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F 411	Continued From page 18 During interview with the Social Service Director on 12-06-06, at 12:05p.m., she stated that she had no knowledge of R4 being seen by a Dentist.	F 411		
F9999	FINAL OBSERVATIONS Licensure Violations Licensure Violations 300.1210a) 300.1210b)1) 300.1210b)3) 300.1610a)1) 300.1610j)3) 300.3240a) 3001210 General Requirments for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous, and intramuscular shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for anlyzing and	F9999		

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F9999	Continued From page 19 determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. j) The contents and number of emergency medication kits shall be approved by the facility's pharmaceutical advisory committee, and shall be available for immediate use at all times in locations determined by the pharmaceutical advisory committee. 3) The contents of emergency medication kits shall be labeled on the outside of each kit. The kits shall be checked and refilled by the pharmacy after use and as otherwise needed. The pharmaceutical advisory committee shall review the list of substances kept in emergency medication kits at least quarterly. Written documentation of this review shall be maintained. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review, observation, and	F9999		

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F9999	Continued From page 20	F9999		

interview, the facility neglected 1 of 5 residents (R6) sampled and failed to ensure that R6, with a diagnosis of Diabetes Mellitus, had the proper supplies while out on pass to monitor his blood sugar levels and to administer his insulin, as required, on a sliding scale basis; failed to educate the resident and the family of the need to monitor blood glucose levels and possible need for insulin, based on a sliding scale; failed to monitor resident's blood sugar levels after returning to facility with elevated blood sugar levels and receiving extra insulin coverage per Physician's telephone order. The facility failed to have emergency medications readily accessible for nursing staff to administer to a resident having a hypoglycemic episode. These failures resulted in R6 becoming unresponsive, having difficulty breathing, vomiting and being transported to the hospital emergency room.

Findings include:

R6's December 2006 Physician's Order Sheet (POS), shows diagnoses which include Insulin Dependent Diabetes Mellitus, Pancreatitis, Chronic Obstructive Pulmonary Disease and Anemia. The December 2006 POS shows an order for a Low Concentrated Sweet diet.

R6's Resident Assessment Instruments (RAI), dated 08-04-06 and 10-23-06, show that he has no problem with memory loss or cognitive skills, and he is independent with eating and toileting. The RAI also states that he is being monitored for an acute medical condition.

Doctor's progress note for R6, dated 08-25-06, states, "(Decreased) intake, refuses to eat. Assessment: Anemia, Cachexia."

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F9999	Continued From page 21 According to R6's History and Physical, date 11-07-06, R6 was admitted to the hospital with Severe Hypoglycemia secondary to poor oral intake and a large dose of Insulin. R6's Care Plan, dated 11-07-06, addresses his decrease in appetite, non-compliance with diet, and his Insulin Dependent Diabetes Mellitus. It does not address his potential for Hypoglycemia. R6's November 2006 POS shows orders for "blood glucose levels 4 times a day (7:00a.m., 11:00a.m., 4:00p.m., 8:00p.m.), Novolin Regular Insulin on sliding scale if results of blood glucose levels are: 150 - 200 give 3 units of insulin 201 - 250 give 6 units of insulin 251 - 300 give 9 units of insulin 301 - 350 give 12 units of insulin 351 - 400 give 15 units of insulin result over 400 call M.D. (Medical Doctor)." The Medication Administration Record (MAR), dated 11-14-06, shows "Lantus 15 units (every) H.S." Lantus 15 units was initialed as given at 8:00p.m., on 11-23-06. Also, on the MAR, dated 11-14-06, another order reads "may give in addition, 10 units regular insulin to sliding scale, (10 additional units if blood glucose levels above 500)." This insulin order was initialed as given on 11-23-06, at 8:00p.m. due to the 8:00p.m. blood glucose levels reading "Hi." The MAR, also, indicates that R6 received another 10 units of regular insulin at 8:00p.m., on 11-23-06, per the sliding scale. But, the sliding scale order called for 15 units of regular insulin if blood glucose level is	F9999		

