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S 000	Initial Comments Complaint Investigation Survey 2498549 / IL179603 2498538 / IL179580 2498539 / IL179581 2498507 / IL179530 2498719 / IL179846	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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	S9999		

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each resident's comprehensive resident care plan. 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

1. Based on observation, interview, and record review, the facility failed to find appropriate roommates for R1, appropriately notify R1 of room change and consider room preferences and follow up with R1's discharge planning. This resulted in R1 being placed in a room with two residents (R11 and R12) that have behaviors and are severely cognitively impaired causing R1 to lose sleep and experience mental distress.

Findings include:

R1 is a 54-year-old female who originally admitted to the facility on 6/8/2024 and moved to the long-term care side of the facility on 10/4/2024. R1 continues to reside in the facility. R1 has multiple diagnoses including but not limited to the following: surgical amputation, type II DM, need for assistance with personal care, HTN, heart failure, CKD V, and left BKA. Per

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Minimum Data Set (MDS) dated 9/13/24 shows R1 has a Brief Interview for Mental Status (BIMS) score of 12 meaning resident is cognitively intact.

On 10/23/24 at 12:50PM, R1 was interviewed regarding roommates and discharge planning. R1 said the facility staff moved her to the long-term care side of the facility without getting her consent or being acclimated to the room or roommates. R1 said she did not want to come to this side of the building and would have rather transferred to another facility instead. R1 said, "I told the staff I did not want to move rooms, but they transferred me here anyway. I have not spoken with a social worker since moving to the long term care side of the building, and even before that I barely saw any social workers".

R1 said, "I have two roommates that are severely cognitively impaired". R1 said R11 will talk all night saying things like 'do not touch me', 'give me my whiskey', and 'where is my food stamp card'. R1 said R11 is constantly saying things that does not make sense and sounds as if she is hallucinating. R1 said R12 will constantly yell out all day and night and scream bloody murder. R1 said, "The staff will move (R12) into the dining room during the day, so I try and sleep during the day when she is out of the room".

R1 said both of these residents prevent R1 from sleeping. R1 said, "The staff is aware that I do not want to be in the room with (R11) and (R12). The staff does not care, they get to go home at night, but I am stuck in this room with (R11) and (R12) that scream all night".

It is to be noted that during observation on 10/23/24, resident's eyes were puffy. R1 was in bed cuddled up with blanket at 12:50PM and was

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sleeping when this surveyor entered the room.

On 10/24/24 at 12:17PM, R1 was observed to be sleeping in bed. R1's name was called twice but was in a deep sleep and did not respond back to surveyor. At 12:40PM, R1 was interviewed again. R1 said she is not getting any sleep because of R11 and R12 screaming all night. R1 was observed to have puffy eyes and to be upset about loss of sleep.

On 10/28/24 at 1:15PM, R1 told this surveyor that on 10/25/24 R1 had a care plan meeting with the interdisciplinary team where R1 let them know R1's concerns with R1 roommates and discharge planning. R1 observed to have wet eyes talking to this surveyor about having a hard time sleeping. R1 said R1 met V6 (Social Worker) for the first time on 10/23/24 after speaking with this surveyor.

It is to be noted that during the course of this survey, 10/23/24-10/30/24, R1 was visited on four different occasions and each time R1 expressed that she cannot sleep due to R11 and R12 yelling all night. R1 was observed to look tired and distraught on all visits from surveyors.

On 10/23/24 at 2:10PM, V1 (Administrator) and V2 (Director of Nursing) were interviewed regarding social services. V1 said, "We recently had a lot of changes in the social service department. All the social service workers are very new".

On 10/23/24 at 3:30PM, V6 (Social Service Worker) was interviewed regarding R1. V6 said, "I have not spoken with (R1) since I started working here and I am unaware of her discharge goals and plans".

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Per social service progress notes, it is to be noted that prior to 10/24/24, the last time discharge planning was discussed with R1 was on 7/25/24.

R1's care plan states in part but not limited to the following: R1's tentative plan is for the resident to return home upon completion of skilled services. As necessary, meet with the R1 on a regular basis to help with preparation for discharge.

