STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44485 Based on interview and record review, the facility failed to consult with the resident's physician; and notify the resident representative for 1 of 3 residents (CR #1) reviewed for change of condition, in that, The facility staff failed to immediately notify the physician when CR#1 started vomiting up a brown substance repeatedly on [DATE]. The facility failed to notify the physician that CR #1 insulin NPH was discontinued when CR#1 was having high glucose readings for 6 days. CR#1 was sent out to the hospital on [DATE] and died in the hospital on [DATE]. An Immediate Jeopardy (IJ) situation was identified on [DATE] while the IJ was removed on [DATE] at 3:58pm, the facility remained out of compliance due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. These failures could expose residents to low quality of care, worsening of condition, hospitalization , and death. Findings included: Record review of CR#1's face sheet revealed a [AGE] year-old female initially admitted to the facility on [DATE]. Current admission was on [DATE] with diagnoses of type 2 diabetes (A chronic condition that affects the way the body processes blood sugar, resulting in too much sugar in the body), kidney failure, cerebral infarction (cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), malnutrition, hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), high blood pressure, sepsis (Sepsis is a serious condition in which the body responds improperly to an infection, causing a cascade of changes that damage multiple organ systems, leading them to system failure, sometimes even death), and heart disease. Review of CR #1's MDS dated [DATE] revealed CR #1 was diagnosed with Diabetes Mellitus, high blood pressure, cerebral infarction, and hemiplegia. MDS also revealed CR #1 was on insulin medication, oxygen therapy treatment, suctioning, and tracheostomy care. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of CR #1's care plan revealed CR #1 was at risk hypoglycemia / hyperglycemia episodes due to diabetes mellitus. The care plan goal was that CR #1's blood sugar will be managed effectively, and the care plan intervention was to do a quick check as ordered and report any abnormal findings to the Physician and family members. Review of Physician order dated [DATE] revealed Accu check with insulin Lispro (AdmeLOG) sliding scale SQ 142 - 180 = 2 units 181 - 220 = 4 units 221 - 240 = 5 units 241 - 260 = 7 units 262 - 280 = 9 units 282 - 300 = 10 units >300 = 12 units and call MD Four Times A Day 09:00 AM, 01:00 PM, 05:00 PM, 09:00 PM Record review of CR#1's blood sugar vitals revealed: [DATE] at 5:34 am 598 mg/dL [DATE] at 11:28 pm 319 mg/dL [DATE] at 11:28 pm 283 mg/dL [DATE] at 1:01 pm 381 mg/dL [DATE] at 10:57 am 468 mg/dL [DATE] at 8:15 am 556 mg/dL [DATE] at 8:02 am 468 mg/dL [DATE] at 7:01 pm 300 mg/dL [DATE] at 11:33 am 386 mg/dL [DATE] at 9:31 am High (above 600) [DATE] at 8:24 am High (above 600) [DATE] at 1 pm 414 mg/dL [DATE] at 9:27 pm 250 mg/dL [DATE] at 5:52 pm 289 mg/dL [DATE] at 1:16 pm 365 mg/dL [DATE] at 5:32 pm 313 mg/dL [DATE] at 12:04 pm 398 mg/dL [DATE] at 9:24 am 388 mg/dL [DATE] at 8:43 pm 382 mg/dL [DATE] at 10:42 am 320 mg/dL [DATE] at 10:24 am 365 mg/dL [DATE] at 7:24 pm 269 mg/dL (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] at 1:55 pm 139 mg/dL [DATE] at 8:39 am 139 mg/dL [DATE] at 10:36 pm 159 mg/dL [DATE]at 11:57 am 300 mg/dL On [DATE] at 11:25am in an interview with CR#1's family member, she stated CR#1 had an infection that was not treated and by the time CR #1 got to the ER she was septic and died on [DATE] at the hospital. CR#1's family member stated there were instances where the Physician stated he did not know about CR#1 and admitted that he did not know CR#1. CR#1's family member stated she went to check CR#1 out of the facility on thanksgiving day, but CR#1 was throwing up that day and no one knew why she was throwing up. CR#1's family member stated she did not want to take CR#1 out of the facility not knowing what was happening. CR#1's family member stated no one knew why CR#1 was throwing up and it was odd for CR#1 to be throwing up so something must have been wrong with CR #1 on that day ([DATE]). CR#1's family member stated the staff (unknown) said CR#1 threw up twice that morning. On [DATE] at 1:58pm with former ADON C she stated she could not remember what happened with CR#1. She stated CR#1 did get sent out to the hospital on the night shift. She stated if someone was throwing up, it is a change in condition, and they needed to do something about that. She stated they needed to call the Nurse Practitioner, Responsible Party, and everyone that needed to be called. On [DATE] at 12:24pm in an interview with CNA A, she stated she remembered CR#1 threw up on [DATE] on thanksgiving day. CNA A stated they noticed CR#1 threw up and she (CNA A) went to tell the Nurse (did not remember who the nurse was). CNA A stated CR#1's emesis was brown and it was a lot. CNA A stated she told the nurse and she went to check CR#1. CNA A stated she did not recognize any other changes in condition for CR #1 on that day. On [DATE] at 12: 38pm in an interview and record review of CR#1's clinical record with the DON, she stated CR#1 came to them from home with dementia, old CVA history, sepsis with shock, malnutrition, diabetes, High blood pressure, and pressure ulcers when admitted . The DON stated CR#1's blood sugars were in the 400's and 500's. She stated CR#1 could spike and go up to 402 within 30 minutes of each other and then went back down to 126. She stated CR#1's blood sugars started going consistently higher on [DATE]. She stated they were holding CR#1's tube feeding, and administered the insulin sliding scale. The DON stated in CR#1's clinical record, the physician note dated [DATE] revealed CR#1's Pt's diabetes is controlled at this time. Will continue to monitor for stability. BS: 557mg/dL, the Physician wrote that it was controlled and will continue to monitor. The DON stated she was not going to second guess a physician when he stated the blood sugar was 557 and that it was controlled. On [DATE] at 3:05pm with LVN B, she stated she worked on [DATE] and [DATE] in the hall where CR #1 was. She stated on [DATE], she went to assess CR#1 and she called CR#1's Physician and told the NP that CR#1 was not doing well. LVN B stated CR#1's O2 Saturation was still okay at the time she came to the shift. She stated when she assessed CR#1 she was just quietly looking, and CR #1 was a quiet person. LVN B stated when she was handing over to the night nurse (LVN A), she and the nurse they checked CR #1's O2 saturation it was below 90. LVN B stated CR#1's O2 saturation was the problem, and she called the RT, and the Respiratory Therapist came to check CR#1's oxygen and it was low so they sent CR#1 out to the hospital on [DATE]. LVN B stated she reported to LVN A because she (LVN A) worked that night. Review of progress note revealed no documentation by LVN B of notification to physician regarding CR #1's condition on [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:21am in an interview with CNA B she stated CR#1 came from the 100 hall doing well and moved to the 200 Hall and after some time, CR#1 stopped eating well the staff had to feed her and she refused sometimes. CNA B stated CR#1 was not really eating enough by mouth when she came to the 200 hall and she had a feeding tube. CNA B stated the day she went with her daughter for Thanksgiving on [DATE] CR#1 was throwing up a lot on that day. CNA B stated she told the nurse on the floor and CR#1's family member that CR#1 was throwing up. She stated the nurse came to the room to speak with the family member and they decided with the family member whether to take CR#1 home for the day or not because of her throwing up. CNA B stated she remembered the day they sent CR#1 to