STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345137		C 01/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VILLAGE	2221 W RALEIGH BLVD ROCKY MOUNT, NC 27803

(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=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 physician interview, staff interview, and record review the facility failed to notify the primary physician of an emergent life-threatening	F 157	Resident #5 experienced a change in condition of 10/16/2013 related to hypoglycemia on 10/16/2013 at 11:45pm.	1/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/17/2014

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	Continued From page 1 situation, prior to Emergency Medical Service (EMS) transport to the emergency room (ER), for 1 of 1 sampled residents (Resident #5) who was found non-responsive. The facility also failed to follow its hypoglycemia protocol in regard to the timing of involving the physician in the resident's care. The immediate jeopardy began on 10/16/13 when Nurse #1 found Resident #5 non-responsive with a blood sugar of 31 and failed to initiate effective medical interventions, including physician notification, and follow the facility's Hypoglycemia Protocol for Adults with Diabetes. The immediate jeopardy was removed on 01/02/14 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Findings included: Resident #5's copy of the Hypoglycemia Protocol for Adults with Diabetes, signed by the physician on 04/09/07, documented "If unconscious and NPO (nothing by mouth) or in nurse's judgment unable to take PO's safely: Position the resident on side and observe seizure precautions. If no IV (intravenous) access, place a small amount of instant glucose between the gum and buccal mucosa in the dependent side of the resident's mouth. Do not leave the resident unattended....If unable to gain IV access, give Glucagon IM (intramuscular) 1 mg (milligrams) if resident weighs greater than or equal to 100 pounds....Recheck CBG (capillary blood glucose)	F 157	She was assessed by the charge nurse and hypoglycemic protocol was implemented. Resident coded and was transferred to the ER for treatment on 10/17/13 at 1:45am by EMS. Resident is no longer in facility. All other residents were assessed, utilizing the 24 hour nursing report, chart reviews, staff interviews, and resident observations for changes in condition to include hypoglycemic, episodes, unresponsiveness and any mental or physical change in condition on 01/01/2014 by the director of nursing (DON). Results were documented by the DON on a newly revised system check of resident change of condition tool. Any changes in condition identified were reassessed by the nurse documented to include vital signs and notification of physician. At the time of a significant change in the resident's physical or mental condition, a comprehensive assessment will be conducted by the licensed nurse to include: 1) vital signs to include, pulse, respiration, blood pressure, 02 sats, blood sugar and 2) the resident's level of consciousness. Licensed nurse will implement the appropriate physician standing orders; then, immediately notify physician of current status and obtain any additional orders. Licensed Staff were in-serviced by the DON and assistant director of nursing (ADON) on F157 on 01/01/2014. At the	

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F 157	Continued From page 2 in 15 minutes. If response is inadequate, repeat treatment....While implementing the above steps, notify the physician for further orders." Resident #5 was admitted to the facility on 10/25/05, and was sent out to the hospital on 10/17/13. The resident's documented diagnoses included diabetes, hypertension, and bipolar disorder. A 10/16/13 11:45 PM nurse's note, written by Nurse #1, documented, "CNA (nursing assistant) reported to nurse that resident was sweating and non-responsive. Nurse went to room and did fingerstick. BS (blood sugar) = 31. Nurse gave 8 oz (ounces) of Medpass (liquid supplement) with (symbol used) 4 sugar packs. Resident drank it. Continue to sweat. Bed wet. Skin cool and clammy. 2400 (12 midnight) BS checked 37. Resident given Glutose 15 one (symbol used) tube. Non-responsive. 2430 (12:30 AM) BS checked was 48. Given Glutose 15 one tube po. 0115 (1:15 AM) Returned to check blood sugar. Called resident's name. Shook her. Check for pulse. Turned light on hands and around mouth blue. 0130 (1:30 AM) went for crash cart called code blue. 0140 (1:40 AM) CPR started. EMTs (emergency medical technicians) called. Resident placed on floor. Compressions started by supervisor. Defibrillator pad applied by this nurse with (symbol used) O2 (oxygen) via NC (nasal cannula) applied at (symbol used) 3 L (liters). Breaths given with (symbol used) Ambu bag....0145 (1:45 AM) EMS (emergency medical services) here. Took over CPR." EMS obtained a blood sugar of 78, and oxygen saturation rates of 91 - 95% were obtained. A 10/17/13 2:35 AM telephone order documented	F 157	time of a significant change in the resident's physical or mental condition, a comprehensive assessment will be conducted by the licensed nurse to include: 1) vital signs to include, pulse, respiration, blood pressure, 02 sats, blood sugar and 2) the resident's level of consciousness. Licensed nurse will implement the appropriate physician standing orders and notify physician of resident's current status and obtain additional orders. Any staff not available for this training will not be allowed to work until training is complete. The DON and or the ADON will complete, on a on-going basis, a system check of reporting change in condition audit tool 5 x per week (Monday - Friday) during morning clinical meeting to ensure that resident physician has been notified of resident change of condition. The DON or ADON will complete random evaluations with licensed nurses to ensure continued compliance with nursing change of condition assessment skills and notification of physician of change of condition. The evaluations will be completed 2 x weekly for 3 months and 1 x monthly on an on-going basis. All new hire nursing staff will be in-serviced during orientation on the facility policy for reporting resident change in condition to include notification of physician of change in condition.	

