STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676212	A. BUILDING _____ B. WING _____	04/11/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLEGE PARK REHABILITATION AND CARE CENTER	1715 MARTIN DR WEATHERFORD, TX 76086

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to be free from neglect for one (Resident #1) of eleven residents reviewed for neglect. The facility failed to have an RN available to supervise RN A, as ordered by the Board of Nursing, who could have intervened and provided emergency care to Resident #1. As a result of this failure, RN A failed to contact the physician, stay with Resident #1, and contact EMS when the resident's blood sugar level was critically low, her condition did not respond to the [MEDICATION NAME] (emergency medication used to increase a person's blood sugar) and the resident was unresponsive. Forty minutes after Resident #1 was found she was transferred to the hospital on [DATE]. She remained unresponsive and was placed on life support. Resident #1 did not become responsive again and expired on [DATE] after being taken off life support. An Immediate Jeopardy was identified on [DATE] as beginning on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. This failure placed the 25 diabetic residents on Halls 100, 200, and 300 where RN A worked at risk of serious physical harm, injury, and/or death. Findings included: Review of Resident #1's closed record revealed an MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year old female who was admitted to the facility on [DATE]. Her admitting [DIAGNOSES REDACTED]. Resident #1 required extensive assistance of two people for activities of daily living. Review of her Care Plan dated [DATE] reflected there was not a care plan regarding her diabetes. Review of Resident #1's (MONTH) physician's orders [REDACTED]. [DATE]: Inject 20 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 30 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 40 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Give 500 mg of [MEDICATION NAME] (medication used to help control and lower blood sugars) twice a day by mouth. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of Resident #1's nurse's note documented by RN A on [DATE] at 3:14 a.m. reflected Resident #1 became unresponsive to stimuli. Skin was cool to touch and clammy. Resident #1 had frothy secretions coming out of her mouth. Head was repositioned to prevent aspiration. FSBS (Finger Stick Blood Sugar) was taken and was noted to be 21 mg/dl. Resident #1's vital signs were noted to be the following: 95.8 temperature, 79 heart rate, 20 respirations per minute, and her blood pressure was ,[DATE]. Continue to monitor closely. According to https://medlineplus.gov/ency/article/ 6.htm, obtained on [DATE], Low blood sugar is a condition that occurs when the body's blood sugar (glucose) decreases and is too low. Blood sugar below 70 mg/dL (3.9 mmol/L) is considered low. Blood sugar at or below this level can be harmful. Review of Resident #1's MAR for (MONTH) (YEAR) reflected the following order: Inject 1 mg of [MEDICATION NAME] intramuscularly as needed for low blood sugar (if blood sugar is less than 60 and resident is unresponsive) which had a start date of [DATE] at 3:10 a.m. and had been put on the MAR by RN A. There was not a signed physician's orders [REDACTED]. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of [MEDICATION NAME]'s Information page for physicians accessed at http://uspl.lilly.com/[MEDICATION NAME]/[MEDICATION NAME].html#pi on [DATE] at 12:49 p.m. reflected the following: [MEDICATION NAME] is indicated as a treatment for [REDACTED]. If the response is delayed .emergency aid should be sought so that [MEDICATION NAME] (route other than oral which is usually either intramuscularly, subcutaneous, or intravenous) glucose can be given. Review of Resident #1's nurse's note documented by RN A on [DATE] at 4:40 a.m. reflected Resident #1 remained unresponsive to stimuli, and her eyes appeared to be rolled back after being given [MEDICATION NAME] at 3:15 a.m. FSBS rechecked at 3:25 a.m. and noted to be at 40 and at 3:45 a.m. at 59. Resident #1 did not arouse to sternum rub. EMS (Emergency Medical Services) was notified at 3:55 a.m. When paramedics arrived to facility, IV was started in left arm and [MEDICATION NAME] at 10% hung and infused. Resident #1 was transferred to the stretcher and taken to ambulance at 4:30 a.m. to be transported to the ER. The notes also reflected the RN was unable to contact the resident's family. No additional vital signs were recorded. Review of Resident #1's Emergency Department Admission reflected her date of admission was [DATE]. The record reflected Resident #1 arrived to the emergency roiagnom on [DATE] at 4:48 a.m. Resident #1 presented with decreased responsiveness and possible cause was listed as low blood sugar. Resident #1 was intubated on [DATE] at 5:08 a.m. and was put on a ventilator to assist with breathing and was admitted to the ICU. Review of the Hospital's Physician Notes reflected that on [DATE], Resident #1 was still on the ventilator and had been off sedation for 24 hours but remained unresponsive and the family requested terminal extubation (The withdrawal of mechanical ventilation from critically ill patients who are not expected to survive without respiratory support.) Resident #1 was discharged from the hospital on [DATE] with hospice services. Resident #1 remained unresponsive and her prognosis was poor. Interview with Resident #1's family on [DATE] at 10:30 a.m. revealed Resident #1 expired on [DATE]. He stated she never woke up after the low blood sugar incident, so he made the difficult decision to take her off life support and take her home. He stated Resident #1's blood sugar went low every once in a while, but it had never gotten as low as 21. Interview with RN A on [DATE] at 11:43 a.m. revealed on [DATE] around 3:15 a.m CNA B told her Resident #1 was not acting right. She stated she went down to Resident #1's room and found her unresponsive and cold and clammy. She stated she took Resident #1's vital signs and knew she was a diabetic so she took her blood sugar. Resident #1's blood sugar was 21. She stated she realized the resident was hypoglycemic (when a resident has low blood sugar). She stated she knew the resident had an order for [REDACTED].#1's room at that time, even though the resident was still unresponsive. RN A stated she came back about ten minutes later and rechecked her blood sugar and it was 40. She stated she left the room at that time and Resident #1 was still unresponsive at that time. She stated she came back about 20 minutes later and took her blood sugar again and it was 59. She stated the resident was still unresponsive so she decided at that point she should send Resident

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

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COLLEGE PARK REHABILITATION AND CARE CENTER	1715 MARTIN DR WEATHERFORD, TX 76086

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) #1 to the hospital. RN A revealed she called 911 and went back to the room and stayed with the resident until the paramedics arrived. She stated the resident remained unresponsive and when EMS arrived, the paramedics started an IV but Resident #1 was still completely unresponsive. RN A stated EMS transferred Resident #1 to the stretcher and the resident started to groan, but other than that she was still out of it. RN A stated she never called the physician during the 45 minutes between finding the resident unresponsive and sending her to the hospital. RN A stated she left a message for the doctor after Resident #1 was sent to the hospital. She stated she did not remember notifying the DON or any administrative staff about the incident, but she did record the incident on the 24 hour report for the upcoming shift. RN A stated if she could go back and change things, she would have given the [MEDICATION NAME] and after a few minutes when it had not worked, she would have called 911. She stated she also would have called the doctor sooner to see what he wanted her to do. She stated she did not know why she waited so long to call 911, but she cannot go back and change it. Interview with CNA B on [DATE] at 10:30 p.m. revealed she was RN A's aide the night of the incident on [DATE]. She revealed she came into work around 10:00 p.m. and started her initial rounds. She said she remembered Resident #1's family was still there and Resident #1 was alert and talking. She stated Resident #1's family left a little after midnight. When she began her second round around 1:30 a.m. she noticed Resident #1 was very pale and had some white stuff coming from her mouth. CNA B stated she went to get RN A and asked her to go assess Resident #1 because something was not right. RN A told her she would go look at Resident #1 in a minute. CNA B continued on her rounds with other residents and went back to check on Resident #1 around 2:00 a.m. CNA B stated Resident #1 was still very pale and appeared to be unconscious because she was not waking up. She asked RN A to go look at Resident #1 again and RN A went down to Resident #1's room and looked at the resident but did not take vital signs or anything. RN A told her she had the situation handled, so she went back to care for other residents. CNA B went back to check on Resident #1 again around 2:30 a.m. and noticed Resident #1 was still pale and was not waking