the hospital she was throwing up also. On [DATE] at 11:21 am with RN C, she stated she took care of CR #1 on 100 hall on [DATE], and on 200 hall on [DATE]. She stated when she took care of CR #1 on 100 hall on [DATE] she checked CR#1's blood sugar and it was very high and that was the only thing she knew that happened that day. She stated she called the Physician, and he told her to give CR#1 a dose of insulin, but she could not remember the units. She stated when they call Physician's number usually they would speak with anyone who picked the line, it could be one of the nurse practitioners working with the physician, but she did not know who specifically she spoke with on that day ([DATE]) on thanksgiving day. RN C stated CR#1's family member wanted to take her out to eat on the thanksgiving day, but she (RN C) told the family member that they had to take care of CR#1's blood sugar before the family member could take CR #1 out. She stated she could not remember if CR#1 was throwing up. She stated there were so many things that happened that day and many families came to pick their family up so she did not recall if she wrote any notes or any assessments. Record review of CR #1's Medication Administration Record (MAR) for the month of [DATE] revealed there was no documentation of blood sugar checked and no insulin administered to CR #1 on the 9pm check schedule on [DATE] when LVN A worked. On [DATE] at 1:00pm in an interview with LVN C, she stated she worked the morning shift on [DATE], but she no longer worked at the facility. She stated if she did a blood sugar and it was 500 she would call the Physician and she would reassess the resident to make sure it's the right reading. She stated if the resident had a sliding scale she would administer the insulin and she would check if they were on continuous feeding and they would pause the feeding. She stated she would also do a water flush for the tube feeding and call the physician. She stated the first thing she would do was to administer the insulin sliding scale and go from there. She stated if the blood sugar was that high in the 500s, she would check it every 30 min and keep rechecking it. She stated if she was able to get the blood sugar down from 500 to 380 within an hour she would still alert the physician and would continue to follow up with the blood sugar. She said she could not remember the patient specifically because she always working with a lot of nurses and orienting them, and that she was not a primary nurse on the floor. She stated she could not recall anything about CR #1, and she could not recall anything happening to CR #1 on ,d+[DATE] 2023. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:39pm in an interview with the Lead NP, she stated she knew all the residents in the facility because she comes to the building everyday. NP stated CR#1 was on 2 different insulins (NPH and Lispro) when she was admitted to the facility. She stated on [DATE] a nurse (she did not remember the nurse) told her that the resident's blood sugar was running too low, and she gave verbal order to the nurse to discontinue the insulin lispro for CR#1 because her blood sugar was low at that time. The Lead NP stated she did not give any order to discontinue the NPH. She stated CR#1 was on NPH 40 units 3 times a day, the nurse was to discontinue only the insulin Lispro, and leave the NPH insulin without any changes. She stated that the nurse erroneously discontinued both insulin (NPH and Lispro). The NP stated if blood sugar was high the nurse was supposed to call and let them know that the resident's insulin was discontinued, because the resident (CR #1) was supposed to be on the NPH as a basal coverage for the resident. She stated insulin lispro was not meant for treating residents with hyperglycemia, she stated the lispro is a short acting insulin which was in place to bring the blood sugar down in case the resident's blood sugar spiked. She stated there should be a scheduled insulin NPH which would be covering the resident for up to 12 hours, The lead NP stated she did not know the insulin NPH was discontinued, she did not check the resident's record, because she believed when they gave order to the nurses, they were supposed to carry out the order accordingly. She stated she was always in the building and most nurses would come to her to get order for anything happening with any resident and she would give verbal order at times. She stated whenever she or any other team members give order, they would always communicate with other team members, so they all be on the same page. The NP stated if a patient started throwing up, she would expect the staff to call them for any change in condition. The Lead NP stated she was at the building on the [DATE] and the resident's vital signs were all good and there was no need to send the resident to hospital. On [DATE] at 2:43pm in an interview with LVN A she said CR#1's blood sugar on [DATE] at 11:28pm was 319. LVN A stated CR#1 was sent out because she was declining compared to the last time she took care of CR #1 on the 100 hall. She stated she got shift report from thee day/evening shift nurse and she took over CR #1's care. She stated on [DATE] during the night shift, she tried to call the physician, but they don't really respond in the middle of the night. She said the physician did respond early in the morning around 5:00am. LVN A said CR#1's oxygen sat was what they were mainly worried about, her oxygen was low in the 80s so they got orders to put CR #1 on oxygen. LVN A said CR#1 was not acting the same like when she was on 100 Hall. She said on [DATE] at 5:34 am CR#1's blood sugar was up to 598 so they gave CR#1 some insulin. LVN A said with CR#1 was declining - oxygen saturation was 88% and resident was placed on non-rebreather with oxygen at 10 liters, but they still could not get CR #1's oxygen level up, the resident (CR #1) was not looking good, and her blood sugar was high, so she got orders to send the CR#1 out to hospital at around 5:00am when she got through to the physician. She said CR #1 was barely trying to open her eyes and that was a big difference from CR#1's normal self, CR #1 appeared lethargic, she knew CR #1 to be more alert than how she appeared on [DATE]. LVN A said EMS came at 6:20 am. Record review of CR #1's progress note documented by LVN A on [DATE] revealed Rsd breathing but non-responsive. bs 598 per Dr order gave 15units of lispro @05am and to send rsd out to hospital v/s , d+[DATE], hr 128, t-97.4, O2 88% w/ non-breather mask on 10L oxygen. Non-emergent line contacted eta 0600 . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:13pm in an interview with LVN B she stated on [DATE] CR#1 had elevated blood sugar at 313. She stated CR#1 was on insulin sliding scale and every time blood sugar was beyond the normal she would give the insulin. She stated on [DATE] she handed CR #1's care over to LVN A to send CR#1 out because the oxygen saturation was low even after they placed CR#1 on oxygen and it was still low. LVN B stated she worked the 2 to 10 pm shift and LVN A worked the 10pm to 6am. She stated before giving CR#1 oxygen it was low and her O2 saturation remained low. LVN B stated she could not remember the date, but the time she charted at 11:28pm she was still at the facility even after she finished her schedule at 10pm she was still doing her chart before leaving for the night. LVN B stated she did not write notes on the resident (CR #1), but she told LVN A that CR#1's oxygen saturation was not ok and she kept following up with the nurse until she (LVN B) left the facility. LVN B stated she gave CR#1 insulin sliding scale. She stated if she did not write it down she must have missed it to document because she was overwhelmed, because their new system where they document was not user-friendly. She stated she took CR#1's blood sugar earlier during the shift and the value