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F 157	Continued From page 3 to send the resident to the emergency room (ER) by EMS for life support. A 10/17/13 4:10 AM Nurse's Note documented, "_____ (name of Resident #5's primary physician) notified of resident's code and that she was sent to _____ (name of hospital)." A 10/17/13 hospital history and physical documented, "On arrival to the ER, she had an agonal rhythm (an extremely slow ventricular rhythm that often indicates dismal outcome) to no rhythm; however, she responded to several rounds of drugs and CPR, recovered blood pressure and junctional rhythm....Do Not Resuscitate per family members include guardian. Basically, they want no CPR. At this point though they would like to continue pressors (type of medications) and ventilatory support....Cardiac arrest with prolonged period of both hypoxemia and hypotension...Acute myocardial infarction probably precipitating factor." A 10/17/13 hospital discharge summary documented, "Family conference was held, and the outlook was described. The patient's family agreed that under the circumstances, they would prefer a withdrawal of support....The patient's withdrawal of support was undertaken, and the patient went on to subsequently expire." The summary documented Resident #5 expired at 12:11 PM on 10/17/13. On 10/18/13 Nurse #1 wrote an addendum to her 10/16/13 nurse's note. The addendum clarified events that happened involving Resident #5 on and after 10/17/13 at 1:15 AM while the resident was still in the facility and as EMS sent the	F 157	The DON/ADON will complete a system check of reporting change in resident condition audit tool 5 x per week. The results of the audits will be forwarded to the QA committee for review monthly X 3 months for review and further recommendations.	

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F 157	Continued From page 4 resident to the ER. As in her previous Nurse's Note Nurse #1 did not document any contact with the resident's primary physician before 4:10 AM on 10/17/13. At 11:58 PM on 12/30/13 Nurse #1 stated she was the nurse caring for Resident #5 when the resident was found non-responsive with a blood sugar of 31 on 10/16/13. She explained the resident did not respond when she called her name, and when she lifted the resident's arm, it fell limply onto the bed. The nurse reported she realized the resident was in an emergency situation so she provided the resident with the quickest intervention she could find that might help raise her blood sugar. She stated the facility's hypoglycemia protocol required physician notification if two tubes of Glutose failed to raise resident blood sugar and nursing had to resort to using an injectable product. According to Nurse #1, she felt involving the physician after getting the blood sugar up and stabilized or calling the physician once injectable measures were resorted to were acceptable parameters for physician notification. However, she commented that the first time Resident #5's primary physician was contacted about the resident's change in condition was at 4:10 AM on 10/17/13. At 12:40 AM on 12/31/13 the third shift supervisor (Nurse #2) stated if she remembered correctly the facility's hypoglycemia protocol encouraged physician notification after trying Medpass (nutrition supplement) or orange juice/crackers three times to raise blood sugar. She reported if the three attempts did not raise blood sugar significantly the next step was to provide Glucagon and notify the physician.	F 157		

