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	145891	A. BUILDING ______ B. WING ______	C 09/02/2010

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F 514	Continued From page 23 records. On 8/13/2010 at 11:20 AM, E2 verified that R5's blood glucose checks, scheduled insulin injections, and sliding scale insulins were not transferred over from the June 2010 MAR to the July 2010 MAR. On 7/5/2010 Nurse's Notes document that R5 was admitted to a local hospital. On 8/13/2010, R5's closed record was reviewed. The closed record did not contain the June 2010 MAR. On 8/13/2010 at 1:00 PM, E2 said that she couldn't find R5's June MAR and didn't know where it could be.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)1)2)3) 300.3240a) Section 300.1210 General Requirements 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 psychological 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	F9999		

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F9999	Continued From page 24 a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: A. Based on observation, record review and interview the facility failed to obtain medications from the pharmacy for R2 on admission (8/6/10). The facility failed to administer R2's Antihypertensive medications on the evening of 8/6/10. These failures contributed to R2 experiencing a Hypertensive Crisis and requiring hospitalization in the Intensive Care Unit for stabilization of her blood pressure on 8/7/10. The facility also omitted R2's anticoagulant medication on the evening of her admission. This applies to one resident (R2) whose medication was omitted on 8/6/10. B. In addition, the facility failed to ensure that a Diabetic resident received his scheduled insulin	F9999		

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and blood glucose checks as ordered by the physician. This failure resulted in R5 having two blood glucose tests that resulted as "HIGH" and required physician intervention. This is for one of seven residents reviewed, R5.

Findings include:

A. R2's August, 6, 2010 (Admission) Physician's Orders showed that R2's diagnoses included Malignant Hypertension, Congestive Heart Failure and Atrial Fibrillation. R2's history included a pacemaker placement, ablation (removal of a part as by incision) for Arterial Fibrillation and a stent placement in 2006 related to Coronary Artery Disease. (Hospital History and Physical 8/18/10) R2's medications included Coreg (Antihypertensive) 25 mg twice a day and Diovan (Antihypertensive) 160 mg, twice a day. Mosby's 2011 Nursing Drug Reference pg. 1159 shows if a dose is missed, take as soon as possible, unless it is within an hour of the next dose. R2's medications also included Clonidine (Antihypertensive) 02 mg, twice a day. Mosby's 2011 Nursing Drug Reference pg. 312 shows that patients should comply with dosing schedule, and not to skip doses. R2's medications also included Clonidine 02 mg transdermal patch. (1 patch every 24 hours Hydralazine (Antihypertensive) 50 mg twice a day, and Coumadin (Anticoagulant) 4 mg to be given at 5:00 PM daily.(Requires therapeutic drug level) Mosby's 2011 Nursing Drug Reference pg. 1181 shows that this medication should be given at the same time each day to maintain therapeutic blood levels.

R2's Minimum Data Set (MDS) of 8/20/10 showed that R2 had no short or long term

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F9999	Continued From page 26 memory problems. The same assessment showed that R2 was independent in cognitive skills for daily decision making. R2's Nursing Notes for 8/6/10 document that R2 was admitted to the facility at 3:30 PM. The same note shows that R2's diagnoses included Malignant Hypertension. R2 had a Clonidine patch that was on her right chest and the nurse documented that it was applied at the hospital on 8/4/10. The next Nursing Note entry is 8/7/10 at 3:00 AM. The note documents that R2 complained of not feeling well. R2 complained of headache and was found to have a blood pressure of 210/100. R2's Physician was notified and R2 was sent to the hospital emergency room. The next entry is for 6:20 AM and shows that R2 was admitted to the hospital with diagnoses of Pulmonary Edema. A hospital report dated 8/7/10 documents, "history of difficult to control blood pressure requiring recent hospitalization, R2 was transferred back from the nursing home to the hospital for symptomatic high blood pressure. Apparently her blood pressure was in the 200's and the patient was short of breath and had a headache. In the emergency room her blood pressure was 209/103. R2 was started on a nitroglycerin drip. (Intravenous Nitroglycerin).The patient was in the hospital recently for similar symptoms and the medications were optimized during her stay. With stable vital signs she was discharged to the nursing home but per patient and nursing report, she did not receive her medications late in the afternoon and in the evening (8/6/10)." The same report showed that R2 was transferred to the hospital for a	F9999		

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Hypertensive Emergency and that R2 developed Pulmonary Edema likely secondary to the Hypertensive Emergency. The report showed that R2's high blood pressure was likely related to skipped doses of her blood pressure medications in the nursing home. The same report showed that R2 was admitted to the ICU (Intensive Care Unit) for monitoring of her blood pressure.

Another hospital report dated 8/7/10 documented " The patient has a history of Refractory (resistant to treatment) Hypertension and the trigger factor for her Hypertensive emergency on the date of admission was that she had not taken her medications during her transition to the nursing home environment for at least 12 hours."