was 313, but she documented it at 11:28pm . She did not recall if she followed up to recheck the blood sugar again, she only documented it into the system at 11:28pm when she had the chance to document. She stated if the blood sugar was that high she was supposed to continue to recheck the blood sugar to make sure it was coming down because high blood sugar could affect the resident negatively if not treated. On [DATE] at 3:57pm in an interview with the DON, she said if CR#1 has a blood sugar above 300 the nurses were to call the Physician to get order. The DON said besides the Physician's order, the nurses were to use nursing judgement and check the blood sugar every 30 minutes to an hour if the resident's blood sugar was still high, and if there are further orders they check with the Physician again. She stated in 30 min to an hour they would be able to identify if the blood sugar was going down, but they don't want to give more insulin because the insulin was still working. The DON stated CR#1's blood sugar was coming down, but then she had a meal in between which could have brought her blood sugar up again. The DON stated blood sugar is a patient specific thing and 300 was high for CR#1 and the nurses were expected to use their nursing judgement to recheck CR #1's blood sugar more frequently to see the blood sugar trending down. The DON said based on the CR#1's blood sugar level and overall change in condition, CR #1 should have been sent by emergency 911 and not non-emergency ambulance. She said the situation with CR #1, high blood sugar and low O2 sat while on non-rebreather mask with 10liters oxygen, was a change in condition and needed prompt interventions. She said when the nurses are given orders by the Physician, nurses were supposed to carry them out, and in this situation she would have implemented the order to send resident out rapidly. The DON stated she was not sure of CR #1 was throwing up on the [DATE]. She stated if a resident throws up only once then she would watch it because it could have been something they ate that did not agree with them, but if it is something that is happening consistently it is a change in condition. The DON said she was not aware that CR#1 vomited multiple times at the facility on Thanksgiving morning. On [DATE] at 4:21pm in an interview with the Primary Physician, he stated he was the primary Physician for CR #1, but he was not the one who was called on the day ([DATE]) when resident was sent to the hospital, he said probably they called the medical director. He stated he was not aware and could not recall anyone called him for CR #1 throwing up on any day. He stated it was an emergency if a resident was having a change in condition, becoming lethargic with low oxygen level at 88% while on non-rebreather with 10 liters of oxygen and high blood sugar in the 500s. The Primary Physician also stated it is a possibility that the high blood sugar could have caused the resident to throw up. He stated when a sliding scale is given and residents blood spiked, the goal was to administer insulin so as to bring the resident's blood sugar down to the lowest level on the slightly scale. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 4:38pm in an interview with LVN D who discontinued the insulin NPH and Lispro for CR #1, she stated the NP gave her order on the [DATE] to discontinue the lispro and that was the only insulin she discontinued, she stated she only discontinued the sliding scale according to what the nurse practitioner (Lead NP) told her. She stated she did not recall discontinuing the insulin NPH for CR #1. Record review of CR #1's Physician order revealed insulin NPH and insulin Lispro was discontinued by LVN D on [DATE]. On [DATE] at 4:23pm in an interview with the facility Medical Director, the Medical Director he state I won't remember that patient at all he stated he was not the Physician for the patient and he stated the Primary Physician was the primary Dr. He said the protocol was that the facility would only reach out to him if the nurses were not able to reach to the NPs that worked with him or not able to reach other Physicians, they would call him. He stated he gets a lot of calls all the time with a lot of things, he said the resident there at the facility their acuity is very high, and they were doing their best to care for the residents. He stated he could not recall anyone calling him about CR #1 throwing up or having extremely high blood sugar of having any change in condition. He stated the nurses must have reached out to the primary care Physician and not him. Review of facility policy titled Change in a Residence Condition or Status Dated Revised February 2021 revealed, in part, The nurse will notify the resident's attending physician or physician on call where there has been it's significant change in residence physical emotional mental condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .A nurse will notify the residence representative when there is a significant change in the resident physical mental or psychosocial status .The nurse will record in the residence medical record information relative to changes in the resident medical or mental condition or status This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 2:57pm. The following Plan of Removal submitted by the facility was accepted on [DATE] at 8:17pm. PLAN OF REMOVAL Name of facility: Date: [DATE] The Texas Department of Health and Human Services entered [facility] on [DATE], for a P1 Complaint Survey. During the survey process an IJ (Immediate Jeopardy) was cited on [DATE] regarding - F580 as stated below: F580: Notify of Change in Condition (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident Status: The resident was discharged to an acute care hospital on [DATE] and did not return. Immediate action: On [DATE] DON under the guidance of the Regional Nurse Consultant initiated an in-service with all nursing staff (all nursing staff to include CNAs) on duty to cover the following topics, this training will be completed by [DATE]. o Notifying Physician and Family of Resident Change of Condition. The physician should be notified as soon as possible after identifying a change of condition, assessing resident needs and providing necessary services. If the physician is unable to be reached, the DON and/or designee should be notified and the Medical Director contact for treatment plan. o Recognizing and Reporting Acute Changes of Condition. Changes of condition include, but are not limited to vomiting, vital signs, mental status changes, functional decline, etc. o Symptoms that include the need for emergency ambulance services. o Documentation of events (Change of Condition), SBAR and Stop & Watch. o Notification of physician upon identifying a high blood sugar level. o Change of Condition policy was reviewed, no changes were made. Staff in-serviced on current policy. o An audit will be conducted of all residents receiving insulin to ensure orders are correct. This audit will be completed by [DATE]. o An audit will be conducted of all residents receiving blood sugar checks to ensure parameters are set. This audit will be completed by [DATE]. o An audit was completed of residents with changes of conditions, within the last 30 days, to ensure the resident physician was notified. This audit will be completed [DATE]. o An audit of residents with diabetes was done to assess for high blood sugar levels or change of condition. This audit was started on [DATE] and will be completed [DATE]. Facility Plan to ensure compliance quickly: o All nursing staff will be in-serviced on the above listed topics prior to beginning their next scheduled work shift. o The DON and/or designee will conduct audits of the 24-hour report to include review of progress notes to ensure that all changes of conditions have been identified and physician notification has been made. This audit