STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. BUILDING _____ B. WING _____	03/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREEMONT HEALTHCARE AND REHABILITATION CENTER	5550 HARVEST HILL RD DALLAS, TX 75230

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to immediately inform the resident: consult with the resident's physician; and if known, notify the resident's legal representative or and interested family member when there is a significant change in the resident's physical, .(i.e., deterioration in health, . in either life-threatening conditions or clinical complications); one (Resident # 19) of 5 residents whose clinical records were reviewed for diabetes. 1. LVN C failed to notify the physician or family representative when Resident #19 experienced a change in condition with a drop in his blood sugar to 49mg/dl. 2. LVN C failed to notify the physician of the resident's change in condition until after he became unresponsive approximately 1 ½ hours after the resident's blood sugar dropped. This failure to notify the physician and or family representative had the potential to affect the 24 insulin dependent diabetics of the facility. An Immediate Jeopardy was identified on [DATE] at 11:31 AM. While the Immediate Jeopardy was removed on [DATE] at 10:33 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm, that is not an immediate jeopardy, because staff were still being trained and the facility was monitoring the implementation of the Plan of Removal. Findings included: Resident #19's Face Sheet dated [DATE] was a [AGE] year old resident who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Resident #19's MDS assessment, dated [DATE] reflected Resident #19 had short tem memory problems, with moderately impaired decision making abilities. Resident #19 was able to make himself understood and he had the ability to understand others. Physician order [REDACTED].#19 was to receive the following treatment for [REDACTED].) The physician for Resident #19 also had Standing Physician order [REDACTED]. The current standing orders dated [DATE] reflected SSI (Sliding Scale Insulin) for readings below 70 mg/dl give [MEDICATION NAME] 1 amp ([MEDICATION NAME]) IM (Intramuscular) and call MD (Medical Doctor). ,[DATE] mg/dl Give Orange Juice and call the MD. These orders were provided by the Coporate Nurse as current on [DATE]. The Departmental Notes dated [DATE] reflected Resident #19 was found unresponsive between 2:45 a.m. and 3:00 a.m. with a blood sugar of 95mg/dl. LVN C placed oxygen on Resident #19, but did not initiate CPR in the absence of a pulse. According to 911 operator the call for EMS (Emergency Medical Services) was received at 3:37 a.m., arrived at the facility at 3:44 a.m. The time of death was not in the report but EMS cleared the facility at 4:33 a.m.The cause of death was sudden death due to [MEDICAL CONDITION] according to the physician written statement on [DATE]. The Departmental Notes dated [DATE] at 7:36 a.m. reflected at approximately 2:00 a.m. Resident #19 reported he was hungry and the resident was given a snack of crackers and chocolate milk. CNA D noted the resident was diaphoretic (sweating). LVN C checked the resident's blood sugar and it was 49mg/dl, LVN C gave orange juice for the low blood sugar instead or the ordered glucose tablets. LVN C did not administer glucose tablets, or the [MEDICATION NAME] by injection. In addition, LVN C failed to notify the physician of Resident #19's low blood sugar of 49 mg/dl or any other blood sugar findingsbelow 70mg/dl. The notes further reflected blood sugars were checked at 2:15 a.m. with a resulting blood sugar of 51 mg/dl and again at 2:30 a.m. with the results being 60mg/dl. The notes further reflected the resident was alert and oriented both times. The Departmental notes reflected between 2:45 a.m. and 3:00 a.m. Resident #19 was found unresponsive and blood sugar was 95. The nurse checked the code status of the resident and noted he was a full code. The facility staff called emergency services (911) at that time, left message on the physician answering service. Upon assessment unable to get vital signs. When paramedics arrived they visualized the resident and assessed his pulse and stated the resident had expired. There was no evidence in the clinical record LVN C spoke with the physician regarding the residents change in condition. On [DATE] at 6:37 p.m. during a telephone interview LVN C reflected Resident #19 was alert and oriented when his blood sugar was 49mg/dl and she gave him orange juice. LVN C revealed she checked the resident frequently and he was alert. An additional interview with LVN C on [DATE] at 2:06 p:m she was asked why she did not follow the physician's orders [REDACTED].