PRINTED: 12/13/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING ______ B. WING ______	C 09/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN ST SILER CITY, NC 27344

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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 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician, nurse practitioner, staff and Emergency Medical Services (EMS) interviews, the facility failed to	F 157	The facility alleges that the immediate jeopardy has been removed effective 09/21/2013. See 10/7/13 Revisit for plan of correction. BAS	9/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffory Carpenter
TITLE: Administrator
(X6) DATE: 12/13/2013

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	Continued From page 1 immediately notify the physician of a significant change in a resident's condition for 1 of 4 residents, Resident #188, reviewed for notification of changes. Immediate Jeopardy began on 2/7/13 when facility staff became aware of Resident #188's change in condition including: lethargy, periodic thrashing, moaning, and elevated blood sugar, and failed to notify the physician. The Immediate Jeopardy is present and ongoing. Findings included: Resident #188 was admitted to the facility on 10/3/12. Her diagnoses included hypertension, diabetes, anemia, end stage renal disease, clostridium difficile, muscle weakness, muscle wasting, dialysis, and asthma. The quarterly Minimum Data Set (MDS) assessment dated 1/4/13 indicated the resident was cognitively intact, did not reject care, participated in the assessment, needed extensive assistance with activities of daily living (ADLs), was on oxygen, and received dialysis. A review of the February 2013 physician orders revealed there were no orders for blood glucose monitoring, oral or subcutaneous glucose medications. There was an order originally dated 1/2/13 for Vicodin 5-500 milligrams (mg) orally, as needed every 6 hours for pain. The nurse's note dated 2/6/13 at 9:30 am indicated the resident had a temperature of 100.3 degrees, was alert and verbal, made her needs known, and was up in her wheelchair.	F 157		

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The nurse's note dated 2/6/13 at 10:30 am indicated the resident was transported to dialysis with no complaints of nausea or pain.

Other than the Change of Condition Documentation, there were no other nurse's notes written on Resident #188 from 2/6/13 at 10:30 am to 2/7/13 at 9:45 am.

The Change of Condition Documentation form, completed by Nurse #1 and dated 2/7/13, stated, "At 2:30 am [Nurse Aide #1] reported resident non-verbal and fluttering eye lids. Nurse noted resident lethargic, both eyes reddened [with] yellowish green matter. Cheeks flushed [and] warm. Temp 100.6. Periodically thrashing both arms during examination [and] moaning [with] sound similar to a cat ' s meow. Nasal cannula out of nostrils [and oxygen saturation] 84%. Reapplied [oxygen at] 4 L [with oxygen saturation increased to] 98%. Bipap replaced. Cleansed eyes, removing matter. Gave Vicodin 5-500mg [orally]. Crushed [due to] decreased [level of consciousness]. Checked blood sugar due to quality of moaning [with] reading HI. Decreased stimulus. Resident said 2-3 words but still not clear headed. At 3:45 am [temperature] 99.1. [No] nausea or vomiting. Continue to moan [and] throw arm slowly at times." Vitals signs were documented at 2:30 am as: blood pressure 100/60, pulse 56, temperature 100.6, respirations 20, and blood sugar "HI".

The Medication Administration Record (MAR) dated 2/7/13 indicated at 2:30 am Resident #188 was given Vicodin 5-500mg by mouth for pain. There was no documentation indicating if pain medication was effective.