began [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Demonstration of and acknowledgement that all licensed nurses are aware of the above: o The DON/ADON and/or designee will contact all licensed nurse staff and get a verbal acknowledgement as a return demonstration of understanding that: o A physician is to be notified immediately of changes of condition. o This in-servicing began [DATE] and will be completed by [DATE]. On [DATE] The facility Administrator, ADON, and Regional Nurse Consultant held an ad hoc QAPI meeting with the Medical Director, via phone, to discuss: o F580 - Notify of Change of Condition - IJ Cited o Plan of Removal and actions taken to ensure continued compliance. QAPI: o The above actions will be reviewed monthly The State Surveyor confirmed the Plan of Removal for the IJ by monitoring from [DATE] through [DATE] as follows: On [DATE] at 3:09pm interview with LVN E, she stated she only worked on weekends, she had not been trained in an in-service today, she said she saw some pieces of paper at the nurses station but nobody has told her anything. On [DATE] at 3:10pm in an interview with CNA C, he stated he had received in-service training when he came to the shift today, the training was about reporting to the nurse and DON immediately if they saw any changes in resident and to complete the Stop & Watch form. On [DATE] at 3:12pm in an interview with LVN F, he stated he was in-serviced today regarding abuse and neglect, documentation of SBAR when resident have change in condition and to document all intervention, he provided to his residents in the nurses note. He stated he was also trained about medication administration medications such as antibiotic insulin and other meds and to monitor blood sugar after administration of insulin to residents and to notify the Physician, the DON and the supervisors if there is any change in condition for his residents. He stated monitoring blood sugar for residents should be done every 30 to 40 minutes for every resident with high blood sugar and to continue to monitor the blood sugar until the blood sugar gets down to the level you don't need to give insulin. On [DATE] at 3:19pm in an interview with RT A, she said she had in-service training yesterday and today they were taught to make sure they document if any patient have change in condition and pay attention to abnormal changes in patient. and they have to communicate with the nurse Physician, NP, DON, and resident's family members. (continued on next page)

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	676064	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:21pm in an interview with CNA D, she stated she had in service training yesterday about reporting any changes in resident at any point in time to the nurse immediately, she said changes could be if patient is not eating as they used to eat, not talking as they used to talk, not opening their eyes, not having enough bowel movement, not having enough urine, or patient is vomiting, patient has any skin issue, she said anything different in the normal condition of the patient she would report immediately to the nurse and to the DON so they can follow up with the necessary intervention. On [DATE] 3:13pm in an interview with CNA E she stated that she was trained this morning and few days ago about changes in condition of a patient to let the nurse know immediately if the CNA's notice any little change in the situation of the patient and to complete the stop and watch form. On [DATE] at 3:15pm in an interview with LVN G, he said he received an in service on Friday [DATE] and the training was about documentation reporting of changes in condition and sending patient out on emergency and completion of SBAR. he said he would send a patient out on emergency if the patient was having a serious change in condition or a life threatening condition, or if it is a situation with ABC (Airway Breathing Circulation) and the vitals like oxygen saturation was low and not able to get the oxygen up, or if the patient is having active bleeding that is uncontrollable, or if the patient stop breathing. He said he would also contact the Physician the DON and the family member if there's any changes in resident condition. On [DATE] at 3:20pm in an interview with RN D, she stated she had training yesterday Sunday ([DATE]), he said the training was about monitoring residents blood sugar, when resident had high blood sugar the nurses have to call the Physician to get order and continue to monitor the patient after administering insulin. RN D said the training also include monitoring patient for any change in condition, she stated clinically when your patient is not looking good to you must call Physician to let him or her know your findings and promptly carry out the order given by the Physician. On [DATE] at 3:37pm, in an interview with RT C, she said she received training on Friday about changes in condition of resident and to report to the nurse who was assigned to the resident, and to report to her manager the respiratory therapy manager and the DON and the Physician about whatever changes she found in her resident. She said she was also trained to check vital sign and documenting her findings or evaluation and what was done for the resident and who she told about the resident's condition. On [DATE] at 3:52pm in an interview with LVN H, she said she received training on Friday ([DATE]) about changes in condition if she noticed any changes in any resident she will call the Physician and also informed the DON. she said it depend on the degree of change if patient was having high temperature, or high blood sugar she will continue to monitor the patient and keep the Physician informed. She said if a resident have high blood sugar in the 500s she will call the Physician and get order and she will continue to recheck resident's blood sugar every 30 minutes to 1 hour. On [DATE] at 3:57pm in an interview with Weekend Supervisor, she stated she had received in-service training from the DON on Friday ([DATE]) about changes in condition of resident blood sugar check and follow up notify family members Physician and Don whenever a resident had a change in condition or any abnormal love values abnormal vital sign. she said the training also included documentation of SBAR and documenting in progress notes in detail about every intervention performed for residents. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the plan of removal was completed: - In-service training documentations were reviewed. - An audit of residents with changes of conditions, within the last 30 days, to ensure the resident physician was notified. - Documentation of the Audit of current residents. - Impromptu QAPI meeting of the Administrator with the medical Director. - An audit of all residents receiving insulin to ensure orders are correct.