STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	C 10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SCOTLAND MANOR	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

(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 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 157		11/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/06/2017

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 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the physician for 1 of 3 sampled residents (Resident #1) who experienced a change in their physical condition. Resident #1 was admitted to the hospital intensive care unit with a blood glucose of 803 mg/dL, evidence of sepsis, urinary tract infection and pneumonia. The findings included: The Facility policy titled "Acute Condition Changes- Clinical Protocol", and dated as revised on December 2015, documented under Assessment and Recognition, the following: #3. Direct care staff, including nursing assistants will be trained to recognize subtle but significant changes in the resident. #6. Before contacting a Physician about someone with an acute change of condition, the Nursing Staff will make detailed observation and collect pertinent information to report to the Physician. a. Phone calls to attending or on call Physicians should be made by an adequately prepared nurse who has collected and prepared pertinent information, including the resident's current symptoms and status. #7. The nursing staff will contact the Physician	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of Federal and State law. 1. Resident #1 was discharged from the facility on 10/3/2017 and did not return. 2. To assure a) residents have been properly assessed to ensure that changes in condition were identified, b) physicians were notified of all changes in condition c) documentation accurately reflects action taken, and that d) intervention was timely and appropriate; residents requiring emergency room visits and those who required hospitalization for the past 30 days will be reviewed in detail by 11/10/2017. Reviews will be completed by Director of Nursing (DON) and/or or Unit Manager. 3. Nurses are being in-serviced on a) proper and comprehensive physical assessment, b) recognizing an acute	

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F 157	Continued From page 2 based on the urgency of the situation. For emergencies, the will call or page the Physician and request a prompt response. Resident #1 was admitted to the facility on 3/26/2014 with diagnoses to included stroke, hemiplegia, dysphagia, and dementia. Her quarterly Minimum Data Set (MDS) assessment dated 7/29/2017 revealed her cognition to be severely impaired. She required 2-person total assistance from staff for bed mobility and transfer, and 1 person total assistance for all other activities of daily living (ADLs). She required a feeding tube for nutrition. A review of a nurse's note dated 9/30/2017, at 6:45 PM, revealed Nurse #1 was called to the Resident's room by the nursing assistant (NA #4) who indicated the resident was alert but not responding. Vitals signs were taken with the temperature of 100.1, the blood pressure was 110/70, pulse 105 and respirations 24. A blood glucose was taken with the result of 486mg/dL (milligrams per deciliter). The tube feeding was turned off. The resident was a little more responsive after the tube feeding had been stopped. The Nurse indicated she would continue to monitor and make the 7:00 PM shift aware of the situation. There was no documentation of calling the Physician. A review of a nurse's note dated 10/1/2017 at 6:22 PM by Nurse #1, revealed the resident's blood sugar that morning (no time given) was 486 mg/dL. The tube feeding was turned off and the blood sugar rechecked (no time given), and a reading of 377 mg/dL was obtained. The tube feeding was turned back on and the labs (laboratory blood work) were ordered. Nurse #1 would report to the night nurse and continue to	F 157	change in condition, c) appropriate notification of physician for orders to intervene and respond to the acute change, d) implementation of physician ordered response -A full return demonstration will be conducted with each nurse. Nurses will receive in-service on and a copy of the NC Nursing Scope of Practice which clearly delineate the requirement for a physician□s order prior to ordering laboratory tests, x-rays, and other tests as well as any treatment. These in-services will be conducted by clinical consultant. All licensed nurses will be in-serviced by 11/20/2017. Nurses will be in-serviced on and receive copies of pertinent policies(to include change of condition, appropriate notification of physician/family, implementation of physician orders, etc.) and sign for that receipt indicating their understanding and agreement to follow the policies as written. In-service will be conducted by DON and/or Unit Manager. All nurses will be in-serviced by 11/10/2017. Any nurse not completing in-service by this time will be in-serviced prior to next shift worked. 4. A comprehensive review of resident records pertaining to all emergency visits and hospitalizations will be completed by the DON and/or Unit Manager to ensure all aspects of the above systemic corrective action are complete. This review will be recorded on the audit tool	