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F 157	Continued From page 3 Nurse #2's note dated 2/7/13 at 9:45 am stated, "Resident unresponsive. Opens eyes then roll back in head. Moans with movement of any kind by staff. Unable to verbalize anything. [Blood glucose level] 57. Refused breakfast this a.m. Hands cold to touch." A Physician order dated 2/7/13 at 10:14 am stated, "Send to [emergency department] for [evaluation] unconsciousness." The nurse's note dated 2/7/13 at 10:15 am stated, "Nurse notified supervisor at 9:45 am that resident was non responsive. Assessed [patient] - decreased [level of consciousness] noted. Pupils equal, reactive to light, sluggish." Nurse #2's note dated 2/7/13 at 10:30 am indicated Emergency Medical Services (EMS) was at the facility to transport the resident to the hospital and the Nurse Practitioner was notified. The Emergency Medical Service (EMS) transport report dated 2/7/13 stated, "Per nursing staff at nursing home, [Resident #188] began experiencing decreased [level of consciousness] last [night]. She is a dialysis [patient] and [non-insulin-dependent diabetic]. She had her dialysis yesterday then early this [morning] (around 2 am) began experiencing decreased [level of consciousness] with fever. Per nurse her [blood glucose level] at that time was over 400. This [morning], [resident] is not responding. Lies in bed and yells and moans (no words). Nursing staff calls 911." The chief complaint indicated on the report was "Unresponsive patient. Duration: 9 hours" and the diagnosis was "Altered level of consciousness, Diabetic symptoms."	F 157		

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F 157	Continued From page 4 During a telephone interview with the EMS Supervisor, on 9/22/13 at 5:40 pm, he indicated "the "Duration" time on an EMS report was "the amount of time the signs and symptoms had been occurring prior to EMS being called." A review of the hospital discharge summary, dated 2/12/13, indicated Resident #188 was admitted on 2/7/13 and passed away on 2/11/13 from cardiopulmonary arrest secondary to septic shock. The discharge summary stated, "In [the emergency department] [patient] was found to be agitated, yelling nonsensically, and had multiple loose stools. She was subsequently intubated and admitted to the medical [intensive care unit]. She was partially resuscitated, requiring vasopressor support (medication to maintain her blood pressure), and a surgical consultation was obtained. Due to evidence of peritonitis (inflammation of the lining of the abdomen), an exploratory laparotomy (incision to examine the inside of the abdominal cavity) was performed, which demonstrated bowel perforation. Bowel resection was performed and the patient was transferred to the surgical intensive care unit. Aggressive attempts at resuscitation and stabilization were unsuccessful. Abdominal compartment syndrome (elevated intra-abdominal pressure) was recognized and a bedside laparotomy (incision into the abdominal cavity) was performed with relief of intra-abdominal pressure. However, the patient was not able to recover, and she expired." During an interview on 9/19/13 at 12:05 pm, Nurse #2 stated, "Her blood sugar was low that morning that she was sent to the [emergency room]. I had gotten report from [Nurse #1] that she was acting different and her blood sugars	F 157		

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were elevated. [Nurse #1] said she filled out a Change In Condition form. When you fill out the form, you automatically notify the physician. The resident had behaviors that morning. She was usually very alert and oriented and would answer questions appropriately. She took her medicine for me that morning but didn't eat breakfast. When I talked to her after breakfast, she was not talking to me as much as before breakfast so I checked her blood sugar. She wouldn't respond when I said her name. I don't recall [Nurse #1] saying anything other than she had filled out the change in condition form."

During an interview on 9/19/13 at 12:30 pm, the Director of Nursing stated, "Intermittant [blood glucose monitoring] would be documented in the nurse's notes because it would not be on the MAR. If the reading said 'HI', I would expect the blood sugar to be rechecked. If it remained 'HI', I would expect the physician to be contacted, depending on the resident's condition and level of consciousness or a change for that particular resident. When I came in the nurse told me about her change in mental status and that the Nurse Practitioner was called and EMS was called." The DON indicated that had she known of the resident's condition, including change in behavior and elevated blood sugar, at 2:30 am she would have called EMS. She further indicated the change in behavior and low blood sugar that resulted in transport to the hospital on 2/7/13 at 10:30am would have been the same reason to transport the resident on 2/7/13 at 2:30 am when she had a documented change in behavior and high blood sugar.