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44485 Based on observation, interview, and record review, the facility failed to ensure resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 (CR #1) out of 3 residents reviewed for quality of care in that: The facility failed to recognize a change in condition for CR#1 when she began throwing up on [DATE] and some days after, and continuously having extremely high blood glucose levels for 6 days ([DATE] - [DATE]). CR#1 was sent out to the hospital on [DATE] and died in the hospital on [DATE]. The facility delayed in sending CR#1 to the hospital by calling the non-emergency line taking the ambulance over an hour to come when CR#1 was nonresponsive, blood sugar was 598, and O2 Saturation was 88% while on nonrebreather mask with 10 liters oxygen on [DATE]. The facility failed to monitor blood glucose levels adequately when CR#1's blood glucose level continued to spike with numbers above 600. An Immediate Jeopardy (IJ) situation was identified on [DATE] while the IJ was removed on [DATE] at 3:58pm, the facility remained out of compliance due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. These failures could expose residents to low quality of care, worsening of condition, hospitalization , and death. Findings included: Record review of CR#1's face sheet revealed a [AGE] year-old female initially admitted to the facility on [DATE]. Current admission was on [DATE] with diagnoses of type 2 diabetes (A chronic condition that affects the way the body processes blood sugar, resulting in too much sugar in the body), kidney failure, cerebral infarction (cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), malnutrition, hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), high blood pressure, sepsis (Sepsis is a serious condition in which the body responds improperly to an infection, causing a cascade of changes that damage multiple organ systems, leading them to system failure, sometimes even death), and heart disease. Review of CR #1's MDS (Minimum Data Set) dated [DATE] revealed CR #1 was diagnosed with Diabetes Mellitus, high blood pressure, cerebral infarction, and hemiplegia. MDS also revealed CR #1 was on insulin medication, oxygen therapy treatment, suctioning, and tracheostomy care. Review of CR #1's care plan revealed CR #1 was at risk hypoglycemia / hyperglycemia episodes due to diabetes mellitus. The care plan goal was that CR #1's blood sugar will be managed effectively, and the careplan intervention was to do accu checks as ordered and report any abnormal findings to the Physician and family members. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's Physician order dated [DATE] revealed insulin NPH and insulin Lispro was discontinued by LVN D on [DATE]. Record review of CR #1's physician orders revealed there was no order for insulin NPH from [DATE] through [DATE]. Review of CR #1's Physician order dated [DATE] revealed the following: Accu check with insulin Lispro (AdmeLOG) sliding scale SQ 142 - 180 = 2 units 181 - 220 = 4 units 221 - 240 = 5 units 241 - 260 = 7 units 261 - 280 = 9 units 281 - 300 = 10 units >300 = 12 units and call MD Four Times A Day 09:00 AM, 01:00 PM, 05:00 PM, 09:00 PM Record review of CR #1's [DATE] MAR revealed there was no insulin NPH administered to CR #1 from [DATE] through [DATE]. Further review revealed there was no documentation of blood sugar checked and no insulin administered to CR #1 on the 9pm accu check schedule on [DATE] when LVN A worked. Record review of CR#1's blood sugar vitals from (date) to (date) revealed no continued follow up on CR #1's blood sugar when the blood sugar was high: [DATE]: 5:34 am 598 mg/dL On [DATE] 11:28 pm 319 mg/dL 11:28 pm 283 mg/dL 1:01 pm 381 mg/dL 10:57 am 468 mg/dL 8:15 am 556 mg/dL 8:02 am 468 mg/dL (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] 7:01 pm 300 mg/dL 11:33 am 386 mg/dL 9:31 am High (above 600) 8:24 am High (above 600) 1 pm 414 mg/dL [DATE] 9:27 pm 250 mg/dL 5:52 pm 289 mg/dL 1:16 pm 365 mg/dL [DATE] 5:32 pm 313 mg/dL 12:04 pm 398 mg/dL 9:24 am 388 mg/dL [DATE] 8:43 pm 382 mg/dL 10:42 am 320 mg/dL 10:24 am 365 mg/dL [DATE] 7:24 pm 269 mg/dL 1:55 pm 139 mg/dL 8:39 am 139 mg/dL [DATE] 10:36 pm 159 mg/dL (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11:57 am 300 mg/dL Record review of CR #1's progress note documented by LVN A on [DATE] revealed Rsd breathing but non-responsive. bs 598 per Dr order gave 15units of lispro @05am and to send rsd out to hospital v/s , d+[DATE], hr 128, t-97.4, O2 88% w/ non-breather mask on 10L oxygen. Non-emergent line contacted eta 0600 . On [DATE] at 11:25am in an interview with CR#1's family member, she stated CR#1 had an infection that was not treated and by the time CR #1 got to the ER she was septic and dies the [DATE]. CR#1's family member stated there were instances where the Physician stated he did not know about CR#1 and admitted that he did not know CR#1. CR#1's family member stated she went to check CR#1 out of the facility on thanksgiving day, but CR#1 was throwing up that day and no one knew why she was throwing up. CR#1's family member stated she did not want to take CR#1 out of the facility not knowing what was happening. CR#1's family member stated no one knew why CR#1 was throwing up and it was odd for CR#1 to be throwing up so something must have been wrong with CR #1 on that day ([DATE]). CR#1's family member stated the staff (unknown) said CR#1 threw up twice that morning. On [DATE] at 12:24pm in an interview with CNA A, she stated she remembered CR#1 threw up on [DATE] on thanksgiving day. CNA A stated they noticed CR#1 threw up and she (CNA A) went to tell the Nurse (unknown). CNA A stated CR#1's emesis was brown and it was a lot. CNA A stated she told the nurse and she went to check CR#1. CNA A stated she did not recognize any other changes in condition for CR #1 on that day. On [DATE] at 10:21am in an interview with CNA B she stated CR#1 came from the 100 hall doing well and moved to the 200 Hall and after CR#1 stopped eating well the staff had to feed her and she refused sometimes. CNA B stated CR#1 was not really eating enough by mouth when she came to the 200 hall and she had a feeding tube. CNA B stated the day she went with her family member for Thanksgiving on [DATE] CR#1 was throwing up a lot on that day. CNA B stated she told the nurse on the floor and CR#1's family member that CR#1 was throwing up. She stated the nurse came to the room to speak with the family member and they decided with the family member whether to take CR#1 home for the day or not because of her throwing up. CNA B stated she remembered the day they sent CR#1 to the hospital she was throwing up also. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 11:21 am with RN C, she stated she took care of CR #1 on 100 hall on [DATE], and on 200 hall on [DATE]. She stated when she took care of CR #1 100 hall on [DATE] she checked CR#1's blood sugar and it was very high and that was the only thing she knew that happened that day. She stated she called the Physician, and he told her to give CR#1 a dose of insulin, but she could not remember the units. When they call Physician's number usually they would speak with anyone who picked the line, it could be one of the nurse practitioners working with the physician, but she did not know who specifically she spoke with on that day ([DATE]) on thanksgiving day. CR#1 used to have insulin scheduled for her blood sugar, she stated she was shocked that CR#1 was not on insulin when she took care of her on that day because CR#1's blood sugar was so high, 402 mg/dL, that she had to call the Physician. She stated CR#1 used to have insulin NPH and sliding scale. RN C stated CR#1's family member wanted to take her out to eat on the thanksgiving day, but she (RN C) told the family member that they had to take care of CR#1's blood sugar before the family member could take CR #1 out. RN C stated she followed up and rechecked the blood sugar and it was lower than what it was before, but she did not remember what the value was and she was not sure if she documented it. She stated she should have put what the blood sugar came down to. She stated she could not remember if CR#1 was throwing up. She stated there were so many things that happened that day and many families came to pick their family up so she did not recall if she wrote any notes or any assessments. On [DATE] at 1:58pm with former ADON C she stated she could not remember what happened with CR#1. She stated CR#1 did get sent out to the hospital on the night shift. She stated if someone was throwing up, it was a change in condition, and they needed to do something about that. She stated they needed to call the Nurse Practitioner, Responsible Party, and everyone that needed to be called. On [DATE] at 2:12pm in an interview with RN B, she stated she walked in on [DATE] and CR#1 did not have any signs and symptoms, CR #1 was acting normal, the blood