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F 157	Continued From page 5 At 1:08 AM on 12/31/13 the DON stated the facility's hypoglycemia protocol was kept on the medical records under the physician order tabs. She explained the protocols were signed by physicians, and therefore, served as physician orders. The DON reported her expectation would be that nurses would contact a physician as soon as hypoglycemic residents did not experience a substantial increase in blood sugar after implementing protocol interventions. At 2:25 PM on 12/31/13, during a telephone conversation, Resident #5's primary physician stated the facility did not follow its hypoglycemic protocol if nursing did not contact him as soon as implementing interventions to raise the blood sugar for a resident who was possibly non-responsive due to severe hypoglycemia. He reported he remembered who Resident #5 was, but could not recall details about any notification received from the facilty about this resident on 10/16/13 or 10/17/13. However, he commented he expected to be notified immediately when a resident experienced a change in condition, including non-responsiveness. The administrator was notified of the immediate jeopardy on 12/31/13 at 3:30 PM. The facility provided the following credible allegation on 01/02/13 at 11:48 AM. credible allegation of compliance: Resident #5 experienced a change in condition of 10/16/2013 related to hypoglycemia on 10/16/2013 at 11:45pm. She was assessed by the charge nurse and hypoglycemic protocol was implemented. Resident coded and was	F 157		

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F 157	Continued From page 6 transferred to the ER for treatment on 10/17/13 at 1:45am by EMS. Resident is no longer in facility. All other residents were assessed, utilizing the 24 hour nursing report, chart reviews, staff interviews, and resident observations for changes in condition to include hypoglycemic, episodes, unresponsiveness and any mental or physical change in condition on 01/01/2014 by the director of nursing (DON). Results were documented by the DON on a newly revised system check of resident change of condition tool. Any changes in condition identified were reassessed by the nurse documented to include vital signs and notification of physician. At the time of a significant change in the resident's physical or mental condition, a comprehensive assessment will be conducted by the licensed nurse to include: 1) vital signs to include, pulse, respiration, blood pressure, 02 sats, blood sugar and 2) the resident's level of consciousness. Licensed nurse will implement the appropriate physician standing orders; then, immediately notify physician of current status and obtain any additional orders. Licensed Staff were in-serviced by the DON and assistant director of nursing (ADON) on F157 on 01/01/2014. At the time of a significant change in the resident's physical or mental condition, a comprehensive assessment will be conducted by the licensed nurse to include: 1) vital signs to include, pulse, respiration, blood pressure, 02 sats, blood sugar and 2) the resident's level of consciousness. Licensed nurse will implement the appropriate physician standing orders and notify physician of resident's current status and obtain additional orders.	F 157		

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F 157	Continued From page 7 Any staff not available for this training will not be allowed to work until training is complete. The DON and or the ADON will complete, on a on-going basis, a system check of reporting change in condition audit tool 5 x per week (Monday - Friday) during morning clinical meeting to ensure that resident physician has been notified of resident change of condition. The DON or ADON will complete random evaluations with licensed nurses to ensure continued compliance with nursing change of condition assessment skills and notification of physician of change of condition. The evaluations will be completed 2 x weekly for 3 months and 1 x monthly on an on-going basis. All new hire nursing staff will be in-serviced during orientation on the facility policy for reporting resident change in condition to include notification of physician of change in condition. The DON/ADON will complete a system check of reporting change in resident condition audit tool 5 x per week. The results of the audits will be forwarded to the QA committee for review monthly X 3 months for review and further recommendations. The facility alleges compliance as of 01/01/2014. On 01/02/14 at 3:20 PM verification of the credible allegation was evidenced by interviews with licensed staff and NAs about in-servicing related to change in condition, hypoglycemia protocol, complete/accurate assessments, and physician notification. In addition, it was verified	F 157		