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F 157	Continued From page 3 monitor. There was no documentation of calling the Physician. A Physician telephone order was reviewed, dated 10/2/2017 (not timed) for #1. CBC (complete blood count), CMP (comprehensive metabolic panel), Hemoglobin A1C (test for diabetes), and #2. Chest x-ray 2 views, written by the Nurse Manager. Laboratory results dated 10/2/2017 at 3:09 PM, and reported on 10/3/2017, included an abnormal blood glucose of 582 mg/dL (milligrams per deciliter), with normal blood glucose value of 70 to 105 mg/dL. A sodium result of 174 mEq/L (milliequivalents per liter, with a normal sodium value of 136 to 145 mEq/L; a chloride result of 125 mEq/L, with a normal chloride value of 125 mEq/L: and a hemoglobin A1C of 11.0%, with a normal value of 4.0 to 6.0%. A radiology report dated 10/2/2017, and electronically signed by the reading Physician at the time of 8:35 PM concluded the resident had slight left lower lobe pneumonia. A review of a nurse's note dated 10/3/2017 at 7:30 AM, revealed the abnormal laboratory results were reported to the on-call Physician, by Nurse #4, who also reported the x-ray showed slight left lower lobe pneumonia. There were no signs and symptoms of respiratory distress. Physician's orders were received to send the resident to the hospital emergency room. The ambulance was called at 12:10 AM, the morning of 10/3/2017. A review of the hospital admission history and physical dated 10/3/2017 revealed Resident #1 had a blood glucose of 803 mg/dL, evidence of sepsis, findings consistent with urinary tract infection and pneumonia. The resident was admitted to the intensive care unit.	F 157	attached for the next 60 days with retraining and reinforcement of standards of practice for any findings suggesting a continued need for re-education or disciplinary action of staff. -The Quality Assurance and Performance Improvement(QAPI) team will review findings on these audit tools at the monthly team meeting for the next 60 days. On an ongoing basis, the audit will be completed on a random selection of 1 out of every 3 emergency visits or hospitalizations for the purpose of assuring sustained compliance with this corrective action.	

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An interview was conducted on 10/16/2017 at 3:29 PM with Nurse #1, who stated on 9/30/2017, NA #4 came to her right before shift change and told her the resident had been sleepier than usual, and was alert, but not responding. The Nurse checked the resident, got her vital signs, and then asked Nurse #2 what she advised. Nurse #2 told her to check the blood sugar, even though the resident did not have diabetes. When the high blood sugar result was found, Nurse #1 was advised by Nurse #2 to turn off the tube feeding for a while. The Nurse stated that since it was right at shift change she did not turn the feeding back on, but informed the night nurse to turn it back on after 20 minutes. When Nurse #1 came back to work the next day on 10/1/2017, she again checked the Resident #1's blood sugar at morning medication pass, about 8:00 AM. The blood sugar result was 486 mg/dL, so she turned off the tube feeding for about 2 ½ hours. The next blood sugar test was done after lunch and was still high at 377mg/dL. The Nurse again asked Nurse #2 what to do, and was told Nurse #2 would call the Director of Nursing (DON) and take care of it. Nurse #1 stated she did not call the Physician for the blood sugar readings, as she assumed Nurse #2 was going to. Nurse #1 stated she did not have a Physician's order to turn off the tube feeding, but it was a nursing judgement call if the tube feeding was not off for an extended period of time. The Nurse stated she turned the tube feeding off for 2.5 hours, and if it had been longer than that she would have called the physician for an order.

An interview was conducted with Nurse #4 on 10/16/2017 at 3:43 PM. The Nurse stated she was informed by the DON to look for an arriving fax of abnormal lab reports for Resident #1, on the night shift of 10/2/2017. The Nurse indicated

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she decided to notify the on-call Physician when she saw the lab reports arrive to the facility. The on-call Physician told her to send Resident #1 to the emergency room. The Nurse stated she called the Emergency Medical Service (EMS) for transport to the hospital, and called Resident #1's responsible party (RP). Nurse #4 indicated the resident was transferred to the hospital at 12:10 AM on 10/3/2017.

On 10/17/2017 at 8:36 AM, an interview was conducted with Nurse #2. The Nurse stated she was not working on the hall with the resident, but had given advice to Nurse #1. The Nurse indicated she called the DON on 10/1/2017 and was told it would be okay to order some lab work, so she informed Nurse #1. Nurse #2 stated she did not call the Physician, or tell Nurse #1 to call the Physician, as she just assumed Nurse #1 would call the Physician.