pressure was normal and then she checked CR#1's blood sugar and CR#1's blood sugar was pretty high in the 491mg/dl, so she called the physician. RN B stated she looked through CR#1's physician orders and saw that her orders for insulin had been discontinued by the physician and she did not know why it was discontinued. RN B stated on the weekend of [DATE] and [DATE], CR#1's blood sugar was in the 300's and they did not document any interventions from the nurses. RN B stated she worked at the facility on [DATE] and [DATE], and it was her first-time taking care of with CR#1. RN B stated she knew that blood glucose of 300 was not a normal thing. RN B stated no one informed her that CR#1 had been throwing up on [DATE] on the thanksgiving day. On [DATE] at 12: 38pm in an interview and record review of CR#1's clinical record with the DON, she stated CR#1 came to them from home with dementia, old CVA history, sepsis with shock, malnutrition, diabetes, High blood pressure, and pressure ulcers when admitted . The DON stated CR#1's blood sugars were in the 400's and 500's. She stated CR#1 could spike and go up to 402 within 30 minutes of each other and then went back down to 126. She stated CR#1's blood sugars started going consistently higher on [DATE]. She stated they were holding CR#1's tube feeding, and administered the insulin sliding scale. The DON stated in CR#1's clinical record, the physician noted dated [DATE] revealed CR#1's Pt's diabetes is controlled at this time. Will continue to monitor for stability. BS: 557mg/dL, the Physician wrote that it was controlled and will continue to monitor. The DON stated she was not going to second guess a physician when he stated the blood sugar was 557 and that it was controlled. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:43pm in an interview with LVN A she said CR#1's blood sugar on [DATE] at 11:28pm was 319. LVN A stated CR#1 was sent out because she was declining compared to the last time she took care of CR #1 on the 100 hall. LVN A said CR#1's oxygen saturation was what they were mainly worried about, her oxygen was low in the 80s so they got orders to put CR #1 on oxygen. LVN A said CR#1 was not acting the same as when she was on 100 Hall. She said on [DATE] at 5:34 am CR#1's blood sugar was up to 598 so they gave CR#1 some insulin. LVN A said with CR#1 was declining oxygen saturation was 88% and resident was placed on non-rebreather with oxygen at 10 liters, but they still could not get CR #1's oxygen level up, the resident (CR #1) was not looking good, and her blood sugar was high, so she got orders to send the CR#1 out to hospital. LVN A stated when she took care of CR#1 on the 100 hall CR #1 was getting insulin NPH in the morning but it was discontinued on [DATE] and she did not know why it was discontinued. LVN A stated she also took care of CR #1 on [DATE] and checked CR #1's blood sugar on [DATE] but could not recall what it was and whether she gave insulin or not. She stated on [DATE] during the night shift, she tried to call the physician, but they don't really respond in the middle of the night. She said the physician did respond early in the morning around 5:00am. She said CR #1 was barely trying to open her eyes and that was a big difference from CR#1's normal self, CR #1 appeared lethargic, she knew CR #1 to be more alert than how she appeared on [DATE]. LVN A said EMS came at 6:20 am. LVN A said she did not recheck CR#1's blood sugar or the oxygen saturation. She stated everything during the shift was going so fast I guess I did not recheck. LVN A said she called the non-emergency line because 911 was called if the resident was not stable. She said CR#1 was still trying to open her eyes, so she thought it was not an emergency, she did not think she needed 911. LVN A stated if a resident was coding and not breathing she would call 911 but CR #1 was still breathing only that she appeared lethargic, O2 low, and blood sugar high. LVN A stated she did not realize the situation with the resident was an emergency because the resident was not in comatose, she stated, I felt it was getting to that point and she had to send her out. On [DATE] at 3:13pm in an interview with LVN B, she stated CR#1 had elevated blood sugar at 313 on [DATE]. She stated CR#1 was on insulin sliding scale and every time blood sugar was beyond the normal she would give the insulin. She stated on [DATE] she handed CR #1's care over to LVN A to send CR#1 out because the oxygen saturation was low even after they placed CR#1 on oxygen and it was still low. LVN B stated she worked the 2 to 10 pm shift and LVN A worked the 10pm to 6am. LVN B stated she could not remember the date, but the time she charted was 11:28pm and she was still at the facility even after she finished her schedule at 10pm. She stated she was still doing her charting before leaving for the night. LVN B stated she did not write notes on the resident (CR #1), but she told LVN A that CR#1's oxygen saturation was not okay and she kept following up with the nurse until she (LVN B) left the facility. LVN B stated she gave CR#1 insulin sliding scale and rechecked, she stated if she did not write it down she must have missed it to document because she was overwhelmed, because their new system where they document was not user-friendly. She stated she took CR#1's blood sugar earlier during the shift on [DATE] and the blood sugar value was 313, but she documented it late at 11:28pm. She did not recall if she followed up to recheck the blood sugar again, she only documented it into the system at 11:28pm when she had the chance to document. She stated if the blood sugar was that high she was supposed to continue to recheck the blood sugar to make sure it was coming down because high blood sugar could affect the resident negatively if not treated. (continued on next page)

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	676064	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Azul Skilled Nursing and Rehabilitation	1480 Katy Flewellen Katy, TX 77494

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	on [DATE] at 3:57pm in an interview with the DON, she said if CR#1 has a blood sugar above 300 the nurses were to call the Physician to get order. The DON said besides the Physician's order, the nurses were to use nursing judgement and check the blood sugar every 30 minutes to an hour if the resident's blood sugar was still high, and if there are further orders they check with the physician again. She stated in 30 minutes to an hour they would be able to identify if the blood sugar was going down, but they do not want to give more insulin because the insulin was still working. The DON stated CR#1's blood sugar was coming down, but then she had a meal in between which could have brought her blood sugar up again. The DON stated blood sugar was a patient specific thing and 300 was high for CR#1 and the nurses were expected to use their nursing judgement to recheck CR #1's blood sugar more frequently to see the blood sugar trending down. The DON said based on the CR#1's blood sugar level and overall change in condition, CR #1 should have been sent by emergency 911 and not non-emergency ambulance. She said the situation with CR #1, high blood sugar and low O2 saturation while on non-rebreather mask with 10liters oxygen, was a change in condition and needed prompt interventions. She said when the nurses are given orders by the physician, nurses were supposed to carry them out, and in this situation she would have implemented the order to send resident out rapidly. The DON stated she was not sure if CR #1 was throwing up on the [DATE]. She stated if a resident threw up only once then she would watch it because it could have been something they ate that did not agree with them, but if it was something happening consistently it was a change in condition. The DON said she was not aware CR#1 vomited multiple times