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that are completed -----6/18/2014.</p> <p>Completion Date 6/18/14.</p> <p>On 6/18/14 at 9:40 PM, the credible allegation of compliance was validated. The surveyor confirmed that the facility implemented the following: Nursing staff interviews confirmed each nurse had been in-serviced on the facility ' s procedures for obtaining glucagon when indicated per the Diabetic Protocol and the procedures to</p>	F 425			

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F 425	Continued From page 69 be followed after using glucagon from the emergency medication box.	F 425			