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F 157	Continued From page 8 that the staff was beginning use of the system check of reporting change in resident condition audit tool.	F 157		
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 physician interview, staff interview, and record review the facility failed to provide effective medical intervention in an emergent life-threatening situation for 1 of 1 sampled residents (Resident #5) who remained non-responsive for an hour and a half until the nurse observed signs of cyanosis and later initiated cardiopulmonary resuscitation (CPR). The facility also failed to follow its hypoglycemia protocol. The immediate jeopardy began on 10/16/13 when Nurse #1 found Resident #5 non-responsive with a blood sugar of 31 and failed to initiate effective medical interventions and follow the facility's Hypoglycemia Protocol for Adults with Diabetes. The immediate jeopardy was removed on 01/02/14 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than	F 309	Resident #5 experienced a change in condition of 10/16/2013 related to hypoglycemia on 10/16/2013 at 11:45pm. She was assessed by the charge nurse and hypoglycemic protocol was implemented. Resident coded and was transferred to the ER for treatment on 10/17/13 at 1:45am by EMS. Resident is no longer in facility. All other residents were assessed, utilizing the 24 hour nursing report, chart reviews, staff interviews, and resident observations for changes in condition to include hypoglycemic episodes, unresponsiveness and any mental or physical change in condition on 01/01/2014 by the director of nursing (DON). Results were documented by the DON on a newly revised system check of resident change of condition monitoring	1/2/14

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F 309	Continued From page 9 minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Findings included: Resident #5's copy of the Hypoglycemia Protocol for Adults with Diabetes, signed by the physician on 04/09/07, documented "If unconscious and NPO (nothing by mouth) or in nurse's judgment unable to take PO's safely: Position the resident on side and observe seizure precautions. If no IV (intravenous) access, place a small amount of instant glucose between the gum and buccal mucosa in the dependent side of the resident's mouth. Do not leave the resident unattended....If unable to gain IV access, give Glucagon IM (intramuscular) 1 mg (milligrams) if resident weighs greater than or equal to 100 pounds....Recheck CBG (capillary blood glucose) in 15 minutes. If response is inadequate, repeat treatment....While implementing the above steps, notify the physician for further orders." Resident #5 was admitted to the facility on 10/25/05, and was sent out to the hospital on 10/17/13. The resident's documented diagnoses included diabetes, hypertension, and bipolar disorder. A 06/17/13 quarterly minimum data set (MDS) documented Resident #5's cognition was severely impaired and the resident was totally dependent on the staff for all of her activities of daily living (ADLs). On 07/29/13 Resident #5's responsible party signed a full code agreement.	F 309	tool. Any changes in condition identified were reassessed by the nurse documented to include vital signs and notification of physician. At the time of a significant change in the resident's physical or mental condition, a comprehensive assessment will be conducted by the licensed nurse to include: 1) vital signs to include, pulse, respiration, blood pressure, 02 sats, blood sugar and 2) the resident's level of consciousness. Licensed nurse will implement the appropriate physician standing orders and immediately notify physician of resident's current status and obtain additional orders. This process has been implemented as a component to the facility Standards of Care for all residents with any change of condition. The DON and or the ADON will complete, on an on-going basis, a system check of reporting change in condition audit tool 5 x per week (Monday - Friday) during morning clinical meeting to review for resident change in condition and nurse intervention to include notification of physician. At the morning clinical meeting the DON and or the ADON will review the 24 hour report, resident chart, staff interviews and resident observation to identify any change of condition to include hypoglycemia, unresponsiveness, and any other mental or physical changes in condition noted for the prior 24 hours. Any noted change of conditions will be documented by the DON and or ADON on the newly revised systems check for	