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F9999	Continued From page 22 400. According to the MAR, documentation for 11-23-06, at 8:00p.m., R6 received only 20 units. R6 should have received a total of 25 units of regular insulin. On R6's Physician Order Sheet is a telephone order dated 11-22-06, which reads, "May go out on pass 11-23-06." (11-23-06 was Thanksgiving day.) Nurse's notes, dated 11-23-06, state that R6 went out of the facility with family at 11:00a.m. This note was signed by the hall nurse, E3, Licensed Practical Nurse (LPN). During interview, on 12-05-06, at 2:10p.m., with E3, she stated, "(R6) got out of here before I could get the 12:00 noon (blood glucose levels). Usually we get the (blood glucose levels) before they leave and right after they get back. I didn't get the chance to ask him to do his (blood glucose levels) for noon and 4:00p.m.. I could have sent the Insulin and monitor with him." During interview with R6, on 12-05-06, at 11:43a.m., he stated, "I went to the hospital because a nurse gave me too much insulin." At the 12:50p.m. interview, on 12-05-06, R6, said, "At my sister's, on Thanksgiving Day, she had turkey, ham , potatoes and gravy, biscuits, several pies, all the goodies and I pigged out, naturally. We ate again at 6:30p.m. and I ate the same things I ate for lunch except the ham. I felt fine when I came back. The nurse gave me Lantus at 9:30p.m., and 20 units of regular insulin. Then, another 20 units a couple of hours later." At 2:07p.m., on 12-05-06, R6 stated, "I did not take Insulin with me nor did I take the (blood glucose level monitor) when I went home on 11-23-06. I can do my own (blood glucose	F9999		

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F9999	Continued From page 23 levels) and give my own insulin. I did it at home and also, for my mom before I came to the facility." During interview on 12-07-06, at 2:30p.m. with Z6, attending Physician, he stated, "The nurse needed to educate (R6) regarding his blood glucose levels while out and Insulin to cover him. She could have sent supplies with him. He is an uncontrolled Diabetic. He bottomed out that night and went to the emergency room. Glucagon injection, in this case, if available, is an emergency response that would have helped bring his (blood glucose level) up. Education, Education." During a subsequent interview with Z6, on 12-13-06, he stated, "(R6) is a Brittle Diabetic and non-compliant, a mess." The Nurse's notes dated 11-23-06, at (9:00p.m.), stated that R6 had returned to the facility and his blood glucose monitor had read "Hi". (The manual for the blood glucose levels monitor states that if the screen shows "Hi," that the monitor has determined that the glucose result is greater than 500.) Nurse's notes indicate that E2, Director of Nursing (DON), at the time, gave R6 25 units of Regular Insulin as ordered and rechecked his blood glucose level at (11:00p.m.). The result was 419. E2, then, called Z6, R6's attending Physician, and received an order to give R6 another 15 units of Regular insulin. During interview on 12-05-06, at 2:35p.m., with E2, she stated, "I was the one here that evening. (R6) has a standing order for Regular insulin 10 units if blood glucose level is above 500. So, the top of the scale is 15 units and 10 units extra is 25 units. I rechecked the blood glucose level at	F9999		

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F9999	Continued From page 24	F9999		

11:00p.m. and it was 417. I called (Z6) and he told me to give 15 units of Regular insulin, at that time. The monitor read "Hi" at 9:00p.m., and that means the blood glucose level is over 500."

R6's next Nurse's notes, written by E6, Agency Licensed Practical Nurse (LPN), and dated 11-24-06, at (4:20a.m.), "(Staff) informed by (R6's) roommate of (R6) being in distress. Immediately, went to room and resident observed to be (unresponsive) to verbal and physical stimuli. Blood glucose reading 30. Resident producing thick white bubbly exudate from oral cavity and gurgling with inspiration and expiration. Head of bed up to 45 degrees. Foam cleared from resident's face and mouth. (4:28a.m.) (Emergency Medical Service) called for transport to (Emergency Room). Doctor (Z6) notified."

During interview on 12-06-06, at 12:50p.m. with E6, he stated, "When I got to (R6's) room, he was unresponsive and his blood glucose level was 30. I went to look for Glucagon on the 300 hall and it wasn't there. I didn't know where it was. I found out later that it was on the 100 hall. I couldn't find it, so, I started the transfer papers for the emergency squad. When they arrived, I told them he was unresponsive, blood glucose level was 30, and that he was having breathing problems."

During a second interview with E6, on 12-07-06, at 12:24p.m., he said, "(E2) reported to me that (R6) was doing fine. That his blood glucose level had been high and that Doctor had been called and given orders. (E2) continued to tell me that his ostomy bags needed changed during the night. She said, otherwise, he was doing good. I

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did not check (R6's) blood glucose level between 11:00p.m. and when I was called to (R6's) room. I got a basic tour of the halls. I was not shown the emergency/convenience boxes or told where they were. This was my first night and I was the only nurse on duty."