up. CNA B asked RN A what was going on with the resident and RN A told her that Resident #1 was going to be okay but to just keep an eye on her. At that point, she went and got CNA C to go look at Resident #1 with her. CNA B stated the time was probably around 3:00 a.m. CNA B and CNA C went down to check on the resident and she was still the same way. Resident #1 was unresponsive, pale, and still frothing at the mouth. CNA B revealed they asked LVN D to come and look at the resident, because RN A was not helping. At that point, RN A got up with them and went down to look at the resident. RN A told LVN D to not go into the room. RN A took Resident #1's vital signs and said her blood sugar was really low. RN A told her (CNA B) she had it handled, so she finished her rounds. CNA B revealed after a while, probably close to 4:00 a.m., she finally saw the paramedics arrive. She stated Resident #1 looked exactly the same. She was still unresponsive and finally around 4:30ish, the paramedics told RN A that it was just better if they took Resident #1 to the hospital. Attempt to interview LVN D was made on [DATE] at 10:44 a.m. but LVN D's phone number was not working. Interview with LVN E on [DATE] at 11:40 a.m. revealed she was one of the other nurses the night of the incident. She revealed LVN D told her CNA B had asked her to go look at Resident #1 because she was looking bad and RN A told her she had it handled. LVN E stated she remembered CNA B coming up to the desk, a little after midnight, a few times throughout the night asking RN A to go look at Resident #1. LVN E stated RN A never let them know what was going on with her residents and ignored aides' concerns regularly. Interview with the DON on [DATE] at 11:43 a.m. revealed she knew Resident #1 had been sent to the hospital, but did not remember why. Once she reviewed RN A's nurse's notes, she stated RN A should not have waited so long to call emergency services. She stated RN A should have called 911 when she found Resident #1 completely unresponsive. The DON stated she did not investigate the incident or ask RN A what happened. She revealed they had not done any in-services with staff regarding changes in conditions or blood sugar checks since the incident. Interview with ADON F on [DATE] at 1:15 p.m. revealed the ADON over RN A's hall that night was no longer employed with the facility, but ADON F did remember the other ADONs and the DON discussed the reason for discharge of Resident #1 the next day during morning meeting. Review of RN A's license on the Board of Nursing website on [DATE] at 12:45 p.m. reflected RN A's nursing license was on probation. Review of the Agreed Order from the Texas Board of Nursing reflected on or about [DATE], while employed at the same facility, she failed to initiate cardio-pulmonary resuscitation (CPR) after finding a resident unresponsive with no respirations or pulse and instead went to check his code status. RN A's conduct resulted in an unnecessary delay in care and was likely to injure the resident, including possible demise from lack of timely interventions and appropriate nursing care. Review of the Agreed Order from the Texas Board of Nursing reflected RN A was to be supervised by another RN who is on the premises. The supervising RN was not required to be on the same unit or ward, but should be on facility grounds and readily available to provide assistance and intervention if necessary. Review of RN A's employee file reflected a Notification of Employment dated [DATE] and signed by the Corporate Director of Clinical Services which stated the following: I have received a complete copy of the Order of the Board and am aware of the stipulations placed on this license by the Texas Board of Nursing. I agree to notify the Board's office and provide information to the Board regarding this nurse's resignation or termination. Review of the staff schedule and sign in sheet since [DATE] reflected RN A worked 24 10pm-6am shifts, including [DATE], without another RN in the building and readily available for supervision. Further review of the sign in sheets revealed RN A had worked on Halls 100, 200, and 300. Review of RN A's job description signed on [DATE] by RN A reflected the following: Initiates emergency support measures . Emergency situations are recognized and appropriate action is instituted. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they were aware RN A was on probation and was to be under the supervision of another RN. The Administrator stated he was the Administrator of the building during the prior incident with RN A when she did not perform CPR on another resident. He stated he was willing to give her a second chance. The DON stated RN A could always call her for advice but she was not on facility grounds as her supervision the night of the incident. Interview with the Administrator on [DATE] at 11:20 a.m. revealed RN A had originally been on the 2pm-10pm shift when they had learned of her probation in (MONTH) (YEAR). He stated RN A then switched to the night shift in December. He stated he was under the impression RN A would be on the same 4 on 2 off schedule (work four days and they are off for two days) as the other RN on night shift, so she could provide supervision. He stated because of their mistake, RN A worked over 20 night shifts since (MONTH) without another RN supervising her according to her probation terms. Review of the facility's Change in Resident's Condition or Status Policy revised in (MONTH) (YEAR) reflected the following: The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. An accident or incident involving the resident .d. A significant change in the resident's physical/emotional/mental conditions . A 'significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . Review of the facility's undated Abuse/Neglect policy reflected the following: Definition of 'Neglect' 'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Signs of/Actual Neglect . 6. Inadequate provision of care . 9. Leaving someone unattended who need supervision.An Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator and DON were informed of the IJ on [DATE] at 1:40 p.m. and a Plan of Removal was requested at that time. The facility's Plan of Removal accepted on [DATE] reflected: Staff will be in-serviced by Corporate Director of Clinical Operations on [DATE] on neglect policy, and to never leave a resident unattended during an emergency. Current staff will be in-serviced today, both day and evening. Night, weekend, and PRN staff will be in-serviced prior to shift. No one will work without having received information. The Plan of Removal will be used for in-service. One hundred percent audit was completed on [DATE] on all residents requiring blood glucose monitoring. Orders were reviewed

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) for high/low parameters and notification of MD Clinical staff were in-serviced by Corporate Director of Clinical Operations on [DATE] on change in resident's condition or status policy. If a resident is found in distress, the charge nurse will notify the resident's attending physician and DON. The nurse will make detailed observations and gather pertinent information utilizing the SBAR assessment. Corporate Director of Clinical Operations in-serviced nursing staff on [DATE] on best nursing practice of using [MEDICATION NAME] injection. If resident continues to be unresponsive after 15 minutes of injection, EMS will be called for additional intervention. Competency checks will be performed on staff for the above in-services on [DATE] and [DATE]. Change in condition policy will be included in all orientations going forward, with included post-test. DON will monitor SBAR assessments that are written for a resident change in condition. Nurse who demonstrated poor judgment during the episode in question was suspended and terminated on [DATE]. Monitoring the Plan of Removal: Interviews with CNA G, LVN H, and CNA B on [DATE] at 10:05 p.m. through 10:30 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in conditions and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interviews with LVN J, LVN K, LVN L, CNA M, CNA N, CNA O, and CNA P on [DATE] between 1:00 p.m. through 2:00 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in condition and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they believed the immediate jeopardy occurred because RN A left a resident alone who was unresponsive and in a state of emergency and did not notify the physician. RN A did not call 911 when the [MEDICATION NAME] did not work. The Administrator stated they should have caught the situation but RN A had not documented the incident correctly. When asked what they would do differently to prevent another IJ, the Administrator stated they would no longer hire nurses who were on probation with the board of nursing. The DON stated they started doing SBAR forms (forms used by nurses when a change in condition is noted) and she would review them all. They both revealed they had been in-serviced over the abuse/neglect policy and reportable events. On [DATE], the Immediate Jeopardy (IJ) was removed. On [DATE] at 4:15 p.m., DON and the Corporate Director of Operations were informed the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. Review of the list of diabetic residents from the DON and dated [DATE] reflected there were 25 diabetic residents who resided on Halls 100, 200, and 300 where RN A worked.