During an interview with the Assistant Director of Nursing (ADON) on 9/19/13 at 11:39 am, she

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stated, "If there was an elevated blood sugar, there would be a doctor's note stating to give insulin. If someone was in distress and a blood sugar was checked, it would be documented in the nurse's notes. I see a blood sugar of 57 on 2/7/13. I do not see any documentation of an elevated blood sugar." "The night nurse would have faxed the change in condition to the physician. We don't keep the face sheets as part of the record so there is no way to know what time the physician was notified by fax. There is an on-call so I would expect the physician would have been called, not just a fax sent, since it was 2:30 in the morning when the change occurred."

During a telephone interview with Nurse #1 on 9/19/13 at 12:00 pm, she stated, "I think [Resident #188's] behavior led me to check her blood sugar. She wasn't really talking. This was different for her. She usually spoke in full sentences and was easy to understand. I took her blood sugar as a vital sign. 'HI' would mean it was over 500. She was not diagnosed with diabetes so I just checked because she was acting like other diabetics with high sugar. She started acting normal about an hour later and maintaining eye contact so I faxed the doctor the change in condition form. I did not call because she started acting better. I did not get an order for insulin or give any insulin or other medication related to her high blood sugar. If her behavior had not improved, I would have called the doctor. I can't remember writing a note about her condition improving. I did not recheck her blood sugar because she did not have an order for [blood glucose monitoring] or a diabetes diagnosis."

During a telephone interview with the Nurse

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F 157	Continued From page 7 Practitioner on 9/19/13 at 3:39 pm, she indicated when she is in the office, and not in the facility, she may not immediately receive an incoming fax and further stated, "If there is a change in a resident at night they should call the on-call provider. There is always someone on call. That is the expectation especially if the resident is acting differently. Even if they can't contact a provider, they should go ahead and call EMS with a high blood sugar and the resident being symptomatic. The expectation is the same if the blood sugar is low and they are symptomatic. They should call the physician and call EMS. They should not wait on a response from a fax that may not even get seen right away. I remember that day I was called and told she was sent out and I did not receive the faxed change in condition until after she had already left the facility." During a telephone interview with the Physician on 9/19/13 at 3:51 pm, he stated, "If there is a change in a resident's condition, the facility should immediately contact EMS and contact the on-call physician. My group policy is a 10-15 minute call back. They should never wait. If the nurse is filling out a change in condition form, they should be calling the physician. They have my primary contact, secondary contact, and even my cell phone. I can always be contacted." The physician indicated, regarding Resident #188, the nurse should have called the physician at 2:30 am when the change in condition was recognized. During an interview with the Administrator on 9/20/13 at 1:25 pm, he stated, "I would expect in a change of condition for the nurse to follow protocol and procedure and follow her nursing judgment and then contact the physician and or	F 157		

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F 157	Continued From page 8 family." The Administrator was notified on 9/20/13 at 1:40 pm of the Immediate Jeopardy. The Immediate Jeopardy is present and ongoing.	F 157		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to provide maintenance services necessary to maintain a safe, orderly, and comfortable interior on 5 of 5 resident halls (100, 200, 300, 400 & 500). The findings included: On 9/17/2013 during a facility tour from 2:30 PM to 4:00 PM the following observations were made on five resident halls. The main community shower room between resident halls 100 and 400 was observed unlocked and unused with pipes exposed and not covered in the main shower bay. In the 500 hall shower room the sink water was running. The faucet and the mounted sink were not secure and both had a one inch movement. The main door knob to residents' room 413 was not secure exposing a sharp edge. Holes were observed in the walls. In residents' room 206 there was a hole through the sheetrock in the corner of room and the ceiling panel was	F 253	See 10/7/13 revisit for plan of correction BKS	