During a second interview with E2, DON, on 12-08-06, at 11:10a.m., she said, "Because I had not seen this (Agency) nurse before, I gave him a tour (at shift change) and told him where everything was. I don't know what orientation is done for Agency nurses prior to them working here. (E6) called me that morning (11-24-06 at 4:30a.m.) about (R6) and I again told him where the Emergency medication box was located."

(Based on Nurse's notes written 11-24-06, between the time the Emergency Squad got to the facility at 4:38a.m. and E6's call to E2 at 4:30a.m., there would have been 8 minutes for E6 to run to 100 hall, get the Emergency medication box, and administer the Glucagon injectable to R6. E6 did not do that. Glucagon is one of the Emergency medications listed on the lid of the Emergency medication box to be kept there at all times.)

Page 761 of the 2007, 61st edition, of the PHYSICIANS' DESK REFERENCE (PDR), identifies Glucagon as an "antihypoglycemic." It states, "blood glucose concentration rises within 10 minutes of injection and maximal concentrations are attained at approximately a half hour after injection."

Review of the facility "24 HOURS SHIFT REPORT" for 11-23-06, evening shift, shows documentation for R6 as "OK." The night shift

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F9999	Continued From page 26 documentation shows NO report at all by E6, LPN. On 12-06-06, at 10:44a.m., E2 accompanied Surveyor to the 100 Hall Medication Room to check the Emergency Medication box. The list of medications to be kept in the box was on the top of the lid. Included in the emergency medications list were Glucagon Injectable IM (Intramuscular) units (2). Upon opening the emergency box, there were none. Both injectable units were gone. There was no evidence of when they had been removed from the box or who had removed them and for whom. E2 stated that she had no idea. E2 stated on 12-06-06 at 10:45a.m., "Someone must have used them. The Pharmacy should have given us more. Glucagon should be available at all times. There is no documentation when Glucagon was used." During an interview with E2 on 12-08-06, at 12:20p.m., Surveyor asked E2 if she had notified the Pharmacy of the need to replace the Glucagon injectables. E2 replied, "I called the Pharmacy 12-06-06 in the afternoon and said we needed a new emergency box. I am not sure if they knew the Glucagon was missing or if I told them." Facility policy entitled: "EMERGENCY PROCEDURE - HYPO/HYPERGLYCEMIA," section #II INSULIN SHOCK (hypoglycemia), lists the signs and symptoms and enumerates the "EMERGENCY CARE: Avoid giving liquids to the unconscious resident, provide "sprinkle" of granulated sugar under tongue. Turn head to the side, provide oxygen, notify physician, transport to the medical facility. Special notes: When faced with a resident who may be suffering from one of these conditions (if the resident is a known or suspected diabetic and insulin shock cannot	F9999		

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F9999	Continued From page 27 be ruled out) assume that it is insulin shock and administer sugar." Facility policy entitled: "RELEASE OF MEDICATIONS," lists the following procedure for residents on leave or pass: A resident permitted to be away from the facility during medication passes may be permitted to take his/her medication with him/her. The Nurse must provide the medication to the resident, and/or his/her representative, and provide written instructions for the administration of such medication." Emergency Department Physician notes, dated 11-24-06, and written by Z7, Emergency Room Physician, states "(R6) was sent from the nursing home because of hypoglycemia. He had a blood sugar of 39. He was given intravenous Dextrose by the paramedics and recheck of his blood sugar showed it to be 140. He arrived here alert and coherent. He complained of shortness of breath. He had profuse diaphoresis when he was found with his low blood sugar. Blood pressure 97/64. Assessment: Hypoglycemia, insulin reaction with secondary diaphoresis and subsequent hypothermia, chronic uncontrolled Diabetes, Chronic Pancreatitis." The facility failed to follow their own policy regarding Release of Medications (a resident leaves on pass and will be absent at medication time), failed to provide a means to measure blood glucose levels and diabetic supplies to administer Regular insulin, if necessary. R6 went to his sister's for Thanksgiving Day meals and missed his 12:00 noon and 4:00p.m. blood glucose levels and possible insulin coverage according to the sliding scale order. Staff failed	F9999		

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F9999	Continued From page 28 to monitor R6's blood sugar through the night of 11-23-06 to the morning of 11-24-06, after an extremely high blood sugar and administration of extra regular insulin at 9:00p.m. and again, at 11:00p.m. R6 was admitted to the emergency room with a diagnosis of hypoglycemia because of a blood sugar of 30 at 4:28a.m., unresponsiveness, difficulty breathing and an episode of vomiting. (A)	F9999		