#19 was alert and she chose to give him orange juice because he was awake and alert. LVN C was then queried if she checked the physician orders [REDACTED]. LVN C was queried regarding Resident #19's physician's standing orders for low blood sugars and she revealed if blood sugar was below 70mg/dl to give [MEDICATION NAME] IM. LVN C revealed the resident was awake. LVN C further stated it was very chaotic that night. An Immediate Jeopardy was identified on [DATE] at 11:30 a.m. The Administrator and Director of Nurses were informed of the Immediate Jeopardy on [DATE] at 11:31 a.m. Internal Investigation Report dated [DATE] the facility initiated an investigation into the alleged neglect of Resident #19. Interviews were conducted on [DATE] with involved nursing staff which included CNA D and LVN C. Review of LVN C's personnel file reflected her temporary Texas License expired on [DATE] and she no longer worked at the facility after her license expired. LVN C worked at the facility until her license expired. The facility initiated re-education of the nursing staff in the care of diabetic residents. This education included defining diabetes, sign and symptoms of high blood sugar includes: blurred vision, drowsy, frequent urination, change in behavior, vomiting, weakness, and increased thirst. Low blood sugar the symptoms include: Confusion or exhaustion, not being able to concentrate, weakness, aggression or irritability, blurred vision, nausea, sweating and shakiness. In-Services were held on [DATE], [DATE] and [DATE] to educate the staff in how to treat a diabetic resident. The facility held a QAPI (Quality Assurance Process Improvement) on [DATE] to review the incident of Resident #19's low blood sugar, treatment of [REDACTED]. The meeting determined the standing orders were to be modified to include a level of consciousness as well as a standard treatment for [REDACTED]. The surveyor reviewed five diabetic consolidated physician insulin orders which reflected the following diabetic treatments: Blood Sugars ,[DATE]mg/dl treat accordingly and Notify MD (Medical Doctor). [MEDICATION NAME] 1 mg Emergency kit inject intramuscular as needed daily for blood sugar less than 70 mg/dl if resident us unable to swallow or unconscious. On [DATE] at 5:02 p.m. during a telephone interview with the facility Medical Director, the physician was asked what did accordingly mean in the treatment of [REDACTED]. He further revealed he was working with the facility corporate nurse and the corporate Medical Director to get some standards set. On [DATE] at 6:10 p.m. in an interview with the Director of Clinical Operations she revealed changes were made based on the QAPI meeting held and clarifying physician orders [REDACTED]. We are auditing on a daily basis for high and low blood

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) sugars to ensure the physician orders [REDACTED]. On [DATE] at 6:30 p.m. the facility DON presented the surveyor with an updated Physician order [REDACTED]. Blood sugars below 70mg/dl give [MEDICATION NAME] 1 [MEDICATION NAME] and call the doctor. On [DATE] at 12:11 p.m., during a telephone interview with Resident #19's physician and the Medical Director he revealed the following regarding the treatment of [REDACTED]. If the patient is alert and awake I would expect glucose to be given. If the patient is unresponsive the [MEDICATION NAME] should be given. Do not generally give [MEDICATION NAME] to a patient who is awake and alert. The physician further revealed he understood the nurse did not follow the physician orders [REDACTED]. On [DATE] the facility was re-entered to monitor the actions in the in-services done by the facility in the treatment of [REDACTED]. The following 16 staff members were interviewed as to their understanding of the facility provided in-services: Administrator, Director of Nurses, Corporate RN, Medical Director, LVN J, RN K, LVN L, LVN M, LVN N, LVN O, LVN P, RN Q, RN S, LVN T, LVN U and RN V. All 16 staff from three shifts were found to have an understanding of what the parameters set