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F 253	Continued From page 9 drooping. 209 had 4 holes in sheetrock in the residents' room and 3 holes in the sheet rock in the bathroom, all at eye level. In room 404 the floor molding was pulling away from the wall providing a hole. The residents' room 311 bathroom was observed in disrepair with broken tile around the toilet and no door strip at the transition between room and bathroom. In residents' room 203 there were gouges in the wall and in resident room 511 there were gouges in the wall at both headboard locations. Exposed cables were observed. In residents' room 103 a television cable was observed hanging out of wall for a length of approximately 2 feet with a sharp edge exposed. In room 209 a television cable was observed hanging out of wall for a length of approximately ten feet knotted up and not in use. In residents' rooms 201, 207, 211, 212, 306, 307, 314, 315, 316 and 404 was observed with the folding closet doors off track and freely swinging. In residents' rooms 109, 202, 206, 316, 406, 410, and 415 the folding closet door knob was missing or loose and dangling. Observations of wall patches that were not sanded or painted were found in residents' rooms 206 506 and 507. And in residents' room 412 the wall was observed patched with the un-matching paint. Observation of a third shower room being used for storage across from the 400 hall nurse station. The room was locked labeled shower room. A second tour of the facility was conducted on 9/19/2013 from 10:00 AM to 11:00 AM. The same observations were made on resident halls 100, 200, 300, 400 and 500 excluding room 507. The patched sections of the walls in resident room 507 had been sanded and painted.	F 253		

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On 9/19/2013 11:18 AM the Director of Nursing (DON) revealed the staff filled out a maintenance request forms or verbally told maintenance about needed repairs. Maintenance was on call for an immediate need like a water leak or a broken emergency door. The small things could wait till the next day like a broken wheelchair. The DON reported the staff knew how to fix the call lights. She had an expectation of her staff to notify her, fill out the form, or tell maintenance for facility disrepair. The DON revealed her staff was focus on call lights, beds and wheelchairs and maintenance went around and painted. She reported not knowing what maintenance system was for building repairs. The DON's expectation was for maintenance to handle structural concerns and the nurses were focused on equipment failures.
A Resident Interview on 9/19/2013 at 3:51 with Resident #73, who resided in room #209, revealed he reported the holes in the bathroom had been present for seven to eight months.
On 9/19/2013 at 3:54 PM Resident #99, who resided in room # 316, who was cognitively intact revealed the closet door in the room had been off track and the knob missing for weeks.
On 9/19/2013 at 3:57 PM Resident #136, who resided on in room #410 and was cognitively intact revealed the closet door knobs in the room had been loose for over a year. The resident explained the maintenance staff tightened the door knobs up but they are worn out.
On 9/19/2013 at 4:01 PM Resident #24, who resided in room 103 and was cognitively intact, revealed the exposed unused television cable in room 103 had been hanging out of the wall for over a year.
On 9/19/2013 at 4:06 PM Resident #160, who

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F 253	Continued From page 11 resided in room 203 and was cognitively intact revealed he was trying to create a homelike environment and the facility did not patch the wall in the room prior to his last roommate's arrival. He reported one of the shower rooms was being used for storage. He wanted to bring a refrigerator but was told by the staff the electrical system would not hold the bed and a refrigerator. And the handicap button for access to the courtyard had not been working since July 2013. An interview with the Maintenance Supervisor on 9/19/2013 at 10:40 AM revealed he completed work orders received from staff with in 2 weeks if not sooner. He reported the facility was 44,000 sq feet and maintenance was busy with clogged toilets and sinks. There were constant holes in the walls from beds and wheelchairs. The maintenance Supervisor revealed he looked at stuff as he walk down the halls but he did not go into the resident rooms. The staff was always verbally asking for stuff to be fixed. He did not always write the staff request down. A record review of the current maintenance work orders revealed request on 9/18/2013 for repair of the wall at the head of bed in room 306; on 9/17/2013 a wall needed repair at the head of bed in room 101; on 9/10/2013 a wheelchair request; and on 9/10/2013 the closet door was off track and bathroom needed a light bulb. The Maintenance Supervisor did not indicate there was a failure in the system. On 9/19/2013 a tour was conducted with the Administrator viewing the interior of residents' rooms. The Administrator did not have a problem with the exposed television cable hanging out of the wall in room 103 and reported he was aware of the bathroom floor in room 311. During an	F 253		