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F 309	Continued From page 10 A review of Resident #5's medication administration records (MARs) for September and October 2013 revealed the resident was receiving Actos 45 mg and Januvia 75 mg daily (both oral blood sugar control medications), Novolin 70/30 insulin 35 units each morning (hold if meal intake less than 50%), Novolin 70/30 insulin 40 units each evening (hold if meal intake less than 50%), and sliding scale Novolin R insulin. The resident had an order to complete accuchecks before meals and at bedtime. These MARs documented the resident's blood sugars were unstable and erratic. For example between 10/01/13 and 10/15/13 6:30 AM blood sugars ran 73 - 267, 12 noon blood sugars ran 79 - 324, 4:30 PM blood sugars ran 68 -351, and 9:00 PM blood sugars ran 85 - 320. Per physician order to obtain vital signs every Wednesday, Resident #5's vital signs on 10/16/13 were temperature 97.5 degrees, respirations 17, pulse 78, and blood pressure 169/70. At 1:10 PM on 01/03/14 the director of nursing (DON) stated vital signs were done by the nursing assistants (NAs) on either first or second shift depending on whether the residents were in beds by the doors or the windows. Resident #5's accucheck readings for 10/16/13, as documented on the MAR, were 133 at 6:30 AM, 116 at 12 noon, 85 at 4:30 PM, and 102 at 9:00 PM. Per the October 2013 MAR, the resident did not receive any sliding scale insulin on 10/16/13, but did received her regularly scheduled 35 units of Novolin 70/30 at 8:00 AM and regularly scheduled 40 units of Novolin 70/30 at 5:00 PM.	F 309	residents with change in condition audit tool for follow-up to be completed within 24 hours. Licensed Staff were in-serviced by the DON and ADON on the 1) facility protocol for hypoglycemia to include notification of physician, 2) the assessment process to identify resident changes in condition particularly unresponsive to include signs and symptoms , vital signs and implementation of protocols and MD notification, and 3) documenting a concise and accurate time line of events including assessment results i.e. vital signs, responsiveness, signs and symptoms of hypoglycemia on 01/01/2014. NAs were in-serviced by the DON and ADON on 1) reporting change in resident condition and 2) recognizing the signs and symptoms of hypoglycemia and reporting changes to the nurse 01/01/14. Any staff not available for this training will not be allowed to work until training is complete. The DON or ADON will complete random evaluations with licensed nurses to ensure continued compliance with nursing change of condition assessment skills. The evaluations will be completed 2 x weekly for 3 months and 1 x monthly on an on-going basis. All new hire nursing staff will be in-serviced during orientation on the	

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F 309	Continued From page 11 A 10/16/13 11:45 PM nurse's note, written by Nurse #1, documented, "CNA (nursing assistant) reported to nurse that resident was sweating and non-responsive. Nurse went to room and did fingerstick. BS (blood sugar) = 31. Nurse gave 8 oz (ounces) of Medpass (liquid supplement) with (symbol used) 4 sugar packs. Resident drank it. Continue to sweat. Bed wet. Skin cool and clammy. 2400 (12 midnight) BS checked 37. Resident given Glutose 15 one (symbol used) tube. Non-responsive. 2430 (12:30 AM) BS checked was 48. Given Glutose 15 one tube po. 0115 (1:15 AM) Returned to check blood sugar. Called resident's name. Shook her. Check for pulse. Turned light on hands and around mouth blue. 0130 (1:30 AM) went for crash cart called code blue. 0140 (1:40 AM) CPR started. EMTs (emergency medical technicians) called. Resident placed on floor. Compressions started by supervisor. Defibrillator pad applied by this nurse with (symbol used) O2 (oxygen) via NC (nasal cannula) applied at (symbol used) 3 L (liters). Breaths given with (symbol used) Ambu bag....0145 (1:45 AM) EMS (emergency medical services) here. Took over CPR." EMS obtained a blood sugar of 78, and oxygen saturation rates of 91 - 95% were obtained. A 10/17/13 2:35 AM telephone order documented to send the resident to the emergency room (ER) by EMS for life support. A 10/17/13 EMS patient care report documented that as transport was backing up to emergency care (time not specified) Resident #5 started taking breaths on her own. At 3:25 AM on 10/17/13 hospital emergency	F 309	facility policy for reporting resident change in condition to include notification of physician of change in condition. The DON/ADON will complete a system check of reporting change in resident condition audit tool 5 x per week. The results of the audits will be forwarded to the QA committee for review monthly X 3 months for review and further recommendations.	