for managing diabetics with low blood sugars were. They all understood when to notify the physician of a change in the resident's blood sugars and how to recognize symptoms of low blood sugar in diabetic residents. On [DATE] at 3:15 p.m. an interview with the Administrator regarding the managing of her staff and ensuring policies were followed she revealed the following: the facility has a daily connect meeting with nursing and we review the twenty-four hour report to pick up any changes on the residents. The Administrator further revealed the IJ occurred because the nurse did not follow the physician orders. The doctor stated we needed more up to date standards, and we are in the process of working with the Corporate Medical Director to get those standards. On [DATE] at 2:25 p.m. during an interview with the DON she revealed changes had been made to the physician orders. Blood sugars ,[DATE]mg/dl treat accordingly and notify the Doctor. Basically the in-service was to call the doctor. The DON revealed the nurses knew what accordingly meant by the in-services we had done. She further revealed the standing orders had not been changed yet. The standing orders were dated [DATE] had Standing Physician order [REDACTED]. The current standing orders dated [DATE] reflected SSI (Sliding Scale Insulin) for readings below 70 mg/dl give [MEDICATION NAME] 1 amp ([MEDICATION NAME]) IM (Intramuscular) and call MD (Medical Doctor). ,[DATE] mg/dl Give Orange Juice and call the MD. These orders were provided by the regional nurse consultant as current. The DON further revealed the Immediate Jeopardy occurred because the nurse did not follow the physician orders. According to the Resident Census and Conditions of Residents completed by the DON on [DATE] there were 24 residents which included residents who were diabetic.
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to provide services that met professional standards of quality for one (Resident # 19) of five residents whose clinical records were reviewed for diabetes. The facility failed to ensure physician's orders were followed when a diabetic resident had a low blood sugar. the blood sugar was critically low with a reading of 49 mg/dl (milligram per dilution). An Immediate Jeopardy was identified on [DATE] at 11:31 AM. While the Immediate Jeopardy was removed on [DATE] at 10:33 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm, that is not an immediate jeopardy, because staff were still being trained and the facility was monitoring the implementation of the Plan of Removal. Findings included: §217.11. Standards of Nursing Practice. The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse's license even if no actual patient injury resulted. (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: (A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice; (B) Implement measures to promote a safe environment for clients and others; (C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same . (G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices; (H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations . Resident #19's Face Sheet dated [DATE] was a [AGE] year old resident who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. The resident expired on [DATE]. The cause of death was sudden death due to [MEDICAL CONDITION]. Resident 19's MDS assissment, dated [DATE] reflected Resident #19 had short tem memory problems, with moderately impaired decision making abilities. Resident #19 was able to make himself understood and he had the ability to understand others. Physician Orders dated [DATE] reflected Resident #19 was to receive the following treatment for [REDACTED].) The physician for Resident #19 also had Standing Physician Orders for blood sugar ranges. The current standing orders dated [DATE] reflected SSI (Sliding Scale Insulin) for readings below 70 mg/dl give [MEDICATION NAME] 1 amp ([MEDICATION NAME]) IM (Intramuscular) and call MD (Medical Doctor). ,[DATE] mg/dl Give Orange Juice and call the MD. These orders were provided by the Coporate Nurse as current. The Departmental Notes dated [DATE] at 7:36 a.m. reflected at approximately 2:00 a.m. Resident #19 reported he was hungry and the resident was given a snack (crackers) and chocolate milk. CNA D noted the resident was diaphoretic (sweating). LVN C checked the resident ' s blood sugar and it was 49mg/dl and orange juice was given. LVN