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F 253	Continued From page 12 interview with the Administrator he revealed there was a process in place and the facility address issues as they were confronted with them. The requests for repairs were done verbally and if not then request were made through a work order. He felt the staff would report anything they felt they needed to report. The Administrators expected time frame for completing work orders was a week's time. Maintenance does not need a work order to patch walls. The maintenance supervisor does initiate projects on his own, " just if he notices them ".	F 253		
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 record review, physician, nurse practitioner, staff and Emergency Medical Services (EMS) interviews, the facility failed to identify and assess the need for medical intervention for a resident with a significant change of condition; and failed to immediately initiate emergency medical services for 1 of 4 residents (Resident #188) reviewed for change of condition. Immediate Jeopardy began on 2/7/13 when facility staff became aware of Resident #188's	F 309	See 10/17/13 revisit on plan of correction BK	

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acute change in condition including: lethargy, periodic thrashing, moaning, and elevated blood sugar, failed to identify and assess her need for emergency medical interventions, and delayed calling EMS for 30 minutes after acute change in condition was recognized (receiving hospital was approximately an hour away). The Immediate Jeopardy is present and ongoing.

Findings included:

Resident #188 was originally admitted to the facility on 10/3/12 and readmitted on 12/28/12. Her diagnoses included hypertension, diabetes, anemia, end stage renal disease, clostridium difficile, muscle weakness, muscle wasting, dialysis, and asthma.

There was a physician order dated 12/28/12 for Zofran 4 milligrams (mg) orally, as needed every 4-6 hours for nausea or vomiting.

The January Medication Administration Record (MAR) indicated Resident #188 received 17 doses of Zofran for nausea.

There was a physician order dated 1/2/13 for Vicodin 5-500mg orally, as needed every 6 hours for pain.

The quarterly Minimum Data Set (MDS) assessment dated 1/4/13 indicated the resident was cognitively intact, did not reject care, participated in the assessment, needed extensive assistance with activities of daily living (ADLs), was on oxygen, and received dialysis.

The social work note dated 1/4/13 indicated the resident had no delirium or behaviors, was tired

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all the time with occasional lack of interest in doing things, "is understood and understands."

The Medication Administration Record dated 1/15/13 indicated Resident #188 was given Vicodin 5-500mg by mouth once for pain. There was no documentation indicating location of pain or if pain medication was effective.

The nurse's note dated 1/21/13 indicated Resident #188 had decreased nausea after her Renvela (phosphorus-binding medication) was discontinued on 1/18/13.

The nurse's note dated 1/24/13 at 9:00 am stated, "[Resident] continues to refuse [appointment] for [upper gastrointestinal exam]. [Physician] in facility and in to assess [resident regarding] refusal. [Resident] continues to refuse despite discussion with [physician]."

The physician assessment dated 1/24/13 stated, "Patient is being seen for routine monthly examination. Patients case and care discussed with nursing staff. Patient is seen and examined. Patient expresses no concerns or new issues. Patient is doing well and no complaints." Diagnoses included: "hypertension, diabetes mellitus without mention of complication, type II, not stated as uncontrolled."

The Medication Administration Record (MAR) dated 1/30/13 indicated Resident #188 was given Vicodin 5-500mg by mouth once for pain. There was no documentation indicating location of pain or if pain medication was effective.