It is to be noted that at no point in R1's care plan does it show R1's plan of care is to move to long-term care within the facility.

It is also to be noted that on 10/30/2024, R1 was observed to still be in room with R11 and R12.

Room change notification form shows R1 was notified of the room change on 10/4/2023 at 11:30AM, which is the same day R1 moved to the long-term care side of the facility.

Resident Rights policy dated 8/1/2022 with revision date of 2/2024 states in part but not limited to the following: The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the residents own needs and preference.

Room Change/Transfer within Facility policy dated 12/2017 with review date of 12/2023 states in part but not limited to the following: To assure that residents are appropriately notified of room transfers. When a resident is being moved to a new room at the request of the facility, the resident shall receive an explanation in writing of

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why the move is required. The resident will be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.

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2. Based on interview and record review, the facility failed to ensure timely signing of a Certificate of Death. This failure applies to one resident (R7) who expired in the facility 9/17/24 and resulted in mental anguish to R7's family and delay of funeral services for R7.

Findings include:

R7 admitted to the facility 5/30/24 and had diagnoses that included pneumonia, severe protein-calorie malnutrition, and multiple pressure ulcers. According to progress notes, on 9/17/24 R7 went into cardiac arrest while participating in resident activities. Emergency Medical Services were called to the facility to provide advanced life saving measures, however R7 was unable to be revived and was pronounced deceased without transfer.

On 10/30/24 at 1:58pm, V33 (Funeral Home Staff) said when R7 expired in the nursing facility, the funeral home recovery team reported to the facility and requested R7's "face sheet" that included R7's demographics such as name, birthdate and physician's contact information. The funeral home reached out to R7's Primary care Physician (V29) to have the Death Certificate signed within 24 to 72 hours of V7's transfer. V33 said when the Funeral home called V29, V29 refused to sign the Death Certificate because V29 said they were not the primary physician. V33 called V34 Pulmonology Consultant as listed on the face sheet and V34 said they could not sign

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the Death Certificate because they were not the primary physician for R7. V33 mentioned notifying R7's family and made several calls to the facility regarding the issue.

On 11/4/24 at 9:52am V34 said a few weeks ago, the Funeral Home contacted V34 to sign the death certificate, however V34 explained that because V34 only saw V7 in the facility under pulmonology consultation, it was not appropriate to sign the death certificate. V34 said V33 was angry and offered to assist with reaching out to V29 (primary physician) however V33 mentioned that they had previously reached out to V29 but refused to sign.

During the interview, V33 said they called the facility several times since R7 was transferred leaving several messages for the administrative staff and did not get any response. Finally, V33 called the facility on 10/17/24 and spoke with the receptionist (V35) and informed V35 that the Funeral Home had been attempting to get a physician to get the death certificate signed. V33 notified V35 that the family would be filing a formal complaint. Later that day, the signed death certificate was received dated 10/17/24. V33 said that the delay in signing the death certificate also delayed proceeding with funeral arrangements for R7's family.

On 10/29/24 at 11:13am, V36 (Family Member of R7) said that when V33 informed them of the delay in getting the death certificate signed, several messages were left with administrative staff, however no one returned their calls. V36 said regarding this issue, "It took a mental toll on all of us because it was like we couldn't even get the process of grieving, or the funeral arrangements made without the death certificate."

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S9999	Continued From page 7 On 10/30/24 at 2:23pm V35 (Receptionist) said they received a call from a family member of R7 who was upset and mentioned suing the facility for refusing to sign the death certificate. V35 transferred the call to an administrative staff member but could not recall who. V35 said later, the funeral home called the facility, relaying the same concern and then V35 notified V2 Director of Nursing directly. On 10/30/24 at 2:23pm V2 Director of Nursing said, the funeral home reached out to the facility a few weeks ago, saying V29 had been refusing to sign the death certificate. V2 spoke with V29 and got it signed later that day. On 10/30/24 at 10:30am V29 said they were notified at the time V7 expired in the facility and signed the death certificate when the facility called. The death certificate was reviewed and was noted to be signed by V29 on 10/17/24, 30 days after V7 expired in the facility. V29 provided a fax confirmation that the signed death certificate was sent to the funeral home on 10/17/24. (B) Statement of Licensure Violations (2 of 2): 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3210t)	S9999		