at the facility on Thanksgiving morning. On [DATE] at 4:21pm in an interview with the Primary physician, he stated he was the primary physician for CR #1, but he was not the physician who was called on the day ([DATE]) when resident was sent to the hospital, he said the facility could have called the medical director. He stated he was not aware and could not recall anyone called him for CR #1 throwing up on any day. He stated it was an emergency if a resident was having a change in condition, becoming lethargic with low oxygen level at 88% while on non-rebreather with 10 liters of oxygen and high blood sugar in the 500s. The Primary physician stated it is a possibility that the high blood sugar could have caused the resident to throw up. He stated when a sliding scale was given and residents blood spiked, the goal was to administer insulin so as to bring the resident's blood sugar down to the lowest level on the slightly scale. On [DATE] at 4:23pm in an interview with the facility Medical Director, he stated I won't remember that patient at all he stated he was not the Physician for the patient and he stated the Primary physician was the primary physician. He said the protocol was that the facility would only reach out to him if the nurses were not able to reach to the NPs that worked with him or not able to reach another physician s, they would call him. He stated he received a lot of calls all the time with a lot of things, he said the residents at the facility had very high acuity, and they were doing their best to care for the residents. He stated he could not recall anyone calling him about CR #1 throwing up or having extremely high blood sugar of having any change in condition. He stated the nurses must have reached out to the primary care Physician and not him. Review of facility policy titled 'Blood Sugar Checks' undated revealed in part, residents receiving insulin should be monitored according to the ordered sliding scale and as needed. Review of facility policy titled 'Pulse Oximetry (Assessing Oxygen Saturation)' dated 'revised [DATE]' revealed in part, normally SpO2 is between 90 and 100 percent .if SpO2 is less than acceptable level for resident's condition, notify the physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility policy titled Change in a Residence Condition or Status Dated Revised February 2021 revealed, in part, a significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .A nurse will notify the residence representative when there is a significant change in the resident physical mental or psychosocial status .The nurse will record in the residence medical record information relative to changes in the resident medical or mental condition or status This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified. The Administrator was provided with the IJ template on [DATE] at 2:57pm. The following Plan of Removal submitted by the facility was accepted on [DATE] at 8:17pm. The plan of removal reflected the following: PLAN OF REMOVAL Name of facility: Date: [DATE] The Texas Department of Health and Human Services entered [facility] on [DATE], for a P1 Complaint Survey. During the survey process an IJ (Immediate Jeopardy) was cited on [DATE] regarding - F684 as stated below: F684: Quality of Care Resident Status: The resident was discharged to an acute care hospital on [DATE] and did not return. Immediate action: On [DATE] DON, under the guidance of the Regional Nurse Consultant initiated an in-service with all nursing staff (all nursing staff to include CNAs) on duty to cover the following topics, this training will be completed on [DATE]. o Notifying Physician and Family of Resident Change of Condition. The physician should be notified as soon as possible after identifying a change of condition, assessing resident needs and providing necessary services. If the physician is unable to be reached, the DON and/or designee should be notified and the Medical Director contact for treatment plan. o Recognizing and Reporting Acute Changes of Condition. Changes of condition include, but are not limited to vomiting, vital signs, mental status changes, functional decline, hyperglycemia, etc. o Notification of physician upon identifying a high blood sugar level. o Monitoring and follow-up of changes of conditions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Symptoms that include the need for emergency ambulance services. o Documentation of events (Change of Condition), SBAR and Stop & Watch. o Change of Condition policy was reviewed, no changes were made. Staff in-serviced on current policy. o Residents receive treatment as per physician orders. o Documentation of events (Change of Condition), SBAR and Stop & Watch. o Residents receive treatment as per physician orders. o An audit will be conducted of all residents receiving insulin to ensure orders are correct. This audit will be completed by [DATE]. o An audit will be conducted of all residents receiving blood sugar checks to ensure parameters are set. This audit will be completed by [DATE]. o An audit was completed of residents with changes of conditions, within the last 30 days, to ensure the resident physician was notified. This audit will be completed [DATE]. o An audit of residents with diabetes was done to assess for high blood sugar levels or change of condition. This audit was started on [DATE] and will be completed [DATE]. o The nurse referenced in the IJ narrative was identified and in-serviced on following physician orders and discontinuation of medications. In-service completed on [DATE]. o 1:1 in-service was completed with LVN-A on assessing and monitoring resident who experience a change of condition; residents receive treatment as per physician orders; and residents receive emergency services timely, if required. Inservice completed on [DATE]. Facility Plan to ensure compliance quickly: o All nursing staff will be in-serviced on the above-listed topics prior to beginning their next scheduled work shift. o The DON and/or designee will conduct audits of the 24-hour report to include review of progress notes to ensure that all changes of conditions have been identified and physician notification has been made; physician orders written in the previous 24 hours; and any resident hospital transfer to ensure emergency services were utilized, when appropriate. This audit began on [DATE]. Demonstration of and acknowledgement that all licensed nurses are aware of the above: o The DON/ADON and/or designee will contact all licensed nurse staff and get a verbal acknowledgement as a return demonstration of understanding of the above listed training topics. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o This in-servicing began [DATE] and will be completed by [DATE]. On [DATE] The facility Administrator, ADON, and Regional Nurse Consultant held an ad hoc QAPI meeting with the Medical Director, via phone, to discuss: o F684 - Quality of Care - IJ Cited o Plan of Removal and actions taken to ensure continued compliance. QAPI: o The above actions will be reviewed monthly in QAPI to ensure continued compliance. The State Surveyor confirmed the facility implemented their Plan of Removal for the IJ to be removed by monitoring from [DATE] through [DATE] as follows: On [DATE] at 3:09pm interview with LVN E, she stated she only worked on weekends, she had not been trained in