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its written policies and procedures that prohibit and prevent neglect for one (Resident #1) of 11 residents reviewed for neglect. 1. The facility failed to have an RN available to supervise RN A, as ordered by the Board of Nursing, who could have intervened and provided emergency care to Resident #1. As a result of this failure, RN A failed to contact the physician, stay with Resident #1, and contact EMS when the resident's blood sugar level was critically low, her condition did not respond to the [MEDICATION NAME] (emergency medication used to increase a person's blood sugar) and the resident was unresponsive. Forty minutes after Resident #1 was found she was transferred to the hospital on [DATE]. She remained unresponsive and was placed on life support. Resident #1 did not become responsive again and expired on [DATE] after being taken off life support. 2. The Administrator and DON failed to identify the neglect by RN A and failed to investigate and report to the State Agency when Resident #1 experienced a significant change in condition related to her blood sugar and level of consciousness. An Immediate Jeopardy was identified on [DATE] as beginning on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. This failure placed the 25 diabetic residents on Halls 100, 200, and 300 where RN A worked at risk of serious physical harm, injury, and/or death. Findings included: Review of the facility's Change in Resident's Condition or Status Policy revised in (MONTH) (YEAR) reflected the following: The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. An accident or incident involving the resident .d. A significant change in the resident's physical/emotional/mental conditions . A 'significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . Review of the facility's undated Abuse/Neglect policy reflected the following: Definition of 'Neglect' 'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Signs of/Actual Neglect . 6. Inadequate provision of care . 9. Leaving someone unattended who need supervision. Review of Resident #1's closed record revealed an MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year old female who was admitted to the facility on [DATE]. Her admitting [DIAGNOSES REDACTED]. Resident #1 required extensive assistance of two people for activities of daily living. Review of her Care Plan dated [DATE] reflected there was not a care plan regarding her diabetes. Review of Resident #1's (MONTH) physician's orders [REDACTED]. [DATE]: Inject 20 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 30 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 40 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Give 500 mg of [MEDICATION NAME] (medication used to help control and lower blood sugars) twice a day by mouth. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of Resident #1's nurse's note documented by RN A on [DATE] at 3:14 a.m. reflected Resident #1 became unresponsive to stimuli. Skin was cool to touch and clammy. Resident #1 had frothy secretions coming out of her mouth. Head was repositioned to prevent aspiration. FSBS (Finger Stick Blood Sugar) was taken and was noted to be 21 mg/dl. Resident #1's vital signs were noted to be the following: 95.8 temperature, 79 heart rate, 20 respirations per minute, and her blood pressure was ,[DATE]. Continue to monitor closely. According to https://medlineplus.gov/ency/article/ 6.htm, obtained on [DATE], Low blood sugar is a condition that occurs when the body's blood sugar (glucose) decreases and is too low. Blood sugar below 70 mg/dL (3.9 mmol/L) is considered low. Blood sugar at or below this level can be harmful. Review of Resident #1's MAR for (MONTH) (YEAR) reflected the following order: Inject 1 mg of [MEDICATION NAME] intramuscularly as needed for low blood sugar (if blood sugar is less than 60 and resident is unresponsive) which had a start date of [DATE] at 3:10 a.m. and had been put on the MAR by RN A. There was not a signed

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) physician's orders [REDACTED]. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of [MEDICATION NAME]'s Information page for physicians accessed at http://uspl.lilly.com/[MEDICATION NAME]/[MEDICATION NAME].html#pi on [DATE] at 12:49 p.m. reflected the following: [MEDICATION NAME] is indicated as a treatment for [REDACTED]. If the response is delayed .emergency aid should be sought so that [MEDICATION NAME] (route other than oral which is usually either intramuscularly, subcutaneous, or intravenous) glucose can be given. Review of Resident #1's nurse's note documented by RN A on [DATE] at 4:40 a.m. reflected Resident #1 remained unresponsive to stimuli, and her eyes appeared to be rolled back after being given [MEDICATION NAME] at 3:15 a.m. FSBS rechecked at 3:25 a.m. and noted to be at 40 and at 3:45 a.m. at 59. Resident #1 did not arouse to sternum rub. EMS (Emergency Medical Services) was notified at 3:55 a.m. When paramedics arrived to facility, IV was started in left arm and [MEDICATION NAME] at 10% hung and infused. Resident #1 was transferred to the stretcher and taken to ambulance at 4:30 a.m. to be transported to the ER. The notes also reflected the RN was unable to contact the resident's family. No additional vital signs were recorded. Review of Resident #1's Emergency Department Admission reflected her date of admission was [DATE]. The record reflected Resident #1 arrived to the emergency roiagnom on [DATE] at 4:48 a.m. Resident #1 presented with decreased responsiveness and possible cause was listed as low blood sugar. Resident #1 was intubated on [DATE] at 5:08 a.m. and was put on a ventilator to assist with breathing and was admitted to the ICU. Review of the Hospital's Physician Notes reflected that on [DATE], Resident #1 was still on the ventilator and had been off sedation for 24 hours but remained unresponsive and the family requested terminal extubation (The withdrawal of mechanical ventilation from critically ill patients who are not expected to survive without respiratory support.) Resident #1 was discharged from the hospital on [DATE] with hospice services. Resident #1 remained unresponsive and her prognosis was poor. Interview with Resident #1's family on [DATE] at 10:30 a.m. revealed Resident #1 expired on [DATE]. He stated she never woke up after the low blood sugar incident, so he made the difficult decision to take her off life support and take her home. He stated Resident #1's blood sugar went low every once in a while, but it had never gotten as low as 21. Interview with RN A on [DATE] at 11:43 a.m. revealed on [DATE] around 3:15 a.m CNA B told her Resident #1 was not acting right. She stated she went down to Resident #1's room and found her unresponsive and cold and clammy. She stated she took Resident #1's vital signs and knew she was a diabetic so she took her blood sugar. Resident #1's blood sugar was 21. She stated she realized the resident was hypoglycemic (when a resident has low blood sugar). She stated she knew the resident had an order for [REDACTED].