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F 309	Continued From page 12 documentation stated, "On arrival of EMS patient was in V. fib (ventricular fibrillation) arrest. She received the the usual medications and a total of 6 defibrillations with a past transient return of an organized rhythm and no palpable pulse. A King airway (an emergency airway system) was placed in the field. On arrival in the ER patient was comatose with an agonal rhythm (an extremely slow ventricular rhythm that often indicates dismal outcome) and no palpable pulse." It was also documented that in the ER the resident was intubated and a central line was placed. A 10/17/13 hospital history and physical documented, "On arrival to the ER, she had an agonal rhythm to no rhythm; however, she responded to several rounds of drugs and CPR, recovered blood pressure and junctional rhythm....Do Not Resuscitate per family members include guardian. Basically, they want no CPR. At this point though they would like to continue pressors (type of medications) and ventilatory support....Cardiac arrest with prolonged period of both hypoxemia and hypotension...Acute myocardial infarction probably precipitating factor." A 10/17/13 hospital discharge summary documented, "Family conference was held, and the outlook was described. The patient's family agreed that under the circumstances, they would prefer a withdrawal of support....The patient's withdrawal of support was undertaken, and the patient went on to subsequently expire." The summary documented Resident #5 expired at 12:11 PM on 10/17/13. On 10/18/13 Nurse #1 wrote an addendum to her 10/16/13 nurse's note. The addendum only	F 309		

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F 309	Continued From page 13 clarified events that happened involving Resident #5 at and after 1:15 AM on 10/17/13. It did not address events that occurred between 10/16/13 at 11:45 PM and 10/17/13 at 1:15 AM. At 11:58 PM on 12/30/13 Nurse #1 stated she was the nurse caring for Resident #5 when the resident was found non-responsive on 10/16/13. She commented if Resident #5 did not eat dinner her blood sugar was frequently low. She reported, however, when she entered the room at 11:45 PM on 10/16/13 the resident did not respond to verbal or tactile stimuli. She explained the resident did not respond when she called her name, and when she lifted the resident's arm, it fell limply onto the bed. Nurse #1 commented she gave the resident Medpass (nutritional supplement) mixed with sugar because it was the quickest thing she could get to in hopes of raising the resident's blood sugar since the resident was definitely in an emergency situation. She remarked that usually she would give orange juice or Glutose, but these were not readily available, and time was of the essence. According to Nurse #1, Resident #5 did not exhibit any active swallowing motions when given the Medpass, and the product ran out of the resident's mouth and down her lips. The nurse stated in about 15 minutes she went back to the room to recheck the resident's blood sugar, and had with her a tube of Glutose which was in the top of the emergency box. The nurse stated the resident's blood sugar had risen very little so she squirted the Glutose on the resident's tongue where it melted. She reported the resident was still non-responsive at this time. In about thirty minutes the nurse commented she returned to find the resident still non-responsive, her blood sugar having only risen to 48, and gave another	F 309		

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F 309	Continued From page 14 tube of Glutose. Nurse #1 stated in her documentation she saw no vital signs recorded, only blood sugars and, once EMS arrived, oxygen saturation rates. She explained that it was not unusual for Resident #5 to experience spells such as this. (However, a review of Nurse's Notes from 05/01/13 until 10/16/13 revealed no documentation of Resident #5 having any episodes of non-responsiveness or episodes of blood sugars low enough to require implementation of the facility's hypoglycemia protocol). At 1:15 AM on 10/17/13 Nurse #1 reported Resident #5 was cyanotic, and she stated this was the first time she checked the resident for a pulse, but was unable to find one. According to the nurse, 1:40 AM on 10/17/13 was the first time her supervisor became involved with Resident #5 by providing CPR assistance. Nurse #1 stated between 11:45 PM on 10/16/13 and 1:15 AM on 10/17/13 she was in and out of Resident #5's room every 15 - 30 minutes to recheck blood sugars and NA #1 was in and out of the resident's room and at the end of the hall near Resident #5's room. However, she reported that no staff members were constantly with the resident during this time period. According to Nurse #1, she knew what to do "to get her (Resident #5) back" so she did not have to refer to the facility's protocol for episodes of hypoglycemia on 10/16/13 and 10/17/13. Looking back on the event, the nurse commented there was nothing she could have done any differently. At 12:20 AM on 12/31/13 NA #1, who went to Nurse #1 with concerns about Resident #5 on 10/16/13, stated she checked on all her residents when she began her shift. She reported when she got to Resident #5's room about 11:45 PM the resident did not respond to her name and did	F 309		