A review of the February 2013 physician orders revealed there were no orders for blood glucose

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F 309	Continued From page 15 monitoring, oral or subcutaneous glucose medications. A review of the Behavior Monthly Flow Sheet for February 2013 revealed the resident exhibited no behaviors. The nurse's note dated 2/6/13 at 9:30 am indicated the resident had a temperature of 100.3 degrees, was alert and verbal, made her needs known, and was up in her wheelchair. There were no physician orders for a fever reducer, no nurse's notes of interventions for the resident's elevated temperature, or reassessment of Resident #188's temperature on 2/6/13. The nurse's note dated 2/6/13 at 10:30 am indicated the resident was transported to dialysis with no complaints. The February MAR indicated Resident #188 received Zofran 4mg orally for nausea on 2/6/13 at 5:00 pm. The Change of Condition Documentation form, completed by Nurse #1 and dated 2/7/13, stated, "At 2:30 am [Nurse Aide #1] reported resident non-verbal and fluttering eye lids. Nurse noted resident lethargic, both eyes reddened [with] yellowish green matter. Cheeks flushed [and] warm. Temp 100.6. Periodically thrashing both arms during examination [and] moaning [with] sound similar to a cat ' s meow. Nasal cannula out of nostrils [and oxygen saturation] 84%. Reapplied [oxygen at] 4 L [with oxygen saturation increased to] 98%. Bipap replaced. Cleansed eyes, removing matter. Gave Vicodin 5-500mg [orally]. Crushed [due to] decreased [level of consciousness]. Checked blood sugar due to	F 309		

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F 309	Continued From page 16 quality of moaning [with] reading HI. Decreased stimulus. Resident said 2-3 words but still not clear headed. At 3:45 am [temperature] 99.1. [No] nausea or vomiting. Continue to moan [and] throw arm slowly at times." Vitals signs were documented at 2:30 am as: blood pressure 100/60, pulse 56, temperature 100.6, respirations 20, and blood sugar "HI". The Medication Administration Record (MAR) dated 2/7/13 indicated at 2:30 am Resident #188 was given Vicodin 5-500mg by mouth once for generalized pain. The as-needed Pain Management Flow Sheet indicated the resident was cognitively impaired and in mild pain at 2:30 am and cognitively impaired and in no pain at 6:30 am. During a telephone interview with Nurse Aide #1 on 9/20/13 at 10:15 am, when asked about Resident #188's usual mental status and how she was different on 2/7/13, she stated, "That night she seemed like she was in a lot of pain. She complained a lot about pain that night and was screaming so loud she was waking up other residents. I reported it to the nurse (Nurse #1). [The resident] was not acting like herself that night." During a telephone interview with Nurse #1 on 9/19/13 at 12:00 pm, she stated, "I think [Resident #188's] behavior led me to check her blood sugar. She wasn't really talking. This was different for her. She usually spoke in full sentences and was easy to understand. I took her blood sugar as a vital sign. 'HI' would mean it was over 500. She was not diagnosed with diabetes so I just checked because she was acting like other diabetics with high sugar. I did	F 309		

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F 309	Continued From page 17 not check her sugar with another machine. I cannot remember if I ran controls on the machine. She started acting normal about an hour later and maintaining eye contact so I faxed the doctor the change in condition form. I did not call because she started acting better. I did not get an order for insulin or give any insulin or other medication related to her high blood sugar. If her behavior had not improved, I would have called the doctor. I can't remember writing a note about her condition improving. I did not recheck her blood sugar because she did not have an order for [blood glucose monitoring] or a diabetes diagnosis." Other than the Change of Condition Documentation, there were no other nurse's notes written on Resident #188 from 2/6/13 at 10:30 am to 2/7/13 at 9:45 am. Nurse #2's note dated 2/7/13 at 9:45 am stated, "[Temperature] 98.6, [pulse] 60, [respirations] 18, [blood pressure] 90/52, [oxygen saturation] 84%. Resident unresponsive. Opens eyes then roll back in head. Moans with movement of any kind by staff. Unable to verbalize anything. [Blood glucose level] 57 on facility accucheck machine. Refused breakfast this a.m. Hands cold to touch." During an interview on 9/19/13 at 12:05 pm, Nurse #2 stated, "Her blood sugar was low that morning that she was sent to the [emergency room]. I had gotten report from [Nurse #1] that she was acting different and her blood sugars were elevated. [Nurse #1] said she filled out a Change In Condition form. When you fill out the form, you automatically notify the physician. The resident had behaviors that morning. She was usually very alert and oriented and would answer	F 309		