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Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall 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 resident care plan. 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.

c) Each direct care-giving staff shall review

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and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

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These requirements were not met as evidenced by:

A. Based on interview and record review the facility 1.) failed to implement effective interventions to prevent accidental removal of tracheostomy cannula and accidental extubation for a ventilator dependent resident; and failed to ensure a ventilator care unit had uninterrupted nursing supervision on 10/2/24, 2.) failed to follow their Hypoglycemia Policy and procedure by not initiating intravenous access to provide intravenous fluids and failed to call 911 immediately upon determining that intervention for hypoglycemia was not effective. These failures applied to one (R3) of three residents reviewed for nursing care and resulted in R3 being found decannulated and in cardiac arrest on 10/2/24 and on 10/23/24 when R3 was assessed as deceased and in rigor mortis (irreversible sign of death) by paramedics. The unit was left in the care of unlicensed staff and (R3) experienced cardiac arrest while the two assigned nurses were on break outside of the facility.

Findings include:

1.) Respiratory progress notes dated 10/2/24 at 2:04am showed that R3 was found decannulated and without pulse. On 10/30/24 at 11:24pm V24 Respiratory Therapist said they worked the night shift 10/1/24 from 7pm to 7am. V24 said towards the beginning their shift, V24 received in report that R3 was "fidgeting" and pulling the tubing attaching the tracheostomy to the ventilator machine. Because of this, the ventilator alarmed

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many times during the previous shift. V24 said this behavior was noted to start at least a week prior. V24 said when this was noted and the ventilator alarm sounded, V24 would go into R3's room, try to calm R3 and notified the nurse of the behavior.

On 10/2/24, V24 responded to an alarm at approximately 1:45am and found R3 with the tracheostomy cannula removed from R3's neck. V24 explained that the cannula is the tubing that is placed in the neck of an individual who is unable to breathe independently, and the ventilator mechanically provides breathing support. Since the cannula was completely removed, R3 was not getting any oxygen or assisted breathing support. When V24 replaced the cannula, R3 was noted to be without a pulse. V24 said this assessment took about 30 seconds. V24 said there were no nurses on the unit at the time, as both nurses were on break. V24 said it took about two minutes to leave the room, called "code blue" (medical emergency) to the overhead speaker and grab the emergency cart to bring into the room. V24 said when going back into the room, V24 attached the automated defibrillator pads, started compressions, and waited for help to arrive. V24 said there was one nurse who responded from the next unit over. V24 and the nurse (V30) performed cardiopulmonary resuscitation until the paramedics arrived.

On 10/29/24 at 11:40am V10 Respiratory Therapist and Respiratory Manager said R3 was known to occasionally pull on the tracheostomy and ventilator tubing. V10 said when residents display this behavior, interventions to address this may include using a 1:1 sitter or a psych consult for agitation and adding medications to treat the agitation. V10 could not recall any of these

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interventions being placed for R3.

R3 received care in the facility on the dialysis/ventilator unit. Interviews from nursing staff on duty at the time R3 was found unresponsive revealed that both nurses (V31 and V32) assigned to the unit had left the facility for break between 1am and 2am. According to the working schedule for night shift 10/1/24 11pm to 7am, seven nurses were on duty. Only one nurse (from long-term care) responded to the emergency and provided CPR (cardiopulmonary resuscitation) with V24 prior to paramedic arrival. When the paramedics arrived, the nurse assigned to R3 (V31) was outside of the facility on break and did not return until after paramedics transferred R3 out of the facility.