On 8/23/10 at 1:00 PM, R2 was observed sitting in a chair in her room. R2 was resting her head on a cervical pillow. R2 was interviewed and said, "My blood pressure went sky high, it was over 200, I was in the ICU. Now they are trying to get it (blood pressure) stable again." R2 said she had gone 12 hours without any medication on her day of admission to the nursing home. R2 said, "I couldn't breathe, they were going to put me on a respirator. I didn't know how sick I would get without my medications." R2 said that she had come into the nursing home around 2:00 PM in the afternoon. That same day, during the night she got sick and had to go by ambulance to the hospital.

On 8/24/10 at 12:10 PM, Z2 (LPN/ pharmacy) was interviewed. Z2 said that they received the order for R2's medication at 6:31 PM. Z2 said that when orders come in at this time of day, they are delivered on the night delivery (between 2-3

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F9999	Continued From page 28 AM). Z2 said that the convenience box at the nursing home did contain Clonidine. According to the facility policy and procedures for Pharmacy, under Procedures; Meds are delivered with next scheduled delivery unless a "stat" order is requested. The pharmacy should be called for stat requests. Record review showed that R2 arrived at the facility on 8/6/10 at 3:30 PM. Z2 confirmed, on 8/24/10 at 12:10 PM, that R2's medication orders were received at 6:31 PM on 8/6/10. Z3 was interviewed on 8/24/10 at 3:00 PM. Z3 said that she received a call at 3:30 AM that R2 was going to the hospital. Z3 said when she became aware that R2 had not received any medications after admission she confirmed it with E3 (nurse) at the nursing home. Z3 said while at the hospital she was told that she should call in a priest for R2's "last rights." Z3 said "I had to call all my family, and the priest." Z3 said that Z5 (Cardiologist) said that if R2 had just received her medications, we wouldn't have to be going through all of this. We thought she had only hours to live." E1 (Administrator) said on 8/23/10 at 11:40 PM, that there was a delivery delay from the pharmacy of R2's medications. E1 said that if the medication orders are faxed over to the pharmacy at a certain time, they will come on the 3:00 AM delivery. E1 said that R2 had missed the medications that she should have received around dinner time. E1 said that Z1 had worked at the facility approximately one and one-half years and she should have known this. E1 said that E4 (LPN) Licensed Practical Nurse should	F9999		

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have called himself or E2 when she became aware that she was not going to receive R2's medications from the pharmacy in time to administer them as ordered.

Z1 (RN) was interviewed on 8/24/10 at 9:55 AM and said that the admitting nurse (E4) is the person responsible to order the patient's medications. Z1 said that she notified R2's physician when R2 complained of headache and had a blood pressure of 210/100. Z1 said she sent R2 to the hospital. Z1 said, "What else could I do, I didn't have any medications." Z2 said that the CNA's (Certified Nursing Assistants) had been in R2's room on rounds at 11:00 PM, 1:00 AM and 3:00 AM. Z1 did not see or assess R2 until the CNA made her aware of R2's complaints of a headache at 3:00 AM.

B. R5 was admitted to the facility on 6/30/10 from a local hospital. The Discharge Summary of 6/30/10 shows that the resident's diagnoses includes Diabetes Mellitus Type II.

The resident's medication orders, according to the hospital transfer record, shows that the resident was to receive 20 units of Humalog 75/25 SQ (subcutaneous) daily with breakfast and Humalog 75/25 SQ with the dinner meal. The resident was also to have blood glucose checks three times daily, before meals. Based on the result of the blood glucose tests, the resident had orders to receive additional insulin (Humalog 100 units/ ML based on sliding scale: If the test result was:

0-199	No insulin
200-250	2 units
251-300	4 units

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301-350 6 units
351-400 8 units.

The July 2010 MAR shows that on 7/1/10, R5 did not receive his 7:30 AM dose of 20 units Humalog 75/30 insulin and glucose levels were not checked before the breakfast meal and before the lunch meal. It is not known if R5 required additional insulin at breakfast and insulin at noon because his insulin is based on the glucose readings.

On 8/13/10 at 11:20 AM, E2 verified that R5's breakfast and lunch blood glucose checks and his scheduled breakfast insulin injections were not given on 7/1/10. She said that the scheduled and sliding scale insulin orders were not transferred over from the June 2010 MAR to the July 2010 MAR. E2 said that because of the transcription error, R5 did not receive his breakfast insulin and his glucose levels were not checked before breakfast and lunch. It is not known if R5 required additional insulins per sliding scale because the resident's glucose levels were not checked.

Nursing Notes show that on 7/1/10 (no time) E7 (Registered Nurse) was informed by E8 and E9 (nurses) that R5 had not received his insulin. The notes show that E7 obtained two glucose readings which read "HI." According to the nurse's notes she rechecked the resident's glucose at 5:30, still receiving a "HI."

The glucose meter manual shows that a reading of "HI" means that the glucose reading is greater than 600mg/dL. The instructions say to repeat the test to confirm the "HI" result and to call the doctor immediately.

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F9999	Continued From page 31 The Mosby's Diagnostic and Laboratory Test Reference book (page 379) states that a blood glucose greater than 400 mg/dL is a possible critical value. E7 contacted R7's physician and received an order to "administer six units Humalog NOW." The facility's Physician Orders Policy and Procedure, dated 11/98, states, " 13. All orders must be transcribed to the computerized POS when they are to be continued in the next month". (A)	F9999		