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F 309	Continued From page 18 questions appropriately. She took her medicine for me that morning but didn't eat breakfast. When I talked to her after breakfast, she was not talking to me as much as before breakfast so I checked her blood sugar. She wouldn't respond when I said her name. I know [Nurse #1] didn't give any insulin because we would have to have an order for that. I don't recall [Nurse #1] saying anything other than she had filled out the change in condition form." A Physician order dated 2/7/13 at 10:14 am stated, "Send to [emergency department] for [evaluation] unconsciousness." The nurse's note dated 2/7/13 at 10:15 am stated, "Nurse notified supervisor at 9:45 am that resident was non responsive. Assessed [patient] - decreased [level of consciousness] noted. Pupils equal, reactive to light, sluggish." Nurse #2's note dated 2/7/13 at 10:30 am indicated Emergency Medical Services (EMS) was at the facility to transport the resident to the hospital and the Nurse Practitioner was notified. The Emergency Medical Service (EMS) transport report dated 2/7/13 stated, "Per nursing staff at nursing home, [Resident #188] began experiencing decreased [level of consciousness] last [night]. She is a dialysis [patient] and [non-insulin-dependent diabetic]. She had her dialysis yesterday then early this [morning] (around 2 am) began experiencing decreased [level of consciousness] with fever. Per nurse her [blood glucose level] at that time was over 400. This [morning], [resident] is not responding. Lies in bed and yells and moans (no words). Nursing staff calls 911." The chief complaint indicated on	F 309		

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the report was "Unresponsive patient. Duration: 9 hours" and the diagnosis was "Altered level of consciousness, Diabetic symptoms."

A review of the EMS assessment, dated 2/7/13 indicated:
At 10:18 am EMS received call
EMS arrived at 10:24 am.
At 10:25 am, the resident was agitated and combative, "eyes open but does not converse. [Patient] moans and yells", decreased level of consciousness, pulse 112, blood pressure 104/80, and had a blood glucose of 34.
At 10:35 am, EMS gave an intramuscular injection of Glucagon 1mg.
At 10:40 am, the resident's blood glucose was rechecked and was 20. Vascular access was started at 10:45 am.
At 10:48 am, Dextrose 25grams was administered through the vascular access.
At 10:50 am, the resident's blood glucose was rechecked and was 211.
At 11:05 am, there was no change in the resident's condition. She continued to not respond, yell, and moan.
At 11:25 am, the resident's blood glucose was rechecked and was 200.
At 11:45 am, the resident was released to the care of the emergency department and there was "no change in [patient] status throughout EMS care."

During a telephone interview with the EMS Supervisor, on 9/22/13 at 5:40 pm, he indicated "Duration" time on an EMS report was "the amount of time the signs and symptoms had been occurring prior to EMS being called."