#1's room at that time, even though the resident was still unresponsive. RN A stated she came back about ten minutes later and rechecked her blood sugar and it was 40. She stated she left the room at that time and Resident #1 was still unresponsive at that time. She stated she came back about 20 minutes later and took her blood sugar again and it was 59. She stated the resident was still unresponsive so she decided at that point she should send Resident #1 to the hospital. RN A revealed she called 911 and went back to the room and stayed with the resident until the paramedics arrived. She stated the resident remained unresponsive and when EMS arrived, the paramedics started an IV but Resident #1 was still completely unresponsive. RN A stated EMS transferred Resident #1 to the stretcher and the resident started to groan, but other than that she was still out of it. RN A stated she never called the physician during the 45 minutes between finding the resident unresponsive and sending her to the hospital. RN A stated she left a message for the doctor after Resident #1 was sent to the hospital. She stated she did not remember notifying the DON or any administrative staff about the incident, but she did record the incident on the 24 hour report for the upcoming shift. RN A stated if she could go back and change things, she would have given the [MEDICATION NAME] and after a few minutes when it had not worked, she would have called 911. She stated she also would have called the doctor sooner to see what he wanted her to do. She stated she did not know why she waited so long to call 911, but she cannot go back and change it. Interview with CNA B on [DATE] at 10:30 p.m. revealed she was RN A's aide the night of the incident on [DATE]. She revealed she came into work around 10:00 p.m. and started her initial rounds. She said she remembered Resident #1's family was still there and Resident #1 was alert and talking. She stated Resident #1's family left a little after midnight. When she began her second round around 1:30 a.m. she noticed Resident #1 was very pale and had some white stuff coming from her mouth. CNA B stated she went to get RN A and asked her to go assess Resident #1 because something was not right. RN A told her she would go look at Resident #1 in a minute. CNA B continued on her rounds with other residents and went back to check on Resident #1 around 2:00 a.m. CNA B stated Resident #1 was still very pale and appeared to be unconscious because she was not waking up. She asked RN A to go look at Resident #1 again and RN A went down to Resident #1's room and looked at the resident but did not take vital signs or anything. RN A told her she had the situation handled, so she went back to care for other residents. CNA B went back to check on Resident #1 again around 2:30 a.m. and noticed Resident #1 was still pale and was not waking up. CNA B asked RN A what was going on with the resident and RN A told her that Resident #1 was going to be okay but to just keep an eye on her. At that point, she went and got CNA C to go look at Resident #1 with her. CNA B stated the time was probably around 3:00 a.m. CNA B and CNA C went down to check on the resident and she was still the same way. Resident #1 was unresponsive, pale, and still frothing at the mouth. CNA B revealed they asked LVN D to come and look at the resident, because RN A was not helping. At that point, RN A got up with them and went down to look at the resident. RN A told LVN D to not go into the room. RN A took Resident #1's vital signs and said her blood sugar was really low. RN A told her (CNA B) she had it handled, so she finished her rounds. CNA B revealed after a while, probably close to 4:00 a.m., she finally saw the paramedics arrive. She stated Resident #1 looked exactly the same. She was still unresponsive and finally around 4:30ish, the paramedics told RN A that it was just better if they took Resident #1 to the hospital. Attempt to interview LVN D was made on [DATE] at 10:44 a.m. but LVN D's phone number was not working. Interview with LVN E on [DATE] at 11:40 a.m. revealed she was one of the other nurses the night of the incident. She revealed LVN D told her CNA B had asked her to go look at Resident #1 because she was looking bad and RN A told her she had it handled. LVN E stated she remembered CNA B coming up to the desk, a little after midnight, a few times throughout the night asking RN A to go look at Resident #1. LVN E stated RN A never let them know what was going on with her residents and ignored aides' concerns regularly. Interview with the DON on [DATE] at 11:43 a.m. revealed she knew Resident #1 had been sent to the hospital, but did not remember why. Once she reviewed RN A's nurse's notes, she stated RN A should not have waited so long to call emergency services. She stated RN A should have called 911 when she found Resident #1 completely unresponsive. The DON stated she did not investigate the incident or ask RN A what happened. She revealed they had not done any in-services with staff regarding changes in conditions or blood sugar checks since the incident. Interview with ADON F on [DATE] at 1:15 p.m. revealed the ADON over RN A's hall that night was no longer employed with the facility, but ADON F did remember the other ADONs and the DON discussed the reason for discharge of Resident #1 the next day during morning meeting. Review of RN A's license on the Board of Nursing website on [DATE] at 12:45 p.m. reflected RN A's nursing license was on probation. Review of the Agreed Order from the Texas Board of Nursing reflected on or about [DATE], while employed at the same facility, she failed to initiate cardio-pulmonary resuscitation (CPR) after finding a resident unresponsive with no respirations or pulse and instead went to check his code status. RN A's conduct resulted in an unnecessary delay in care and was likely to injure the resident, including possible demise from lack of timely interventions and appropriate nursing care. Review of the Agreed Order from the Texas Board of Nursing reflected RN A was to be supervised by another RN who is on the premises. The supervising RN was not required to be on the same unit or ward, but should be on facility grounds and readily available to provide assistance and intervention if necessary. Review of RN A's employee file reflected a Notification of Employment dated [DATE] and signed by the Corporate Director of Clinical Services which stated the following: I have received a complete copy of the Order of the Board and am aware of the stipulations placed on this license by the Texas Board of Nursing. I agree to notify the Board's office and provide information to the Board regarding this nurse's resignation or termination. Review of the staff schedule and sign in sheet since [DATE] reflected RN A worked 24 10pm-6am shifts, including [DATE], without another RN in the building and readily available for supervision. Further review of the sign in sheets revealed RN A had worked on Halls 100, 200, and 300.