On 10/17/2017 at 9:45 AM, an interview was conducted with the Nurse Manager, who stated on 10/2/2017 she did not see an order written for lab work, but she had been informed in the morning meeting that lab work had been ordered for Resident #1. The Nurse Manager called the Physician's office and spoke with his nurse, and they determined a chest x-ray should also be ordered, and that was done on 10/2/2017. The Nurse Manager stated she informed the Physician's nurse that Resident #1 had high blood sugars, but not the values, and had secretions. She did not inform the Physician's nurse of the vital signs, the unresponsiveness on 9/30/17 or that the tube feedings had been stopped at various times. The Nurse Manager stated she had spoken with Resident #1 on the morning of 10/2/2017 and the resident had responded back to her with a head nod or a word, and that was normal for her, and so she did not

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appear in distress that morning. The Nurse Manager stated it was not in the nursing scope of practice to order lab work without a Physician's order.

On 10/17/2017 at 9:55 AM an interview was conducted with the DON. The DON stated she was called by Nurse #2 on 10/1/2017 and told that Resident #1 was having some high blood sugars and the nurses had stopped the tube feedings for a while and that had helped the blood sugar. The DON told Nurse #2 that the Physician on call should be contacted so lab work could be ordered. The DON stated she expected the floor nurse to call the physician, and inform him of the blood sugar to see what lab work should be ordered. The DON indicated on 10/2/2017, the Nurse Manager had checked on Resident #1. Later that evening, the DON received a page that critical results were being faxed to the facility, for Resident #1. The DON called Nurse #4 and told her to look for a fax that would be arriving with critical values, and that was when Nurse #4 called the Physician and sent the resident to the hospital. The DON stated the facility did not have a specific policy that addressed the time a continuous tube feeding could be turned off. The DON stated it was not within the nursing scope of practice to order lab work without a Physician's order.

On 10/17/2017, at 10:04 AM, an interview was conducted with the Physician. The Physician stated if he had known of the high blood sugar level he would have started the resident on a sliding scale insulin order, and although it wouldn't have prevented a hospital visit, it might have decreased the magnitude of the blood sugar at the hospital. The Physician stated he could not remember when he was contacted about Resident #1, or any details of orders for the

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resident. The Physician stated he could not comment on the resident's condition or if anything could have made it better or worse because he had many patients to care for and could not remember the details of this one case.
On 10/17/2017 at 12:08 PM, an interview was conducted with the Administrator. The Administrator stated she would expect the nursing staff to use their assessment skills, and thought that would have probably lead to calling the Physician.
On 10/23/2017 at 10:10 AM, a phone interview was conducted with the Physician's Certified Medical Assistant (CMA). The CMA stated she received a phone call from the Nurse Manager on 10/2/2017, and at that time was notified that Resident #1's blood sugars had been high, and that labs had been ordered on 10/1/17 and she had made a note in the Resident's chart at the office, for the doctor. The CMA stated she and the Nurse Manager determined a chest x-ray was also indicated for the Resident and it was ordered on 10/2/2017. The CMA stated she had not been informed that the tube feedings were stopped, the vital signs were abnormal, or the condition of the resident.
On 10/23/2017 at 4:45 PM, a second interview was conducted with Nurse #2. The Nurse stated it was possible she talked to the Physician Assistant (PA) on-call on 10/1/2017, but could not remember for sure since it was so long ago. She indicated she called the PA for one of her residents and it was possible she had told him about Resident #1. She stated it was possible the PA ordered the lab work for the resident, otherwise she would not have written out the blood work for the lab to obtain. The Nurse stated it was possible she told the PA that Resident #1 had high blood sugar, but not the

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F 157	Continued From page 8 value, as she wouldn't have known that information. She stated she would not have told him about stopping the tube feeding, her unresponsiveness, or the low-grade temp and other vital signs, because she would not have known that. She stated she was aware that an order was needed to stop a tube feeding for an extended period, anything over an hour. She stated she did not tell Nurse #1 to call the Physician because she assumed Nurse #1 would already know she needed to call the Physician. Nurse #2 could not say directly if the PA was notified, only the possibility of a call. The Nurse did not call the Physician's CMA because it was a weekend and all phones calls went to an on-call person.	F 157		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309		11/20/17