C did not administer [MEDICATION NAME] and notify the physician. The notes further reflected blood sugars were checked at 2:15 a.m. with a resulting blood sugar of 51 mg/dl and again at 2:30 a.m. with the results were 60mg/dl. It was noted in the notes the resident was alert and oriented both times. The Departmental notes reflected between 2:45 a.m. and 3:00 a.m. Resident #19 was found unresponsive and blood sugar was 95. The facility staff called emergency services (911). On [DATE] at 6:37 p.m. during a telephone interview LVN C revealed Resident #19 was alert and oriented when his blood sugar was 49mg/dl and she gave him orange juice. LVN C revealed she checked the resident frequently and he was alert. On [DATE] at 2:06 p.m. during a telephone interview with LVN C she was asked why she did not follow the physician's orders and she stated the Resident #19 was alert and she chose to give him orange juice because he was awake and alert. LVN C was then queried if she checked the physician orders for treatment or called the physician and she stated she had not. LVN C was queried regarding Resident #19's physician's standing orders for low blood sugars and she revealed if blood sugar was below 70mg/dl to give [MEDICATION NAME] IM. LVN C revealed the resident was awake. LVN C further stated it was very chaotic that night. The following 16 staff members were interviewed as to their understanding of the facility provided in-services: Administrator, Director of Nurses, Corporate RN, Medical Director, LVN J, RN K, LVN L, LVN M, LVN N, LVN O, LVN P, RN Q, RN S, LVN T, LVN U and RN V. All 16 staff from three shifts were found to have an understanding of what the parameters set for managing diabetics with low blood sugars were. They all understood when to notify the physician of a change in the resident's blood sugars and how to recognize symptoms of low blood sugar in diabetic residents. On [DATE] at 3:15 p.m. an interview with the Administrator regarding the managing of her staff and ensuring policies were followed she revealed the following: the facility has a daily meeting with nursing and we review the twenty-four hour report to pick up any changes on the residents. The Administrator further revealed the IJ occurred because the nurse did

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F 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) not follow the physician orders. The doctor stated we needed more up to date standards, and we are in the process of working with the Corporate Medical Director to get those standards. The Resident Census and Conditions of Residents dated [DATE] reflected there were 105 residents.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to provide the necessary care and services to attain physical, well-being, in accordance with the comprehensive assessment and plan of care for one (Resident # 19) of 5 residents whose clinical records was reviewed for diabetes. 1. LVN C failed to follow physician's orders [REDACTED]. The blood sugar was low with a reading of 49 mg/dl -normal levels (70mg/dl to 110mg/dl). The physician orders [REDACTED]. The physician's standing orders (orders given by the physician for all diabetic residents who may experience high or low blood sugars) reflected,for readings below 70 mg/dl give [MEDICATION NAME] 1 amp ([MEDICATION NAME]) IM (Intramuscular) and call MD (Medical Doctor). For reading between ,[DATE] mg/dl, give orange juice and call the MD. 2. LVN C failed to consult the physician of the resident's change in condition until after he became unresponsive approximately 1 ½ and hours after the resident's blood sugar dropped and subsequently expired at that time. 3. The facility failed to ensure 5 of 5 current diabetic resident was thoroughly assessed, and treated as the physician directed. There is a potential for the 24 diabetic resident's of the facility to be affected. An Immediate Jeopardy was identified on [DATE] at 11:31 AM. While the Immediate Jeopardy was removed on [DATE] at 10:33 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm, that is not an immediate jeopardy, because staff were still being trained and the facility was monitoring the implementation of the Plan of Removal. Findings included: Resident #19's Face Sheet dated [DATE], reflected the resident was a [AGE] year old male admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. The Departmental Notes dated [DATE] reflected Resident #19 was found unresponsive between 2:45 a.m. and 3:00 a.m. with a blood sugar of 95mg/dl. LVN C placed oxygen on Resident #19, but did not initiate CPR in the absence of a pulse. According to 911 operator the call for EMS (Emergency Medical Services) was received at 3:37 a.m., arrived at the facility at 3:44 a.m. The time of death was not in the report but EMS cleared the facility at 4:33 a.m.The cause of death was sudden death due to [MEDICAL CONDITION] according to the physician written statement on [DATE]. Resident #19's MDS assessment, dated [DATE] two days after the resident expired reflected Resident #19 had short term memory problems, with moderately impaired decision making abilities. Resident #19 was able to make himself understood and he had the ability to understand others. MDS assessment dated [DATE] reflected the following Diagnoses: [REDACTED]. physician's orders [REDACTED].#19 was to receive the following treatment for [REDACTED].) The physician for Resident #19 also had Standing Physician order [REDACTED]. The current standing orders dated [DATE] reflected the following: SSI (Sliding Scale Insulin) for readings below 70 mg/dl give [MEDICATION NAME] 1 amp ([MEDICATION NAME]) IM (Intramuscular) and call MD (Medical Doctor). ,[DATE] mg/dl Give Orange Juice and call the MD. These orders were provided by the regional nurse consultant as current on [DATE]. The Departmental Notes dated [DATE] at 7:36 a.m. reflected at approximately 2:00 a.m. Resident #19 reported he was hungry and the resident was given a snack of crackers and chocolate milk. CNA D noted the resident was diaphoretic (sweating). LVN C checked the resident's blood sugar and it was 49mg/dl, LVN C gave orange juice for the low blood sugar instead of the ordered glucose tablets. LVN C did not administer glucose tablets, or the [MEDICATION NAME] by injection. In addition, LVN C failed to notify the physician of Resident #19's low blood sugar of 49 mg/dl or any other blood sugar findings. The notes further reflected blood sugars were checked at 2:15 a.m. with a resulting blood sugar of 51 mg/dl and again at 2:30 a.m. with the results being 60mg/dl. The notes further reflected the resident was alert and oriented both times. The Departmental notes reflected between 2:45 a.m. and 3:00 a.m. Resident #19 was found unresponsive and blood sugar was 95mh/dl. The nurse checked the code status of the resident and noted he was a full code. The facility staff called emergency services (911) at that time, left message on the physician answering service. Upon assessment unable to get vital signs. When paramedics arrived they visualized the resident and assessed his pulse and stated the resident had expired. On [DATE] the facility contacted 911 and according to 911 operator the call for EMS (Emergency Medical Services) on [DATE] was received at 3:37 a.m., EMS arrived at the facility at 3:44 a.m. The time of death was not in the report but EMS cleared the facility at 4:33 a.m. The Medical Director in a hand written note dated [DATE] documented cause of death was sudden death due to [MEDICAL CONDITION]. On [DATE] at 6:37 p.m. during a telephone interview LVN C revealed Resident #19 was alert and oriented when his blood sugar was 49mg/dl and she gave him orange juice. LVN C revealed she checked the resident frequently and he was alert. An additional telephone interview with LVN C on 03 /,[DATE] at 2:06 p.m. LVN C she was asked why she did not follow the physician's orders [REDACTED].#19 was alert and she chose to give him orange juice because he was awake and alert. LVN C was then queried if she checked the physician orders [REDACTED]. LVN C was queried regarding Resident #19's physician's standing orders for low blood sugars and she revealed if (blood sugar was below 70mg/dl to give [MEDICATION NAME] IM). LVN C revealed the resident was awake. LVN C further stated it was very chaotic that night. On [DATE] at 6:39 p.m. during a telephone interview, CNA D revealed Resident #19 told her he was hungry,after talking with LVN C, she got him a snack of crackers and chocolate milk. According to CNA D, the following events occurred with Resident #19: the resident spilled the milk and I went to clean him up and noticed he was diaphoretic (sweating) and told the nurse to come quick. The nurse checked his blood glucose several times and CNA D stated it was (50, 60, then 95). The resident