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	676212	A. BUILDING _____ B. WING _____	04/11/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLEGE PARK REHABILITATION AND CARE CENTER	1715 MARTIN DR WEATHERFORD, TX 76086

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 0607 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 4) Review of RN A's job description signed on [DATE] by RN A reflected the following: Initiates emergency support measures . Emergency situations are recognized and appropriate action is instituted. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they were aware RN A was on probation and was to be under the supervision of another RN. The Administrator stated he was the Administrator of the building during the prior incident with RN A when she did not perform CPR on another resident. He stated he was willing to give her a second chance. The DON stated RN A could always call her for advice but she was not on facility grounds as her supervision the night of the incident. Interview with the Administrator on [DATE] at 11:20 a.m. revealed RN A had originally been on the 2pm-10pm shift when they had learned of her probation in (MONTH) (YEAR). He stated RN A then switched to the night shift in December. He stated he was under the impression RN A would be on the same 4 on 2 off schedule (work four days and they are off for two days) as the other RN on night shift, so she could provide supervision. He stated because of their mistake, RN A worked over 20 night shifts since (MONTH) without another RN supervising her according to her probation terms. An Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator and DON were informed of the IJ on [DATE] at 1:40 p.m. and a Plan of Removal was requested at that time. The facility's Plan of Removal accepted on [DATE] reflected: Staff will be in-serviced by Corporate Director of Clinical Operations on [DATE] on neglect policy, and to never leave a resident unattended during an emergency. Current staff will be in-serviced today, both day and evening. Night, weekend, and PRN staff will be in-serviced prior to shift. No one will work without having received information. The Plan of Removal will be used for in-service. One hundred percent audit was completed on [DATE] on all residents requiring blood glucose monitoring. Orders were reviewed for high/low parameters and notification of MD Clinical staff were in-serviced by Corporate Director of Clinical Operations on [DATE] on change in resident's condition or status policy. If a resident is found in distress, the charge nurse will notify the resident's attending physician and DON. The nurse will make detailed observations and gather pertinent information utilizing the SBAR assessment. Corporate Director of Clinical Operations in-serviced nursing staff on [DATE] on best nursing practice of using [MEDICATION NAME] injection. If resident continues to be unresponsive after 15 minutes of injection, EMS will be called for additional intervention. Competency checks will be performed on staff for the above in-services on [DATE] and [DATE]. Change in condition policy will be included in all orientations going forward, with included post-test. DON will monitor SBAR assessments that are written for a resident change in condition. Nurse who demonstrated poor judgment during the episode in question was suspended and terminated on [DATE]. Monitoring the Plan of Removal: Interviews with CNA G, LVN H, and CNA B on [DATE] at 10:05 p.m. through 10:30 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in conditions and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interviews with LVN J, LVN K, LVN L, CNA M, CNA N, CNA O, and CNA P on [DATE] between 1:00 p.m. through 2:00 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in condition and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they believed the immediate jeopardy occurred because RN A left a resident alone who was unresponsive and in a state of emergency and did not notify the physician. RN A did not call 911 when the [MEDICATION NAME] did not work. The Administrator stated they should have caught the situation but RN A had not documented the incident correctly. When asked what they would do differently to prevent another IJ, the Administrator stated they would no longer hire nurses who were on probation with the board of nursing. The DON stated they started doing SBAR forms (forms used by nurses when a change in condition is noted) and she would review them all. They both revealed they had been in-serviced over the abuse/neglect policy and reportable events. On [DATE], the Immediate Jeopardy (IJ) was removed. On [DATE] at 4:15 p.m., DON and the Corporate Director of Operations were informed the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. Review of the list of diabetic residents from the DON and dated [DATE] reflected there were 25 diabetic residents who resided on Halls 100, 200, and 300 where RN A worked.
F 0610 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all alleged neglect violations were investigated thoroughly and residents were protected from further abuse during the investigation for one (Residents #1) of 11 residents reviewed for abuse and neglect. 1. The facility failed to have an RN available to supervise RN A, as ordered by the Board of Nursing, who could have intervened and provided emergency care to Resident #1. As a result of this failure, RN A failed to contact the physician, stay with Resident #1, and contact EMS when the resident's blood sugar level was critically low, her condition did not respond to the [MEDICATION NAME] (emergency medication used to increase a person's blood sugar) and the resident was unresponsive. Forty minutes after Resident #1 was found she was transferred to the hospital on [DATE]. She remained unresponsive and was placed on life support. Resident #1 did not become responsive again and expired on [DATE] after being taken off life support. 2. The Administrator and DON failed to identify the neglect by RN A and failed to investigate and report to the State Agency when Resident #1 experienced a significant change in condition related to her blood sugar and level of consciousness. An Immediate Jeopardy was identified on [DATE] as beginning on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. This failure placed the 25 diabetic residents on Halls 100, 200, and 300 where RN A worked at risk of serious physical harm, injury, and/or death. Findings included: Review of Resident #1's closed record revealed an MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year old female who was admitted to the facility on [DATE]. Her admitting [DIAGNOSES REDACTED]. Resident #1 required extensive assistance of two people for activities of daily living. Review of her Care Plan dated [DATE] reflected there was not a care plan regarding her diabetes. Review of Resident #1's (MONTH) physician's orders [REDACTED]. [DATE]: Inject 20 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 30 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 40 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Give 500 mg of [MEDICATION NAME] (medication used to help control and lower blood sugars) twice a day by mouth. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of Resident #1's nurse's note documented by RN A on [DATE] at 3:14 a.m. reflected Resident #1 became unresponsive to stimuli. Skin was cool to touch and clammy. Resident #1 had frothy secretions coming out of her mouth. Head was repositioned to prevent aspiration. FSBS (Finger Stick Blood Sugar) was taken and was noted to be 21 mg/dl. Resident #1's vital signs were noted to be the following: 95.8 temperature, 79 heart rate, 20 respirations per minute, and her blood

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	676212	A. BUILDING _____ B. WING _____	04/11/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLEGE PARK REHABILITATION AND CARE CENTER	1715 MARTIN DR WEATHERFORD, TX 76086

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 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) pressure was ,[DATE]. Continue to monitor closely. According to https://medlineplus.gov/ency/article/ 6.htm, obtained on [DATE], Low blood sugar is a condition that occurs when the body's blood sugar (glucose) decreases and is too low. Blood sugar below 70 mg/dL (3.9 mmol/L) is considered low. Blood sugar at or below this level can be harmful. Review of Resident #1's MAR for (MONTH) (YEAR) reflected the following order: Inject 1 mg of [MEDICATION NAME] intramuscularly as needed for low blood sugar (if blood sugar is less than 60 and resident is unresponsive) which had a start date of [DATE] at 3:10 a.m. and had been put on the MAR by RN A. There was not a signed physician's orders [REDACTED]. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of [MEDICATION NAME]'s Information page for physicians accessed at http://uspl.lilly.com/[MEDICATION NAME]/[MEDICATION NAME].html#pi on [DATE] at 12:49 p.m. reflected the following: [MEDICATION NAME] is indicated as a treatment for [REDACTED]. If the response is delayed .emergency aid should be sought so that [MEDICATION NAME] (route other than oral which is usually either intramuscularly, subcutaneous, or intravenous) glucose can be given. Review of Resident #1's nurse's note documented by RN A on [DATE] at 4:40 a.m. reflected Resident #1 remained unresponsive to stimuli, and her eyes appeared to be rolled back after being given [MEDICATION NAME] at 3:15 a.m. FSBS rechecked at 3:25 a.m. and noted to be at 40 and at 3:45 a.m. at 59. Resident #1 did not arouse to sternum rub. EMS (Emergency Medical Services) was notified at 3:55 a.m. When paramedics arrived to facility, IV was started in left arm and [MEDICATION NAME] at 10% hung and infused. Resident #1 was transferred to the stretcher and taken to ambulance at 4:30 a.m. to be transported to the ER. The notes also reflected the RN was unable to contact the resident's family. No additional vital signs were recorded. Review of Resident #1's Emergency Department Admission reflected her date of admission was [DATE]. The record reflected Resident #1 arrived to the emergency roiagnom on [DATE] at 4:48 a.m. Resident #1 presented with decreased responsiveness and possible cause was listed as low blood sugar. Resident #1 was intubated on [DATE] at 5:08 a.m. and was put on a ventilator to assist with breathing and was admitted to the ICU. Review of the Hospital's Physician Notes reflected that on [DATE], Resident #1 was still on the ventilator and had been off sedation for 24 hours but remained unresponsive and the family requested terminal extubation (The withdrawal of mechanical ventilation from critically ill patients who are not expected to survive without respiratory support.) Resident #1 was discharged from the hospital on [DATE] with hospice services. Resident #1 remained unresponsive and her prognosis was poor. Interview with Resident #1's family on [DATE] at 10:30 a.m. revealed Resident #1 expired on [DATE]. He stated she never woke up after the low blood sugar incident, so he made the difficult decision to take her off life support and take her home. He stated Resident #1's blood sugar went low every once in a while, but it had never gotten as low as 21. Interview with RN A on [DATE] at 11:43 a.m. revealed on [DATE] around 3:15 a.m CNA B told her Resident #1 was not acting right. She stated she went down to Resident #1's room and found her unresponsive and cold and clammy. She stated she took Resident #1's vital signs and knew she was a diabetic so she took her blood sugar. Resident #1's blood sugar was 21. She stated she realized the resident was hypoglycemic (when a resident has low blood sugar). She stated she knew the resident had an order for [REDACTED].#1's room at that time, even though the resident was still unresponsive. RN A stated she came back about ten minutes later and rechecked her blood sugar and it was 40. She stated she left the room at that time and Resident #1 was still unresponsive at that time. She stated she came back about 20 minutes later and took her blood sugar again and it was 59. She stated the resident was still unresponsive so she decided at that point she should send Resident #1 to the hospital. RN A revealed she called 911 and went back to the room and stayed with the resident until the paramedics arrived. She stated the resident remained unresponsive and when EMS arrived, the paramedics started an IV but Resident #1 was still completely unresponsive. RN A stated EMS transferred Resident #1 to the stretcher and the resident started to groan, but other than that she was still out of it. RN A stated she never called the physician during the 45 minutes between finding the resident unresponsive and sending her to the hospital. RN A stated she left a message for the doctor after Resident #1 was sent to the hospital. She stated she did not remember notifying the DON or any administrative staff about the incident, but she did record the incident on the 24 hour report for the upcoming shift. RN A stated if she could go back and change things, she would have given the [MEDICATION NAME] and after a few minutes when it had not worked, she would have called 911. She stated she also would have called the doctor sooner to see what he wanted her to do. She stated she did not know why she waited so long to call 911, but she cannot go back and change it. Interview with CNA B on [DATE] at 10:30 p.m. revealed she was RN A's aide the night of the incident on [DATE]. She revealed she came into work around 10:00 p.m. and started her initial rounds. She said she remembered Resident #1's family was still there and Resident #1 was alert and talking. She stated Resident #1's family left a little after midnight. When she began her second round around 1:30 a.m. she noticed Resident #1 was very pale and had some white stuff coming from her mouth. CNA B stated she went to get RN A and asked her to go assess Resident #1 because something was not right. RN A told her she would go look at Resident #1 in a minute. CNA B continued on her rounds with other residents and went back to check on Resident #1 around 2:00 a.m. CNA B stated Resident #1 was still very pale and appeared to be unconscious because she was not waking up. She asked RN A to go look at Resident #1 again and RN A went down to Resident #1's room and looked at the resident but did not take vital signs or anything. RN A told her she had the situation handled, so she went back to care for other residents. CNA B went back to check on Resident #1 again around 2:30 a.m. and noticed Resident #1 was still pale and was not waking up. CNA B asked RN A what was going on with the resident and RN A told her that Resident #1 was going to be okay but to just keep an eye on her. At that point, she went and got CNA C to go look at Resident #1 with her. CNA B stated the time was probably around 3:00 a.m. CNA B and CNA C went down to check on the resident and she was still the same way. Resident #1 was unresponsive, pale, and still frothing at the mouth. CNA B revealed they asked LVN D to come and look at the resident, because RN A was not helping. At that point, RN A got up with them and went down to look at the resident. RN A told LVN D to not go into the room. RN A took Resident #1's vital signs and said her blood sugar was really low. RN A told her (CNA B) she had it handled, so she finished her rounds. CNA B revealed after a while, probably close to 4:00 a.m., she finally saw the paramedics arrive. She stated Resident #1 looked exactly the same. She was still unresponsive and finally around 4:30ish, the paramedics told RN A that it was just better if they took Resident #1 to the hospital. Attempt to interview LVN D was made on [DATE] at 10:44 a.m. but LVN D's phone number was not working. Interview with LVN E on [DATE] at 11:40 a.m. revealed she was one of the other nurses the night of the incident. She revealed LVN D told her CNA B had asked her to go look at Resident #1 because she was looking bad and RN A told her she had it handled. LVN E stated she remembered CNA B coming up to the desk, a little after midnight, a few times throughout the night asking RN A to go look at Resident #1. LVN E stated RN A never let them know what was going on with her residents and ignored aides' concerns regularly. Interview with the DON on [DATE] at 11:43 a.m. revealed she knew Resident #1 had been sent to the hospital, but did not remember why. Once she reviewed RN A's nurse's notes, she stated RN A should not have waited so long to call emergency services. She stated RN A should have called 911 when she found Resident #1 completely unresponsive. The DON stated she did not investigate the incident or ask RN A what happened. She revealed they had not done any in-services with staff regarding changes in conditions or blood sugar checks since the incident. Interview with ADON F on [DATE] at 1:15 p.m. revealed the ADON over RN A's hall that night was no longer employed with the facility, but ADON F did remember the other ADONs and the DON discussed the reason for discharge of Resident #1 the next day during morning meeting. Review of RN A's license on the Board of Nursing website on [DATE] at 12:45 p.m. reflected RN A's nursing license was on probation. Review of the Agreed Order from the Texas Board of Nursing reflected on or about [DATE], while employed at the same facility, she failed to initiate cardio-pulmonary resuscitation (CPR) after finding a resident unresponsive with no respirations or pulse and instead went to check his code status. RN A's conduct resulted in an unnecessary delay in care and was likely to injure the resident, including possible demise from lack of timely interventions and appropriate nursing care. Review of the Agreed Order from the Texas Board of Nursing reflected RN A was to be supervised by another RN who is on the premises. The supervising RN was not required to be on the same unit or ward, but should be on facility grounds and readily available to provide assistance and intervention if necessary. Review of RN A's employee file reflected a Notification of Employment dated [DATE] and signed by the Corporate Director of