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F 309	Continued From page 9 care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to recognize changes in condition for 1 of 3 sampled residents (Resident #1) reviewed for well-being for 2 days. Resident #1 was admitted to the hospital intensive care unit with a blood glucose of 803 mg/dL, evidence of sepsis, urinary tract infection and pneumonia. The findings included: The Facility policy titled "Acute Condition Changes- Clinical Protocol", and dated as revised on December 2015, documented under Assessment and Recognition, the following: #3. Direct care staff, including nursing assistants will be trained to recognize subtle but significant changes in the resident. #6. Before contacting a Physician about someone with an acute change of condition, the Nursing Staff will make detailed observation and collect pertinent information to report to the Physician. a. Phone calls to attending or on call Physicians	F 309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of Federal and State law. 1. Resident #1 was discharged from the facility on 10/3/2017 and did not return. 2. To assure a) residents have been properly assessed to ensure that changes in condition were identified, b) physicians were notified of all changes in condition c) documentation accurately reflects action taken, and that d) intervention was timely and appropriate; residents requiring emergency room visits and those who required hospitalization for the past 30 days will be reviewed in detail by	

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F 309	Continued From page 10 should be made by an adequately prepared nurse who has collected and prepared pertinent information, including the resident's current symptoms and status. #7. The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, the will call or page the Physician and request a prompt response. Resident #1 was admitted to the facility on 3/26/2014 with diagnoses to included stroke, hemiplegia, dysphagia, and dementia. Her quarterly Minimum Data Set (MDS) assessment dated 7/29/2017 revealed her cognition to be severely impaired. She required 2-person total assistance from staff for bed mobility and transfer, and 1 person total assistance for all other activities of daily living (ADLs). She required a feeding tube for nutrition. A review of a nurse's note dated 9/30/2017, at 6:45 PM, revealed Nurse #1 was called to the Resident's room by the nursing assistant (NA #4) who indicated the resident was alert but not responding. Vitals signs were taken with the temperature of 100.1, the blood pressure was 110/70, pulse 105 and respirations 24. A blood glucose was taken with the result of 486mg/dL (milligrams per deciliter). The tube feeding was turned off. The resident was a little more responsive after the tube feeding had been stopped. The Nurse indicated she would continue to monitor and make the 7:00 PM shift aware of the situation. There was no documentation of calling the Physician. A review of a nurse's note dated 10/1/2017 at 6:22 PM by Nurse #1, revealed the resident's blood sugar that morning (no time given) was 486 mg/dL. The tube feeding was turned off and the	F 309	11/10/2017. Reviews will be completed by Director of Nursing (DON) and/or or Unit Manager. 3. Nurses are being in-serviced on a) proper and comprehensive physical assessment, b) recognizing an acute change in condition, c) appropriate notification of physician for orders to intervene and respond to the acute change, d) implementation of physician ordered response -A full return demonstration will be conducted with each nurse. Nurses will receive in-service on and a copy of the NC Nursing Scope of Practice which clearly delineate the requirement for a physician's order prior to ordering laboratory tests, x-rays, and other tests as well as any treatment. These in-services will be conducted by clinical consultant. All licensed nurses will be in-serviced by 11/20/2017. Nurses will be in-serviced on and receive copies of pertinent policies(to include change of condition, appropriate notification of physician/family, implementation of physician orders, etc.) and sign for that receipt indicating their understanding and agreement to follow the policies as written. In-service will be conducted by DON and/or Unit Manager. All nurses will be in-serviced by 11/10/2017. Any nurse not completing in-service by this time will be in-serviced prior to next shift worked. 4. A comprehensive review of resident	