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F 309	Continued From page 15 not respond to touch. The NA recalled the resident being slumped over in the bed, with her face and body being very wet, and her eyes closed. She commented, "It was like the resident had been like this before I got there." She stated she stayed in the room for awhile as Nurse #1 obtained Resident #5's blood sugar. NA #1 reported the nurse attempted to give the resident some Medpass, but the resident was not capable of swallowing it. According to NA #1, the resident was non-responsive when she left the resident's room. She explained she was down on the end of Resident #5's hall looking after some other residents. She stated later in the evening Nurse #1 asked her to get her things such as the crash cart. NA#1 reported she did not take any vital signs on Resident #5, and did not witness Nurse #1 doing so either, although she thought she may have recalled seeing a blood pressure cuff in the resident's room. NA #1 stated she did not recall Resident #5 having any non-responsive episodes in the last eight months that she had cared for her. At 12:40 AM on 12/31/13 the third shift supervisor (Nurse #2) stated in the two years she had worked in the facility she never recalled Resident #5 being non-responsive until the night of 10/16/13. She reported the resident experienced a low blood sugar level maybe one out of seven days during the week, but the blood sugar was never as low as 31. The supervisor commented during Resident #5's 10/16/13 non-responsive episode she became involved in caring for the resident on 10/17/13 at 1:30 AM. When she entered the resident's room she stated the resident was blue around the mouth and nail beds and vital signs were absent. According to the supervisor, Nurse #1 told her she had been	F 309		

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F 309	Continued From page 16 checking the resident's blood sugar every 25 - 30 minutes, but Nurse #1 did not mention attempting to obtain any vital signs prior to 1:30 AM. Nurse #2 stated her expectation was for vital signs or the absence thereof to be documented in initial Nurse's Notes by nurses who were assessing changes in resident condition, and periodically throughout follow-up Nurse's Notes. The supervisor reported the facility's hypoglycemic protocol required nurses to provide residents experiencing hypoglycemia with Medpass or juice/crackers, and this was repeated up to three times until there was a substantial rise in blood sugar, and if no rise occurred, then the administration of Glucagon was begun. She commented this protocol did not change even if a resident was non-responsive., and the protocol required nurses to recheck blood sugar every 15 minutes. The supervisor reported if she was caring for a diabetic resident who was exhibiting signs of hypoglycemia she would refer to the medical record where the official protocol was kept. At 1:08 AM on 12/31/13 the DON stated the facility's hypoglycemia protocol was kept on the medical records under the physician order tabs. She explained the protocols were signed by physicians, and therefore, served as physician orders. She commented that giving interventions by mouth to non-responsive residents was dangerous because it could cause the residents to choke or aspirate. For non-responsive residents, she explained Glucagon or IVs were supposed to be the first hypoglycemic interventions attempted. According to the DON, she expected staff to stay with non-responsive residents in case there was a change in condition which required immediate action. The DON	F 309		