Ventilator flow sheets document R3 pulling and disconnecting ventilator tubing on 9/27/24, 10/1/24 and 10/2/24. On 9/27/24 at 10:27pm V24 wrote "patient disconnected couple of times, vitals stable." On 10/1/24 at 7:11pm R24' note included, "(R3) frequently disconnected his ventilator circuit over 10 times the first hour. (R3) calmed down with (as needed) nursing meds and has desisted. On 10/2/24 at 1:08AM V24 wrote, "(R3) had a major reduction of self-circuit disconnection. Just one incident tonight in the 7-12 interval where 15 incidents occurred in recent shifts from 7-12. (Respiratory Therapist) noted no new distress presentation."

Respiratory progress notes dated 10/2/24 at 2:04am said R3 was found decannulated and without pulse.

On 10/30/24 at 11:24pm V24 Respiratory Therapist said they worked the night shift 10/1/24 from 7pm to 7am. On 10/2/24, V24 responded to

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an alarm at approximately 1:45am and found R3 with the tracheostomy cannula removed from R3's neck. V24 explained that the cannula is the tubing that is placed in the neck of an individual who is unable to breathe independently, and the ventilator mechanically assists with breathing. Since the cannula was completely removed, R3 was not getting any oxygen or assisted breathing support. When V24 replaced the cannula, R3 was noted to be without a pulse. V24 said this assessment took about 30 seconds. V24 said there were no nurses on the unit at the time, as both nurses were on break. V24 said it took about two minutes to leave the room, called "code blue" (medical emergency) to the overhead speaker and grab the emergency cart to bring into the room. V24 said when going back into the room, V24 attached the automated defibrillator pads, started compressions, and waited for help to arrive. V24 said there was one nurse who responded from the next unit over. V24 and the nurse (V30) performed cardiopulmonary resuscitation until the paramedics arrived.

On 10/31/24 at 8:03am, V30 LPN (Licensed Practical Nurse) said on 10/2/24, V30 was charting at the nurse's station on the long term care unit, when an agency CNA (Certified Nursing Assistant) came to notify V30 of the active emergency regarding R3. V30 said that they had not heard a code blue called over the speaker prior to this notification. V30 said they announced the code overhead to get help to respond and called 911. V30 said the CNA only communicated the room number because they were from agency and did not know the name of the resident. V30 said after calling 911, V30 ran to the room which was right outside of the long term care unit and took over compressions with V24. V30 said there were two agency CNAs in the room and with V24,

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they took turns alternating the breathing bag and compressions. V30 said, they were getting tired from the exertion of compressions as they continued and no other staff from the building responded. V30 said the fire department paramedics arrived at the bedside, after letting themselves in the building. It wasn't until the paramedics took over that staff from other units reported to the room.

On 10/31/24 at 11:56am V31 (agency nurse on duty) was asked about the emergency code blue for R3 and V31 said "the RT (Respiratory Therapist) took care of it." V31 said they were outside taking a break in the car when a staff nurse came to inform V31 that R3 was coding in the building. V31 couldn't recall what time they left the building and did not know that they were required to tell any staff that they were leaving the unit or the building for break. V31 said they did not punch out or record any time leaving or re-entering the facility. V31 said they were aware the other nurse on the unit was on break at this time. During this interview, V31 repeatedly insisted they were unable to complete their break, due to being interrupted by staff because of the emergency with R3. When V31 said when they returned to the facility, the emergency had been cleared- meaning paramedics had already transported R3 to the hospital. V31 said, they couldn't recall when R3 was last assessed prior to going on break.

On 10/31/24 at 2:10pm V32 LPN said, on 10/2/24, they notified the CNAs and V31 they would be leaving the building for break around 1am. V32 left their cell phone number to the CNAs and V31 because they were from agency and in case of emergencies. V32 said they did not punch out or record time leaving or

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re-entering the facility. V32 said once they arrived at the restaurant, an agency CNA called to notify V32 that an active emergency was taking place on the unit. V32 drove back to the facility and found that paramedics had already arrived. V24, V30 and CNAs were continuing CPR and other nurses were outside of the room. The paramedics were asking, 'who is the nurse' and no one responded. V32 then asked the staff "where is the nurse?" to no one in particular.