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ACCORDIUS HEALTH AT SCOTLAND MANOR	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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F 309	Continued From page 11 blood sugar rechecked (no time given), and a reading of 377 mg/dL was obtained. The tube feeding was turned back on and the labs (laboratory blood work) were ordered. Nurse #1 would report to the night nurse and continue to monitor. There was no documentation of calling the Physician. A Physician telephone order was reviewed, dated 10/2/2017 (not timed) for #1. CBC (complete blood count), CMP (comprehensive metabolic panel), Hemoglobin A1C (test for diabetes), and #2. Chest x-ray 2 views, written by the Nurse Manager. Laboratory results dated 10/2/2017 at 3:09 PM, and reported on 10/3/2017, included an abnormal blood glucose of 582 mg/dL (milligrams per deciliter), with normal blood glucose value of 70 to 105 mg/dL. A sodium result of 174 mEq/L (milliequivalents per liter, with a normal sodium value of 136 to 145 mEq/L; a chloride result of 125 mEq/L, with a normal chloride value of 125 mEq/L: and a hemoglobin A1C of 11.0%, with a normal value of 4.0 to 6.0%. A radiology report dated 10/2/2017, and electronically signed by the reading Physician at the time of 8:35 PM concluded the resident had slight left lower lobe pneumonia. A review of a nurse's note dated 10/3/2017 at 7:30 AM, revealed the abnormal laboratory results were reported to the on-call Physician, by Nurse #4, who also reported the x-ray showed slight left lower lobe pneumonia. There were no signs and symptoms of respiratory distress. Physician's orders were received to send the resident to the hospital emergency room. The ambulance was called at 12:10 AM, the morning of 10/3/2017. A review of the hospital admission history and physical dated 10/3/2017 revealed Resident #1	F 309	records pertaining to all emergency visits and hospitalizations will be completed by the DON and/or Unit Manager to ensure all aspects of the above systemic corrective action are complete. This review will be recorded on the audit tool attached for the next 60 days with retraining and reinforcement of standards of practice for any findings suggesting a continued need for re-education or disciplinary action of staff. -The Quality Assurance and Performance Improvement(QAPI) team will review findings on these audit tools at the monthly team meeting for the next 60 days. On an ongoing basis, the audit will be completed on a random selection of 1 out of every 3 emergency visits or hospitalizations for the purpose of assuring sustained compliance with this corrective action.	

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had a blood glucose of 803 mg/dL, evidence of sepsis, findings consistent with urinary tract infection and pneumonia. The resident was admitted to the intensive care unit.

An interview was conducted on 10/16/2017 at 3:29 PM with Nurse #1, who stated on 9/30/2017, NA #4 came to her right before shift change and told her the resident had been sleepier than usual, and was alert, but not responding. The Nurse checked the resident, got her vital signs, and then asked Nurse #2 what she advised. Nurse #2 told her to check the blood sugar, even though the resident did not have diabetes. When the high blood sugar result was found, Nurse #1 was advised by Nurse #2 to turn off the tube feeding for a while. The Nurse stated that since it was right at shift change she did not turn the feeding back on, but informed the night nurse to turn it back on after 20 minutes. When Nurse #1 came back to work the next day on 10/1/2017, she again checked the Resident #1's blood sugar at morning medication pass, about 8:00 AM. The blood sugar result was 486 mg/dL, so she turned off the tube feeding for about 2 ½ hours. The next blood sugar test was done after lunch and was still high at 377mg/dL. The Nurse again asked Nurse #2 what to do, and was told Nurse #2 would call the Director of Nursing (DON) and take care of it. Nurse #1 stated she did not call the Physician for the blood sugar readings, as she assumed Nurse #2 was going to. Nurse #1 stated she did not have a Physician's order to turn off the tube feeding, but it was a nursing judgement call if the tube feeding was not off for an extended period of time. The Nurse stated she turned the tube feeding off for 2.5 hours, and if it had been longer than that she would have called the physician for an order.

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An interview was conducted with Nurse #4 on 10/16/2017 at 3:43 PM. The Nurse stated she was informed by the DON to look for an arriving fax of abnormal lab reports for Resident #1, on the night shift of 10/2/2017. The Nurse indicated she decided to notify the on-call Physician when she saw the lab reports arrive to the facility. The on-call Physician told her to send Resident #1 to the emergency room. The Nurse stated she called the Emergency Medical Service (EMS) for transport to the hospital, and called Resident #1's responsible party (RP). Nurse #4 indicated the resident was transferred to the hospital at 12:10 AM on 10/3/2017.

On 10/17/2017 at 8:36 AM, an interview was conducted with Nurse #2. The Nurse stated she was not working on the hall with the resident, but had given advice to Nurse #1. The Nurse indicated she called the DON on 10/1/2017 and was told it would be okay to order some lab work, so she informed Nurse #1. Nurse #2 stated she did not call the Physician, or tell Nurse #1 to call the Physician, as she just assumed Nurse #1 would call the Physician.