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44485 Based on observation, interview, and record review the facility failed to provide pharmaceutical services that include procedures to ensure accurate acquiring, receiving, dispensing, and administering of all drugs for 1 of 3 residents (CR #1) reviewed for medications. The facility failed to follow Physician's order to only discontinue insulin Lispro for CR #1, but facility discontinued all insulin (NPH and Lispro), leaving CR #1 with no insulin to administer for CR #1 while CR #1 was having high blood sugar for multiple days. The facility failed to notify the physician that CR #1 insulin NPH was discontinued when CR#1 was having high glucose readings for 6 days. CR#1 was sent out to the hospital on [DATE] and died in the hospital on [DATE]. These failures could place the residents in the facility at risk for not receiving needed medications to maintain optimum health, resulting in deterioration in their condition. Findings included: Record review of CR#1's face sheet revealed a [AGE] year-old female initially admitted to the facility on [DATE]. Current admission was on [DATE] with diagnoses of type 2 diabetes (A chronic condition that affects the way the body processes blood sugar, resulting in too much sugar in the body), kidney failure, cerebral infarction (cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), malnutrition, hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), high blood pressure, sepsis (Sepsis is a serious condition in which the body responds improperly to an infection, causing a cascade of changes that damage multiple organ systems, leading them to system failure, sometimes even death), and heart disease. Review of CR #1's MDS dated [DATE] revealed CR #1 was diagnosed with Diabetes Mellitus, high blood pressure, cerebral infarction, and hemiplegia. MDS also revealed CR #1 was on insulin medication, oxygen therapy treatment, suctioning, and tracheostomy care. Review of CR #1's care plan revealed CR #1 was at risk hypoglycemia / hyperglycemia episodes due to diabetes mellitus. The care plan goal was that CR #1's blood sugar will be managed effectively, and the care plan intervention was to do accu checks as ordered and report any abnormal findings to the Physician and family members. Record review of physician orders revealed there was no insulin NPH for CR #1 from [DATE] through [DATE] when CR #1 was sent to the hospital. Record review of MAR (Medication Administration Record) for the month of [DATE] revealed there was no insulin NPH administered to CR #1 from [DATE] through [DATE] (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR #1's Physician order revealed insulin NPH and insulin Lispro was discontinued by LVN D on [DATE] at 2:20pm. On [DATE] at 2:12pm in an interview with RN B, she stated she walked in on [DATE] and CR#1 did not have any signs and symptoms, CR #1 was acting normal, the blood pressure was normal and then she checked CR#1's blood sugar and CR#1's blood sugar was pretty high in the 491mg/dl, so she called the physician. RN B stated she looked through CR#1's physician orders and saw that her orders for insulin NPH had been discontinued by the physician and she did not know the reason for it to be discontinued, but she did not ask anyone regarding the NPH, seeing that it was discontinued by the Physician. RN B stated on the weekend of [DATE] and [DATE], CR#1's blood sugar was in the 300's and they did not document any interventions from the nurses. She stated on [DATE] and [DATE] the weekend nurses did not document any interventions. On [DATE] at 11:21 am with RN C, she stated CR#1 used to have insulin scheduled for her blood sugar, she stated she was shocked that CR#1 was not on insulin when she took care of her on that day because CR#1's blood sugar was so high, 402 mg/dL, that she had to call the Physician. She stated CR#1 used to have insulin NPH and sliding scale but when she cared for CR #1 on 200 hall on that day [DATE], the resident did not have any insulin, all CR #1's insulin were discontinued. She stated she only asked the physician for insulin order so she could administer it to help lower the resident's blood sugar. On [DATE] at 2:39pm in an interview with the Lead NP, she stated she knew all the residents in the facility because she comes to the building everyday. NP stated CR#1 was on 2 different insulins (NPH and Lispro) when she was admitted to the facility. She stated on [DATE] a nurse (she did not remember the nurse) told her that the resident's blood sugar was running too low, and she gave verbal order to the nurse to discontinue the insulin lispro for CR#1 because her blood sugar was low at that time. The Lead NP stated she did not give any order to discontinue the NPH. She stated CR#1 was on NPH 40 units 3 times a day, the nurse was to discontinue only the insulin Lispro, and leave the NPH insulin without any changes. She stated that the nurse erroneously discontinued both insulin (NPH and Lispro). The NP stated if blood sugar was high the nurse was supposed to call and let them know that the resident's insulin was discontinued, because the resident (CR #1) was supposed to be on the NPH as a basal coverage for the resident. She stated insulin lispro was not meant for treating residents with hyperglycemia, she stated the lispro is a short acting insulin which was in place to bring the blood sugar down in case the resident's blood sugar spiked. She stated there should be a scheduled insulin NPH which would be covering the resident for up to 12 hours, The lead NP stated she did not know the insulin NPH was discontinued, she did not check the resident's record, because she believed when they gave order to the nurses, they were supposed to carry out the order accordingly. She stated she was always in the building and most nurses would come to her to get order for anything happening with any resident and she would give verbal order at times. She stated whenever she or any other team members give order, they would always communicate with other team members, so they all be on the same page. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:43pm in an interview with LVN A stated when she took care of CR#1 on the 100 hall CR #1 was getting insulin NPH in the morning but it was discontinued on [DATE] and she did not know why it was discontinued. LVN A stated she also took care of CR #1 on [DATE] and checked CR #1's blood sugar on [DATE] but could not recall what it was and whether she gave insulin or not. She stated nursed were the ones who get orders from the prescriber and document the order, sometimes the prescriber would document the order into resident's record, but if it was a verbal order from the Physician or NP, the nurses would make sure they understood the order and document and implement the order. On [DATE] at 3:13pm in an interview with LVN B she stated on [DATE] CR#1 had elevated blood sugar at 313. She stated CR#1 was on insulin sliding scale and every time blood sugar was beyond the normal she would give the insulin. LVN B stated she gave CR#1 insulin sliding scale. She stated she noticed there was no NPH for CR #1, but she followed what was in the resident's order and gave the sliding scale. On [DATE] at 3:57pm in an interview with the DON, she said if CR#1 has a blood sugar above 300 the nurses were to call the Physician according to the instruction in the order. The DON said besides the Physician's order, the nurses were to use nursing judgement and check the blood sugar every 30 minutes to an hour if the resident's blood sugar was still high, and if there are further orders they check with the Physician again. The nurses get order from the prescriber and entered it into the system. The nurses were responsible to make sure the order they carried out was right. On [DATE] at 4:21pm in an interview with the Primary Physician, he stated the nurse practitioners come to the facility very often and they give orders for residents. The expectation was that if there was an order given, the nurses would clarify if there was any misunderstanding or confusion. He stated when a sliding scale is given and residents blood spiked, the goal was to administer insulin so as to bring the resident's blood sugar down to the lowest level on the sliding scale. Record review of facility policy titled 'Administering Medications' undated, revealed in part medications are to be administered in accordance with prescriber orders .