According to the fire department run sheet, 911 was notified at 1:51am. Paramedics responded to the bedside of R3 at 1:57am. When paramedics arrived, they found V24 providing bag ventilation to R3's tracheostomy and another staff member doing CPR. Automated Defibrillator pads had been placed and advised no shock. R3 was assessed and was not breathing and did not have a pulse. The staff in the room did not know how long R3 had been unresponsive when asked by paramedics. R3 regained a pulse with resuscitative efforts from the paramedics, however, on transport to the hospital, R3 went into cardiac arrest again. Assessments maintain that R3 did not exhibit any eye movement or motor response. R3 was resuscitated in the emergency department and admitted to the Intensive Care Unit.

On 10/31/24 at 4:01pm V2 Director of Nursing said, V2 was unaware of R3 exhibiting behaviors that included removal of tracheostomy cannula or ventilator tubing and R3 did not have any care plans for these behaviors. V2 said for R3 and other residents that exhibit this behavior, the facility is able to initiate the use of soft restraints, medications and more frequent observation which is prompted by an increased frequency of ventilator alarms. V2 said if they had known that

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R3 had these behaviors, interventions would have been ordered and documented on the care plan. V2 was also unaware that the unit was left without nursing supervision at the time R3 was found unresponsive.

Provider and Nursing progress notes were reviewed for R3 from September 2024 to October 2024, and did not include assessments by providers or nurses that addressed Respiratory Therapy's observations of R3 disconnecting tubing and removing the tracheostomy cannula.

An interview was attempted on 11/4/24 at 2:34pm to V37 (R3's Primary Physician). V37 refused to answer questions related to R3 due to being out of the country.

A care plan for R3 was initiated for ventilator dependence on 8/2/24. Interventions included (8/2/24): "Prevent accidental extubating by taping tube securely, checking every 2 hours and restraining/sedating as needed." Care Plan was also initiated 8/2/24 for "trach (tracheostomy): at risk for complications (related to) tracheostomy placement secondary to respiratory failure." Interventions included "replace trach immediately if removed."

Physician Order sheet reviewed during R3's admission did not include any interventions for preventing accidental decannulation or extubation.

Facility employee handbook (no revision) states in part; "You are not permitted to leave the facility grounds during personal breaks. If you leave facility grounds at any time, you must punch out. Your supervisor will assign meal and break times. Meal and break times will be staggered among

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employees in order to provide adequate staffing at all times to meet resident needs. During emergencies it may not be possible to allow personal break periods."

2.) R3 was admitted to the facility 4/22/24 with diagnoses that included but are not limited to cerebral infarction, type II diabetes mellitus, chronic obstructive pulmonary disease, tracheostomy, and dependence on ventilator. On admission and according to the MDS (Minimum Data Assessment) R3 had severe cognitive impairment, was non-verbal and unable to follow commands. According to the physician's order sheet and care plan, R3 was considered "full code" which indicates all life saving measures should be performed in the event of cardiac arrest.

Fire Department run sheet dated 10/23/24 notes the facility called the fire department at 1:13am. Fire department crew reported to the bedside for assessment of R3 at 1:18am and noted R3 lying in bed on a ventilator, and unresponsive. Crew's assessment as stated in the report said R3 was deceased on arrival as evidenced by cold to touch, no palpable pulse, rigor mortis setting in, and asystole (no heart rhythm) on cardiac monitor.

The Crew obtained report from the nurse as documented: 'Nurse stated that while doing rounds R3 was noticed to have low blood sugar. The nurse gave glucagon twice, but the blood sugar kept dropping to the 30's.

Per the fire department run sheet, no resuscitation measures were performed by the facility staff or fire department crew, and fire

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department contacted the local hospital for orders. The hospital physician on-call pronounced R3's time of death at 1:30am.