On 10/17/2017 at 9:45 AM, an interview was conducted with the Nurse Manager, who stated on 10/2/2017 she did not see an order written for lab work, but she had been informed in the morning meeting that lab work had been ordered for Resident #1. The Nurse Manager called the Physician's office and spoke with his nurse, and they determined a chest x-ray should also be ordered, and that was done on 10/2/2017. The Nurse Manager stated she informed the Physician's nurse that Resident #1 had high blood sugars, but not the values, and had secretions. She did not inform the Physician's nurse of the vital signs, the unresponsiveness on 9/30/17 or that the tube feedings had been

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stopped at various times. The Nurse Manager stated she had spoken with Resident #1 on the morning of 10/2/2017 and the resident had responded back to her with a head nod or a word, and that was normal for her, and so she did not appear in distress that morning. The Nurse Manager stated it was not in the nursing scope of practice to order lab work without a Physician's order.

On 10/17/2017 at 9:55 AM an interview was conducted with the DON. The DON stated she was called by Nurse #2 on 10/1/2017 and told that Resident #1 was having some high blood sugars and the nurses had stopped the tube feedings for a while and that had helped the blood sugar. The DON told Nurse #2 that the Physician on call should be contacted so lab work could be ordered. The DON stated she expected the floor nurse to call the physician, and inform him of the blood sugar to see what lab work should be ordered. The DON indicated on 10/2/2017, the Nurse Manager had checked on Resident #1. Later that evening, the DON received a page that critical results were being faxed to the facility, for Resident #1. The DON called Nurse #4 and told her to look for a fax that would be arriving with critical values, and that was when Nurse #4 called the Physician and sent the resident to the hospital. The DON stated the facility did not have a specific policy that addressed the time a continuous tube feeding could be turned off. The DON stated it was not within the nursing scope of practice to order lab work without a Physician's order.

On 10/17/2017, at 10:04 AM, an interview was conducted with the Physician. The Physician stated if he had known of the high blood sugar level he would have started the resident on a sliding scale insulin order, and although it

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wouldn't have prevented a hospital visit, it might have decreased the magnitude of the blood sugar at the hospital. The Physician stated he could not remember when he was contacted about Resident #1, or any details of orders for the resident. The Physician stated he could not comment on the resident's condition or if anything could have made it better or worse because he had many patients to care for and could not remember the details of this one case.

On 10/17/2017 at 12:08 PM, an interview was conducted with the Administrator. The Administrator stated she would expect the nursing staff to use their assessment skills, and thought that would have probably lead to calling the Physician.

On 10/23/2017 at 10:10 AM, a phone interview was conducted with the Physician's Certified Medical Assistant (CMA). The CMA stated she received a phone call from the Nurse Manager on 10/2/2017, and at that time was notified that Resident #1's blood sugars had been high, and that labs had been ordered on 10/1/17 and she had made a note in the Resident's chart at the office, for the doctor. The CMA stated she and the Nurse Manager determined a chest x-ray was also indicated for the Resident and it was ordered on 10/2/2017. The CMA stated she had not been informed that the tube feedings were stopped, the vital signs were abnormal, or the condition of the resident.

On 10/23/2017 at 4:45 PM, a second interview was conducted with Nurse #2. The Nurse stated it was possible she talked to the Physician Assistant (PA) on-call on 10/1/2017, but could not remember for sure since it was so long ago. She indicated she called the PA for one of her residents and it was possible she had told him about Resident #1. She stated it was possible

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F 309	Continued From page 16 the PA ordered the lab work for the resident, otherwise she would not have written out the blood work for the lab to obtain. The Nurse stated it was possible she told the PA that Resident #1 had high blood sugar, but not the value, as she wouldn't have known that information. She stated she would not have told him about stopping the tube feeding, her unresponsiveness, or the low-grade temp and other vital signs, because she would not have known that. She stated she was aware that an order was needed to stop a tube feeding for an extended period, anything over an hour. She stated she did not tell Nurse #1 to call the Physician because she assumed Nurse #1 would already know she needed to call the Physician. Nurse #2 could not say directly if the PA was notified, only the possibility of a call. The Nurse did not call the Physician's CMA because it was a weekend and all phones calls went to an on-call person.	F 309		