went to sleep. Later, when I went to the resident's room to empty his trash, I noticed he was breathing. Later the nurse went in and said he was unresponsive. The other nurse came and felt a carotid pulse. The nurses were about to start CPR when the paramedics came in. On [DATE] review of personnel records for LVN C reflected her temporary Texas Nursing License expired on [DATE]. At approximately 3:00 p.m. The Administrator was asked about LVN C. The Administrator revealed LVN C had not worked in the facility since her license had expired. She did however work the week-end prior to [DATE]. In-services were conducted on [DATE] for LVN C regarding glucose monitoring, signs and symptoms of low blood sugars. Immediate Jeopardy was identified on [DATE]. The Administrator and Director of Nurses were identified of the Immediate Jeopardy on [DATE] at 11:31 a.m. Internal Investigation Report dated [DATE] the facility initiated an investigation into the allegation of neglect of Resident #19. Interviews were conducted on [DATE] with involved nursing staff which included CNA D and LVN C. Review of LVN C's personnel file reflected her temporary Texas License expired on [DATE] and she no longer worked at the facility after her license expired. The facility initiated re-education of the nursing staff in the care of diabetic residents. This education included defining diabetes, sign and symptoms of high blood sugar includes: blurred vision, drowsy, frequent urination, change in behavior, vomiting, weakness, and increased thirst. Low blood sugar the symptoms include: Confusion or exhaustion, not being able to concentrate, weakness, aggression or irritability, blurred vision, nausea, sweating and shakiness. In-Services were held on [DATE], [DATE] and [DATE] to educate the staff in how to treat a diabetic resident. On [DATE] at 3:00p.m. an in-service was conducted on recognizing low blood sugars by the DON and 26 licensed nurses attended the training. On0 [DATE] at 2:00 p.m. an in-service was given by the DON regarding diabetic care, which included a change in condition. Twenty- six licensed staff attended the meeting. On [DATE] at 4:00p.m. an in-service was given by the DON regarding availability of glucose tablets. Twenty one licensed staff attendede the training. On [DATE] at 4:00p.m.an in-service was given by the DON regarding availability of glucose tablets, overview of diabetes and timely notification of the physician when a change in condition occurs. Eighteen licensed staff attended the training.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) Review of the Facility Provider Report dated [DATE] reflected the facility held a QAPI (Quality Assurance Process Improvement) on [DATE] to review the incident of Resident #19's low blood sugar, treatment of [REDACTED]. The meeting determined the standing orders were to be modified to include a level of consciousness as well as a standard treatment for [REDACTED]. The surveyor reviewed five diabetic consolidated physician insulin orders which reflected the following diabetic treatments: Blood Sugars ,[DATE]mg/dl treat accordingly and Notify MD (Medical Doctor). [MEDICATION NAME] 1 mg Emergency kit inject intramuscular as needed daily for blood sugar less than 70 mg/dl if resident us unable to swallow or unconscious. On [DATE] at 5:02 p.m. during a telephone interview with the facility Medical Director, the physician was asked what did accordingly mean in the treatment of [REDACTED]. He further revealed he was working with the facility corporate nurse and the corporate Medical Director to get some standards set. On [DATE] at 6:10 p.m. in an interview with the Director of Clinical Operations she revealed changes were made based on the QAPI meeting held and clarifying physician orders [REDACTED]. We are auditing on a daily basis for high and low blood sugars to ensure the physician orders [REDACTED]. On [DATE] at 6:30 p.m. the facility DON presented the surveyor with an updated Physician order [REDACTED]. Blood sugars below 70mg/dl give [MEDICATION NAME] 1 [MEDICATION NAME] and call the doctor. On [DATE] at 12:11 p.m., during a telephone interview with Resident #19's physician who was also the Medical Director revealed the following regarding the treatment of [REDACTED]. If the patient is alert and awake I would expect glucose to be given. If the patient is unresponsive the [MEDICATION NAME] should be given. Do