A review of the emergency department

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F 309	Continued From page 20 assessment, dated 2/7/13 at 11:51 am indicated Resident #188 was anxious, appeared to be in pain, was agitated, had a blood pressure of 82/39, heart rate of 120, respiratory rate of 26, temperature of 99, oxygen saturation of 96% on 2 liters of oxygen, had a soft, nontender abdomen, cool skin, was "confused, combative and disoriented to person, place and time.", had incoherent responses, and inappropriate speech. A review of the hospital discharge summary, dated 2/12/13, indicated Resident #188 was admitted on 2/7/13 and passed away on 2/11/13 from cardiopulmonary arrest secondary to septic shock. The discharge summary stated, "In [the emergency department] [patient] was found to be agitated, yelling nonsensically, and had multiple loose stools. She was subsequently intubated and admitted to the medical [intensive care unit]. She was partially resuscitated, requiring vasopressor support (medication to maintain her blood pressure), and a surgical consultation was obtained. Due to evidence of peritonitis (inflammation of the lining of the abdomen), an exploratory laparotomy (incision to examine the inside of the abdominal cavity) was performed, which demonstrated bowel perforation. Bowel resection was performed and the patient was transferred to the surgical intensive care unit. Aggressive attempts at resuscitation and stabilization were unsuccessful. Abdominal compartment syndrome (elevated intra-abdominal pressure) was recognized and a bedside laparotomy (incision into the abdominal cavity) was performed with relief of intra-abdominal pressure. However, the patient was not able to recover, and she expired." During an interview on 9/19/13 at 12:30 pm, the	F 309		

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F 309	Continued From page 21 Director of Nursing stated,"Intermittant [blood glucose monitoring] would be documented in the nurse's notes because it would not be on the MAR. If the reading said 'HI', I would expect the blood sugar to be rechecked. If it remained 'HI', I would expect the physician to be contacted, depending on the resident's condition and level of consciousness or a change for that particular resident. When I came in the nurse told me about her change in mental status and that the Nurse Practitioner was called and EMS was called." The DON indicated that had she known of the resident's condition, including change in behavior and elevated blood sugar, at 2:30 am she would have called EMS. She further indicated the change in behavior and low blood sugar that resulted in transport to the hospital on 2/7/13 at 10:30 am would have been the same reason to transport the resident on 2/7/13 at 2:30 am when she had a documented change in behavior and high blood sugar. During an interview with the Assistant Director of Nursing (ADON) on 9/19/13 at 11:39 am, she stated, "If there was an elevated blood sugar, there would be a doctor's note stating to give insulin. If someone was in distress and a blood sugar was checked, it would be documented in the nurse's notes. I see a blood sugar of 57 on 2/7/13. I do not see any documentation of an elevated blood sugar." "The night nurse would have faxed the change in condition to the physician. We don't keep the face sheets as part of the record so there is no way to know what time the physician was notified by fax. There is an on-call so I would expect the physician would have been called, not just a fax sent, since it was 2:30 in the morning when the change occurred."	F 309		

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F 309	Continued From page 22 During a telephone interview with the Nurse Practitioner on 9/19/13 at 3:39 pm, she indicated when she is in the office, and not in the facility, she may not immediately receive an incoming fax and further stated, "If there is a change in a resident at night they should call the on-call provider. There is always someone on call. That is the expectation especially if the resident is acting differently. Even if they can't contact a provider, they should go ahead and call EMS with a high blood sugar and the resident being symptomatic. The expectation is the same if the blood sugar is low and they are symptomatic. They should call the physician and call EMS. They should not wait on a response from a fax that may not even get seen right away. I remember that day I was called and told she was sent out and I did not receive the faxed change in condition until after she had already left the facility." During a telephone interview with the Physician on 9/19/13 at 3:51 pm, he stated, "If there is a change in a resident's condition, the facility should immediately contact EMS and contact the on-call physician. My group policy is a 10-15 minute call back. They should never wait. If the nurse is filling out a change in condition form, they should be calling the physician. They have my primary contact, secondary contact, and even my cell phone. I can always be contacted." The physician indicated, regarding Resident #188, the nurse should have called the physician at 2:30 am when the change in condition was recognized. During an interview with the Administrator on 9/20/13 at 1:25 pm, he stated, "I would expect in a change of condition for the nurse to follow protocol and procedure and follow her nursing	F 309		

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F 309	Continued From page 23 judgment and then contact the physician and or family." The Administrator was notified on 9/20/13 at 1:40 pm of the Immediate Jeopardy.	F 309		