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F 309	Continued From page 17 stated she did discuss the 10/16/13 situation involving Resident #5 with Nurse #1, and a resulting addendum was written on 10/18/13 which more clearly documented what facility nursing did versus what EMS did in attempts to resuscitate Resident #5 after a code blue was called. The DON reported, according to Nurse's Notes, Nurse #1 did not follow the facility's hypoglycemic protocol because she provided a non-responsive resident with Medpass, left a non-responsive resident unattended, and did not notify the physician of the resident's non-responsiveness. At 2:25 PM on 12/31/13, during a telephone conversation, Resident #5's primary physician stated vital signs were important to obtain during resident changes in condition such as non-responsiveness since they helped him make decisions about treatment options. He reported he remembered who Resident #5 was, but could not recall details about any notification received from the facilty about this resident on 10/16/13 or 10/17/13. However, he commented he expected to be notified immediately when a resident experienced a change in condition, including non-responsiveness. The administrator was notified of the immediate jeopardy on 12/31/13 at 3:30 PM. The facility provided the following credible allegation on 01/02/13 at 11:48 AM. credible allegation of compliance: Resident #5 experienced a change in condition of 10/16/2013 related to hypoglycemia on 10/16/2013 at 11:45pm. She was assessed by	F 309		

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F 309	Continued From page 18 the charge nurse and hypoglycemic protocol was implemented. Resident coded and was transferred to the ER for treatment on 10/17/13 at 1:45am by EMS. Resident is no longer in facility. All other residents were assessed, utilizing the 24 hour nursing report, chart reviews, staff interviews, and resident observations for changes in condition to include hypoglycemic episodes, unresponsiveness and any mental or physical change in condition on 01/01/2014 by the director of nursing (DON). Results were documented by the DON on a newly revised system check of resident change of condition monitoring tool. Any changes in condition identified were reassessed by the nurse documented to include vital signs and notification of physician. At the time of a significant change in the resident's physical or mental condition, a comprehensive assessment will be conducted by the licensed nurse to include: 1) vital signs to include, pulse, respiration, blood pressure, 02 sats, blood sugar and 2) the resident's level of consciousness. Licensed nurse will implement the appropriate physician standing orders and immediately notify physician of resident's current status and obtain additional orders. This process has been implemented as a component to the facility Standards of Care for all residents with any change of condition. The DON and or the ADON will complete, on an on-going basis, a system check of reporting change in condition audit tool 5 x per week (Monday - Friday) during morning clinical meeting to review for resident change in condition and nurse intervention to include notification of physician. At the morning clinical meeting the	F 309		

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F 309	Continued From page 19 DON and or the ADON will review the 24 hour report, resident chart, staff interviews and resident observation to identify any change of condition to include hypoglycemia, unresponsiveness, and any other mental or physical changes in condition noted for the prior 24 hours. Any noted change of conditions will be documented by the DON and or ADON on the newly revised systems check for residents with change in condition audit tool for follow-up to be completed within 24 hours. Licensed Staff were in-serviced by the DON and ADON on the 1) facility protocol for hypoglycemia to include notification of physician, 2) the assessment process to identify resident changes in condition particularly unresponsive to include signs and symptoms , vital signs and implementation of protocols and MD notification, and 3) documenting a concise and accurate time line of events including assessment results i.e. vital signs, responsiveness, signs and symptoms of hypoglycemia on 01/01/2014. NAs were in-serviced by the DON and ADON on 1) reporting change in resident condition and 2) recognizing the signs and symptoms of hypoglycemia and reporting changes to the nurse 01/01/14. Any staff not available for this training will not be allowed to work until training is complete. The DON or ADON will complete random evaluations with licensed nurses to ensure continued compliance with nursing change of condition assessment skills. The evaluations will be completed 2 x weekly for 3 months and 1 x monthly on an on-going basis.	F 309		

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F 309	Continued From page 20 All new hire nursing staff will be in-serviced during orientation on the facility policy for reporting resident change in condition to include notification of physician of change in condition. The DON/ADON will complete a system check of reporting change in resident condition audit tool 5 x per week. The results of the audits will be forwarded to the QA committee for review monthly X 3 months for review and further recommendations. The facility alleges compliance as of 01/01/2014. On 01/02/14 at 3:20 PM verification of the credible allegation was evidenced by interviews with licensed staff and NAs about in-servicing related to change in condition, hypoglycemia protocol, and complete/accurate assessments. In addition, it was verified that the staff was beginning use of the system check of reporting change in resident condition audit tool.	F 309		