not generally give [MEDICATION NAME] to a patient who is awake and alert. The physician further revealed he understood the nurse did not follow the physician orders [REDACTED]. The following 16 staff members were interviewed as to their understanding of the facility provided in-services: Administrator, Director of Nurses, Corporate RN, Medical Director, LVN J, RN K, LVN L, LVN M, LVN N, LVN O, LVN P, RN Q, RN S, LVN T, LVN U and RN V. All 16 staff from three shifts were found to have an understanding of what the parameters set for managing diabetics with low blood sugars were. They all understood when to notify the physician of a change in the resident's blood sugars and how to recognize symptoms of low blood sugar in diabetic residents. On [DATE] at 3:15 p.m. an interview with the Administrator regarding the managing of her staff and ensuring policies were followed she revealed the following: the facility has a daily meeting with nursing and we review the twenty-four hour report to pick up any changes on the residents. The Administrator further revealed the IJ occurred because the nurse did not follow the physician orders. The doctor stated we needed more up to date standards, and we are in the process of working with the Corporate Medical Director to get those standards. On [DATE] at 2:25 p.m. during an interview with the DON she revealed changes had been made to the physician orders. Blood sugars ,[DATE]mg/dl treat accordingly and notify the Doctor. Basically the in-service was to call the doctor. The DON revealed the nurses knew what accordingly meant by the in-services we had done. She further revealed the standing orders had not been changed yet. The standing orders were dated [DATE] had Standing Physician order [REDACTED]. The current standing orders dated [DATE] reflected SSI (Sliding Scale Insulin) for readings below 70 mg/dl give [MEDICATION NAME] 1 amp ([MEDICATION NAME]) IM (Intramuscular) and call MD (Medical Doctor). ,[DATE] mg/dl Give Orange Juice and call the MD. These orders were provided by the regional nurse consultant as current. The DON further revealed the Immediate Jeopardy occurred because the nurse did not follow the physician orders. According to the Resident Census and Conditions of Residents completed by the DON on [DATE] there were 24 residents which included residents who were diabetic.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure the medication error rate was less than 5 percent. Twenty-nine opportunities were observed with a total of five errors, resulting in a 17 percent error rate. Two (MA A and MA B) of four staff observed administering medication made errors. Five (Residents #5, #8, #22, #23, and #24) of nine residents observed during the medication pass were affected. 1) MA A failed to administer Carvedilol (for the treatment of [REDACTED].#5. 2) MA A failed to administer [MEDICATION NAME] (for the control of blood sugar in residents with Diabetes Mellitus)at the physician - ordered time for Resident #22. 3) MA A failed to administer [MEDICATION NAME] (for the treatment of [REDACTED].#23. 4. MA B failed to administer Refresh PM 42.5% - 57.3% ointment (an eye lubricant for the treatment of [REDACTED].#8. 5. MA B failed to administer [MEDICATION NAME] (reduces muscle spasms of the bladder and urinary tract in residents with Overactive Bladder) at the physician-ordered time for Resident #24. These failures could affect the 62 residents, including Residents #5, #8, #22, #23, and #24 who resided on the Second Floor Unit and for whom MA A and MA B were responsible for passing medications during the 2 PM to 10 PM shift and the 6 AM to 2 PM shift, respectively. These failures placed these 62 residents at risk for not receiving the full therapeutic benefits from medication. Findings included: 1) An observation of the evening medication pass was conducted on 03/11/15. The following observations of MA A were made: a. At 3:38 PM, MA A prepared and administered one medication, 3.25 milligrams of Carvedilol ([MEDICATION NAME]) for Resident #5. During reconciliation of the medication pass, Resident #5's March 2015 consolidated physician orders [REDACTED]. Review of Resident #5's March 2015 MAR indicated [REDACTED]. The 12th Edition of the Geriatric Dosage Handbook, 2007, page 238, reflected the following information on [MEDICATION NAME] under the section titled Administration: Administer with food. Under the section