

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Eldon Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 East North Street Eldon, MO 65026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>43024</p> <p>Based on interview and record review, facility staff failed to notify one resident's (Resident #1's) out of three sampled residents physician of the resident's blood glucose (the main sugar found in your blood) results over 400 milligrams (mg) per deciliter (dL) results in a timely manner which resulted in the resident being admitted to the local hospital for diabetic ketoacidosis (a complication of diabetes in which acids build up in the blood to levels that can be life-threatening). The census was 57.</p> <p>1. Review of the facility's policies showed the facility did not have a policy to direct staff on when to notify the physician for changes in resident conditions.</p> <p>2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 2/01/24, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> -Severely cognitively impaired; -Complete dependence on staff for eating, personal hygiene, toileting, locomotion and mobility; -Diagnoses of Diabetes Mellitus (a metabolic disease, involving inappropriately elevated blood glucose levels); -Insulin injections given seven of seven days in the lookback period. <p>Review of the resident's Physician Order Sheet (POS), dated 2/1/24 to 2/29/24, showed a physician order directing staff to administer Novolog Flexpen U-100 (insulin) four times per day per sliding scale of one unit for every twenty (20) units over a glucose result of 150.</p> <p>Review of the resident's electronic health record under the results tab, showed blood glucose test results, dated 2/29/24 to 3/29/24 as follows:</p> <ul style="list-style-type: none"> -3/4/24 at 11:31 A.M., 430 milligrams (mg) per deciliter (dL); -3/6/24 at 11:02 A.M., 470 mg/dL; -3/12/24 at 11:10 A.M., 441 mg/dL; <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-3/14/24 at 4:21 P.M., 407 mg/dL;</p> <p>-3/22/24 at 5:38 A.M., 478 mg/dL,</p> <p>-3/22/24 at 10:49 A.M., 556 mg/dL,</p> <p>-3/22/24 at 3:44 P.M., 422 mg/dL;</p> <p>-3/23/24 at 5:27 A.M., too high for glucometer to provide results.</p> <p>Review of the resident's progress notes, dated 3/1/24-3/23/24, showed staff did not document they notified the residents physician of the resident high blood glucose results.</p> <p>Review of the resident's progress notes, dated 3/23/24, showed staff documented around 5:30 A.M., resident blood glucose test results HI over 600 hundred on the facilities glucometer, two types if insulin administered with results still HI. Resident physicians notified, resident to be sent to hospital.</p> <p>Review of the resident's hospital records, dated 3/23/24, showed the resident was admitted for decreased level of consciousness and, reportedly exhibiting decreased levels of consciousness on 3/22/24 and found essentially unresponsive on the morning of 3/23/24. Resident admitted to the intensive care unit with insulin infusion for profound diabetic ketoacidosis.</p> <p>During an interview on 3/29/24 at 11:12 A.M., the physician said he/she expects to be contacted if the resident's blood sugar is over 400 mg/dL or is under 60 mg/dL, he/she said he/she was contacted about sending the resident out due to high blood sugar but was not notified before that.</p> <p>During an interview on 3/29/24 at 11:53 A.M., the Director of Nursing (DON) said the expectation is any blood sugar reading over 400 mg/dL would be reported to the physician.</p> <p>During an interview on 3/29/24 at 1:39 P.M., Certified Medication Techniican (CMT) A said he/she would contact the physician or have the charge nurse contact the physician for any blood sugar reading over 400 mg/dL. He/She does not know why this was not done for the resident.</p> <p>During an interview on 3/29/24 at 1:40 P.M., Licensed Practical Nurse (LPN) B said he/she would contact the physician for high blood sugar between 300 and 400 mg/dL, he/she said it depends on the resident. He/She said it is the responsibility of the nurse or the CMT on duty and to chart the physician's response. LPN B said he/she assumed the physician was getting notified.</p> <p>During an interview on 3/29/24 at 1:47 P.M., the DON said the charge nurse is responsible for reporting high blood sugars to the physician, but the CMT is responsible for telling the charge nurse if the resident's glucose reading is high. He/She said if staff speak to the physician regarding resident care, it is to be documented in the progress notes. He/She does not know why the physician was not contacted, especially on 3/22/24 when the resident had multiple high readings in one day.</p> <p>During an interview on 3/29/24 at 1:59 P.M., the administrator said his/her expectation is facility staff notify the resident's physician with any significant change. He/She does not know why the resident's physician was not notified.</p> <p>(continued on next page)</p>		

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 4/11/24 at 3:09 P.M., CMT C said he/she alerts the charge nurse if a resident's blood glucose test results are under 60 or over 400 mg/dL because it is the professional standard. He/She said he/she does not know why the nurses on duty the days of 3/4/24, 3/6/24, 3/12/24, and 3/14/24, when the resident had over 400 results, did not contact the physician. MO00233892		