Facility Policy "Hypoglycemia" (6/2015, no revision) states in part; 1. Hypoglycemia is defined as a blood glucose of less than 70. If the resident has any symptoms of hypoglycemia including pallor, clammy skin, restless sleep, hunger fatigue, headache confusion, irritability or sweatiness notify the physician. (3.) If semi-conscious, uncooperative, unable to swallow or is NPO (nothing by mouth): a. Administer 50 milliliters of D50W (Dextrose 50% in Water) (1 amp) slow IV (intravenous) push and start IV D5W (Dextrose IV solution) at 100 milliliters/hour. B. If NO IV access: Glucagon 1 milligram Subcutaneously or IM then establish an IV access and start IV D5W at 100 milliliters/hour. C. Repeat glucose check and treatment every 15 minutes until greater than 70. D. Once greater than 70, repeat blood glucose check every one hour for 3 hours to monitor for recurrence.

According to R3's electronic health record, R3 did not have intravenous access prior to the incident. Progress notes do not indicate the nurse on duty called a Registered Nurse for assistance to start intravenous access at any time during this incident.

On 11/6/24 at 2:37pm V38 LPN (Licensed Practical Nurse) said they were about 15 minutes late reporting for the 11pm to 7am shift on 10/22/23. V38 said after getting report, V38 completed visual rounds on the unit and saw R3 in bed on the ventilator, noted rise and fall of the chest and R3 did not appear to be in distress. V38 did not perform any physical assessment during this initial round. V38 said they returned to

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R3's bedside at approximately 12:30am to give medications which included insulin. When V38 took R3's blood sugar, it was noted to be low. According to V38's progress note, R3's blood sugar was 52. V38 said they gave R3 a dose of glucagon injection to increase the blood sugar and took vital signs. Vital signs as written in the progress note: Blood Pressure: 145/75, Pulse: 78 (beats per minute), Respirations: 18 (breaths per minute) and Temperature 97.5F. V38 said R3 did not have an active order for glucagon at the time, however it was "standard protocol" that in the event of low blood sugar, the glucagon medication should be given and an order from the physician would be obtained after administration. V38 said R3's primary physician was called, but V38 did not receive an answer. V38 said they could have called the telemedicine service but didn't, because it often takes "a long time" for a provider to answer the call. V38 said after giving the glucagon injection, no additional interventions were initiated while waiting for R3's physician to respond. V38 also said they did not ask any staff for assistance and did not call any other providers for guidance.

In the progress note, V38 wrote after about 15 minutes giving the glucagon injection, R3's blood sugar increased to 65, however, R3's pulse increased to 99 beats per minute, and R3 was noted to be diaphoretic (excessive sweating) and short of breath. During the interview, V38 said R3's physician didn't respond within the 15 minutes of reassessment, so V38 called 911. V38 did not stay at the bedside of R3 and was outside of the room with the paramedics arrived. V38 said when the paramedics arrived, they attached the heart monitor to R3. V38 was unaware R3 did not have a pulse until V38 was notified by the paramedics.

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S9999	Continued From page 20 11/7/24 at 1:51pm, V2 Director of Nursing said, according to the progress notes, when V38 reassessed R3's condition had not improved after giving glucagon, 911 should have been called right away. According to the facility policy "Hypoglycemia", glucagon should be given and then IV access should be established as to administer IV fluids to increase blood sugar. V2 said R3 did not have an IV access, and that considering R3 is a "hard stick" (difficult to establish IV access), 911 should have been notified immediately after giving glucagon. The facility's Medical Director (V26) was interviewed 11/7/24 at 5:42pm. V26 said when a nurse assesses the blood sugar of a patient to be significantly low (less than 70), it is expected that the nurses do their best to stabilize the patient by giving food, or intramuscular glucagon to immediately increase the blood sugar. V26 said at that time, the nurses should call 911 right away rather than wait because a continuous decrease in blood sugar could result in the resident going into a diabetic ketoacidosis, which could be potentially life threatening. 911 should be called immediately, because in the nursing facility, dextrose intravenous solution is not usually immediately on-hand. V26 was unsure if the nurses were experienced enough to provide this acute intervention. V26 said they had not been notified of this particular situation until this interview. V26 explained that in emergency cases such as this, if the primary physician was not available, V26 should be called as an alternate for immediate guidance, although V26 would prefer the nurses to use proper judgement in calling 911 during an emergency and then notifying the physician after. (AA)	S9999		