titled Patient Information: Should be taken with food to minimize the risk of [MEDICAL CONDITION]. b. At 3:42 PM, MA A prepared and administered one medication, 500 milligrams of [MEDICATION NAME] for Resident #22. During reconciliation of the medication pass, Resident #22's March 2015 consolidated physician orders [REDACTED]. Review of Resident #22's March 2015 MAR indicated [REDACTED]. The 12th Edition of the Geriatric Dosage Handbook, 2007, page 978, reflected the following information on [MEDICATION NAME] under the section titled Patient Information: Take with meals to minimize gastrointestinal symptoms . c. At 3:45 PM, MA A prepared and administered one medication, five milligrams of [MEDICATION NAME], for Resident #23. During reconciliation of the medication pass, Resident #23's March 2015 consolidated physician orders [REDACTED]. Review of Resident #23's March MAR indicated [REDACTED]. The 12th Edition of the Geriatric Dosage Handbook, 2007, page 1004, reflected the following information on [MEDICATION NAME] under the section titled Patient Information: Take medication 30 minutes before meals . 3. The supper meal was observed to start at 5:38 PM on the second floor unit when the first meal tray cart arrived. Therefore, Resident #5 received her Carvedilol at least two hours before the physician - ordered time; Resident #22 received his [MEDICATION NAME] at least one hour and 56 minutes before the physician - ordered time; and Resident #23 received her [MEDICATION NAME] at least on hour and 23 minutes before the physician - ordered time. 4) An observation of the morning medication pass was conducted on 03/12/15. MA B was observed to prepare and administer nine medications for Resident #8 between 8:14 AM and 8:36 AM: At 8:14 AM, MA B administered: [MEDICATION NAME] (an opioid [MEDICATION NAME]); Ramipril (for the treatment of [REDACTED].#8's eye, she commented, This is the Refresh. MA B then waited until 8:36 AM to administer the [MEDICATION NAME] eye drops to Resident #8's left eye as she had administered an ointment to the left eye at 8:14 AM(Altalube). At the same time, she also also administered [MEDICATION NAME] (for the treatment of [REDACTED].#8. At 8:36 AM on 03/12/15, MA B was asked and stated she had given all of Resident #8's medication for the morning medication pass. Pharmacist E with the facility-contracted pharmacy was contacted on 03/12/15 at 10:43 AM. Pharmacist E stated Altalube was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. BUILDING _____ B. WING _____	**03/23/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREEMONT HEALTHCARE AND REHABILITATION CENTER	**5550 HARVEST HILL RD DALLAS, TX 75230**

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

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F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) the same as Artificial Tears but Altalube was not equivalent to Refresh PM. During the reconciliation of the medication pass, the March 2015 consolidated physician orders [REDACTED]. An order was discovered for Refresh P.M. 42.5% - 57.3% ointment. Instill 1 drop 4 times daily in each eye . At 11:20 AM on 03/12/15, the Director of Nursing and the Corporate RN were informed the Refresh P. M. order needed clarification regarding did the prescriber want Resident #8 to receive the ointment or drops. In addition, they were informed that MA B thought the Altalube was Refresh PM when she administered the Altalube. At 2:11 PM the Director of Nursing provided a clarification order dated 03/12/15 which reflected the prescriber wanted a quarter inch strip of Refresh PM applied to Resident #8's left eye four times daily. The DON stated the prescriber informed her Refresh PM was not the same as Altalube and Resident #8 had orders to receive both. 5. At 8:31 AM on 03/12/15, MA B was observed to prepare and administer ten medications including five milligrams of [MEDICATION NAME], to Resident #24. During the reconciliation of the medication pass, the March 2015 consolidated physician orders [REDACTED]. The order for [MEDICATION NAME] reflected Resident #24 was to receive the medication at bedtime. A review of Resident #24's March 2015 MAR indicated [REDACTED] 6) Review of the 03/11/15 Census List provided by facility administration on the same date following the entrance conference, reflected there were 105 residents in the facility and 62 resided on the Second Floor Unit.