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) Clinical Services which stated the following: I have received a complete copy of the Order of the Board and am aware of the stipulations placed on this license by the Texas Board of Nursing. I agree to notify the Board's office and provide information to the Board regarding this nurse's resignation or termination. Review of the staff schedule and sign in sheet since [DATE] reflected RN A worked 24 10pm-6am shifts, including [DATE], without another RN in the building and readily available for supervision. Further review of the sign in sheets revealed RN A had worked on Halls 100, 200, and 300. Review of RN A's job description signed on [DATE] by RN A reflected the following: Initiates emergency support measures . Emergency situations are recognized and appropriate action is instituted. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they were aware RN A was on probation and was to be under the supervision of another RN. The Administrator stated he was the Administrator of the building during the prior incident with RN A when she did not perform CPR on another resident. He stated he was willing to give her a second chance. The DON stated RN A could always call her for advice but she was not on facility grounds as her supervision the night of the incident. Interview with the Administrator on [DATE] at 11:20 a.m. revealed RN A had originally been on the 2pm-10pm shift when they had learned of her probation in (MONTH) (YEAR). He stated RN A then switched to the night shift in December. He stated he was under the impression RN A would be on the same 4 on 2 off schedule (work four days and they are off for two days) as the other RN on night shift, so she could provide supervision. He stated because of their mistake, RN A worked over 20 night shifts since (MONTH) without another RN supervising her according to her probation terms. Review of the facility's Change in Resident's Condition or Status Policy revised in (MONTH) (YEAR) reflected the following: The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. An accident or incident involving the resident .d. A significant change in the resident's physical/emotional/mental conditions . A 'significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . Review of the facility's undated Abuse/Neglect policy reflected the following: Definition of 'Neglect' 'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Signs of/Actual Neglect . 6. Inadequate provision of care . 9. Leaving someone unattended who need supervision. An Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator and DON were informed of the IJ on [DATE] at 1:40 p.m. and a Plan of Removal was requested at that time. The facility's Plan of Removal accepted on [DATE] reflected: Staff will be in-serviced by Corporate Director of Clinical Operations on [DATE] on neglect policy, and to never leave a resident unattended during an emergency. Current staff will be in-serviced today, both day and evening. Night, weekend, and PRN staff will be in-serviced prior to shift. No one will work without having received information. The Plan of Removal will be used for in-service. One hundred percent audit was completed on [DATE] on all residents requiring blood glucose monitoring. Orders were reviewed for high/low parameters and notification of MD Clinical staff were in-serviced by Corporate Director of Clinical Operations on [DATE] on change in resident's condition or status policy. If a resident is found in distress, the charge nurse will notify the resident's attending physician and DON. The nurse will make detailed observations and gather pertinent information utilizing the SBAR assessment. Corporate Director of Clinical Operations in-serviced nursing staff on [DATE] on best nursing practice of using [MEDICATION NAME] injection. If resident continues to be unresponsive after 15 minutes of injection, EMS will be called for additional intervention. Competency checks will be performed on staff for the above in-services on [DATE] and [DATE]. Change in condition policy will be included in all orientations going forward, with included post-test. DON will monitor SBAR assessments that are written for a resident change in condition. Nurse who demonstrated poor judgment during the episode in question was suspended and terminated on [DATE]. Monitoring the Plan of Removal: Interviews with CNA G, LVN H, and CNA B on [DATE] at 10:05 p.m. through 10:30 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in conditions and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interviews with LVN J, LVN K, LVN L, CNA M, CNA N, CNA O, and CNA P on [DATE] between 1:00 p.m. through 2:00 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in condition and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they believed the immediate jeopardy occurred because RN A left a resident alone who was unresponsive and in a state of emergency and did not notify the physician. RN A did not call 911 when the [MEDICATION NAME] did not work. The Administrator stated they should have caught the situation but RN A had not documented the incident correctly. When asked what they would do differently to prevent another IJ, the Administrator stated they would no longer hire nurses who were on probation with the board of nursing. The DON stated they started doing SBAR forms (forms used by nurses when a change in condition is noted) and she would review them all. They both revealed they had been in-serviced over the abuse/neglect policy and reportable events. On [DATE], the Immediate Jeopardy (IJ) was removed. On [DATE] at 4:15 p.m., DON and the Corporate Director of Operations were informed the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. Review of the list of diabetic residents from the DON and dated [DATE] reflected there were 25 diabetic residents who resided on Halls 100, 200, and 300 where RN A worked. Review of the list of diabetic residents from the DON and dated [DATE] reflected there were 30 diabetic residents.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that Resident #1 received treatment and care in accordance with professional standards of practice for one (Resident #1) of 11 residents reviewed for quality of care. RN A failed to contact the physician, stay with Resident #1, and contact EMS when the resident's blood sugar level was critically low, the resident's condition did not respond to [MEDICATION NAME] (medication to help raise a person's blood sugar) and the resident was unresponsive. Forty minutes after Resident #1 was found she was transferred to the hospital on [DATE]. She remained unresponsive and was placed on life support. Resident #1 did not become responsive again and expired on [DATE] after being taken off life support.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676212	A. BUILDING _____ B. WING _____	04/11/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLEGE PARK REHABILITATION AND CARE CENTER	1715 MARTIN DR WEATHERFORD, TX 76086

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) An Immediate Jeopardy was identified on [DATE] as beginning on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. This failure placed the 25 diabetic residents who resided on Hall 100, 200, and 300 where RN A worked at risk of serious physical harm, injury, and/or death. Findings included: Review of Resident #1's closed record revealed an MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year old female who was admitted to the facility on [DATE]. Her admitting [DIAGNOSES REDACTED]. Resident #1 required extensive assistance of two people for activities of daily living. Review of her Care Plan dated [DATE] reflected there was not a care plan regarding her diabetes. Review of Resident #1's (MONTH) physician's orders [REDACTED]. [DATE]: Inject 20 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 30 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 40 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Give 500 mg of [MEDICATION NAME] (medication used to help control and lower blood sugars) twice a day by mouth. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of Resident #1's nurse's note documented by RN A on [DATE] at 3:14 a.m. reflected Resident #1 became unresponsive to stimuli. Skin was cool to touch and clammy. Resident #1 had frothy secretions coming out of her mouth. Head was repositioned to prevent aspiration. FSBS (Finger Stick Blood Sugar) was taken and was noted to be 21 mg/dl. Resident #1's vital signs were noted to be the following: 95.8 temperature, 79 heart rate, 20 respirations per minute, and her blood pressure was ,[DATE]. Continue to monitor closely. According to https://medlineplus.gov/ency/article/ 6.htm, obtained on [DATE], Low blood sugar is a condition that occurs when the body's blood sugar (glucose) decreases and is too low. Blood sugar below 70 mg/dL (3.9 mmol/L) is considered low. Blood sugar at or below this level can be harmful. Review of Resident #1's MAR for (MONTH) (YEAR) reflected the following order: Inject 1 mg of [MEDICATION NAME] intramuscularly as needed for low blood sugar (if blood sugar is less than 60 and resident is unresponsive) which had a start date of [DATE] at 3:10 a.m. and had been put on the MAR by RN A. There was not a signed physician's orders [REDACTED]. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of [MEDICATION NAME]'s Information page for physicians accessed at http://uspl.lilly.com/[MEDICATION NAME]/[MEDICATION NAME].html#pi on [DATE] at 12:49 p.m. reflected the following: [MEDICATION NAME] is indicated as a treatment for [REDACTED]. If the response is delayed .emergency aid should be sought so that [MEDICATION NAME] (route other than oral which is usually either intramuscularly, subcutaneous, or intravenous) glucose can be given. Review of Resident #1's nurse's note documented by RN A on [DATE] at 4:40 a.m. reflected Resident #1 remained unresponsive to stimuli, and her eyes appeared to be rolled back after being given [MEDICATION NAME] at 3:15 a.m. FSBS rechecked at 3:25 a.m. and noted to be at 40 and at 3:45 a.m. at 59. Resident #1 did not arouse to sternum rub. EMS (Emergency Medical Services) was notified at 3:55 a.m. When paramedics arrived to facility, IV was started in left arm and [MEDICATION NAME] at 10% hung and infused. Resident #1 was transferred to the stretcher and taken to ambulance at 4:30 a.m. to be transported to the ER. The notes also reflected the RN was unable to contact the resident's family. No additional vital signs were recorded. Review of Resident #1's Emergency Department Admission reflected her date of admission was [DATE]. The record reflected Resident #1 arrived to the emergency roiagnom on [DATE] at 4:48 a.m. Resident #1 presented with decreased responsiveness and possible cause was listed as low blood sugar. Resident #1 was intubated on [DATE] at 5:08 a.m. and was put on a ventilator to assist with breathing and was admitted to the ICU. Review of the Hospital's Physician Notes reflected that on [DATE], Resident #1 was still on the ventilator and had been off sedation for 24 hours but remained unresponsive and the family requested terminal extubation (The withdrawal of mechanical ventilation from critically ill patients who are not expected to survive without respiratory support.) Resident #1 was discharged from the hospital on [DATE] with hospice services. Resident #1 remained unresponsive and her prognosis was poor. Interview with Resident #1's family on [DATE] at 10:30 a.m. revealed Resident #1 expired on [DATE]. He stated she never woke up after the low blood sugar incident, so he made the difficult decision to take her off life support and take her home. He stated Resident #1's blood sugar went low every once in a while, but it had never gotten as low as 21. Interview with RN A on [DATE] at 11:43 a.m. revealed on [DATE] around 3:15 a.m CNA B told her Resident #1 was not acting right. She stated she went down to Resident #1's room and found her unresponsive and cold and clammy. She stated she took Resident #1's vital signs and knew she was a diabetic so she took her blood sugar. Resident #1's blood sugar was 21. She stated she realized the resident was hypoglycemic (when a resident has low blood sugar). She stated she knew the resident had an order for [REDACTED].#1's room at that time, even though the resident was still unresponsive. RN A stated she came back about ten minutes later and rechecked her blood sugar and it was 40. She stated she left the room at that time and Resident #1 was still unresponsive at that time. She stated she came back about 20 minutes later and took her blood sugar again and it was 59. She stated the resident was still unresponsive so she decided at that point she should send Resident #1 to the hospital. RN A revealed she called 911 and went back to the room and stayed with the resident until the paramedics arrived. She stated the resident remained unresponsive and when EMS arrived, the paramedics started an IV but Resident #1 was still completely unresponsive. RN A stated EMS transferred Resident #1 to the stretcher and the resident started to groan, but other than that she was still out of it. RN A stated she never called the physician during the 45 minutes between finding the resident unresponsive and sending her to the hospital. RN A stated she left a message for the doctor after Resident #1 was sent to the hospital. She stated she did not remember notifying the DON or any administrative staff about the incident, but she did record the incident on the 24 hour report for the upcoming shift. RN A stated if she could go back and change things, she would have given the [MEDICATION NAME] and after a few minutes when it had not worked, she would have called 911. She stated she also would have called the doctor sooner to see what he wanted her to do. She stated she did not know why she waited so long to call 911, but she cannot go back and change it. Interview with CNA B on [DATE] at 10:30 p.m. revealed she was RN A's aide the night of the incident on [DATE]. She revealed she came into work around 10:00 p.m. and started her initial rounds. She said she remembered Resident #1's family was still there and Resident #1 was alert and talking. She stated Resident #1's family left a little after midnight. When she began her second round around 1:30 a.m. she noticed Resident #1 was very pale and had some white stuff coming from her mouth. CNA B stated she went to get RN A and asked her to go assess Resident #1 because something was not right. RN A told her she would go look at Resident #1 in a minute. CNA B continued on her rounds with other residents and went back to check on Resident #1 around 2:00 a.m. CNA B stated Resident #1 was still very pale and appeared to be unconscious because she was not waking up. She asked RN A to go look at Resident #1 again and RN A went down to Resident #1's room and looked at the resident but did not take vital signs or anything. RN A told her she had the situation handled, so she went back to care for other residents. CNA B went back to check on Resident #1 again around 2:30 a.m. and noticed Resident #1 was still pale and was not waking up. CNA B asked RN A what was going on with the resident and RN A told her that Resident #1 was going to be okay but to just keep an eye on her. At that point, she went and got CNA C to go look at Resident #1 with her. CNA B stated the time was probably around 3:00 a.m. CNA B and CNA C went down to check on the resident and she was still the same way. Resident #1 was unresponsive, pale, and still frothing at the mouth. CNA B revealed they asked LVN D to come and look at the resident, because RN A was not helping. At that point, RN A got up with them and went down to look at the resident. RN A told LVN D to not go into the room. RN A took Resident #1's vital signs and said her blood sugar was really low. RN A told her (CNA B) she had it handled, so she finished her rounds. CNA B revealed after a while, probably close to 4:00 a.m., she finally saw the paramedics arrive. She stated Resident #1 looked exactly the same. She was still unresponsive and finally around 4:30ish, the paramedics told RN A that it was just better if they took Resident #1 to the hospital. Attempt to interview LVN D was made on [DATE] at 10:44 a.m. but LVN D's phone number was not working. Interview with LVN E on [DATE] at 11:40 a.m. revealed she was one of the other nurses the night of the incident. She revealed LVN D told her CNA B had asked her to go look at Resident #1 because she was looking bad and RN A told her she had it handled. LVN E stated she remembered CNA B coming up to the desk, a little after midnight, a few times throughout the

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) night asking RN A to go look at Resident #1. LVN E stated RN A never let them know what was going on with her residents and ignored aides' concerns regularly. Interview with the DON on [DATE] at 11:43 a.m. revealed she knew Resident #1 had been sent to the hospital, but did not remember why. Once she reviewed RN A's nurse's notes, she stated RN A should not have waited so long to call emergency services. She stated RN A should have called 911 when she found Resident #1 completely unresponsive. The DON stated she did not investigate the incident or ask RN A what happened. She revealed they had not done any in-services with staff regarding changes in conditions or blood sugar checks since the incident. Interview with ADON F on [DATE] at 1:15 p.m. revealed the ADON over RN A's hall that night was no longer employed with the facility, but ADON F did remember the other ADONs and the DON discussed the reason for discharge of Resident #1 the next day during morning meeting. Review of RN A's license on the Board of Nursing website on [DATE] at 12:45 p.m. reflected RN A's nursing license was on probation. Review of the Agreed Order from the Texas Board of Nursing reflected RN A was to be supervised by another RN who is on the premises. The supervising RN was not required to be on the same unit or ward, but should be on facility grounds and readily available to provide assistance and intervention if necessary. Review of RN A's employee file reflected a Notification of Employment dated [DATE] and signed by the Corporate Director of Clinical Services which stated the following: I have received a complete copy of the Order of the Board and am aware of the stipulations placed on this license by the Texas Board of Nursing. I agree to notify the Board's office and provide information to the Board regarding this nurse's resignation or termination. Review of the staff schedule and sign in sheet since [DATE] reflected RN A worked 24 10pm-6am shifts, including [DATE], without another RN in the building and readily available for supervision. Further review of the sign in sheets revealed RN A had worked on Halls 100, 200, and 300. Review of RN A's job description signed on [DATE] by RN A reflected the following: Initiates emergency support measures . Emergency situations are recognized and appropriate action is instituted. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they were aware RN A was on probation and was to be under the supervision of another RN. The Administrator stated he was the Administrator of the building during the prior incident with RN A when she did not perform CPR on another resident. He stated he was willing to give her a second chance. The DON stated RN A could always call her for advice but she was not on facility grounds as her supervision the night of the incident. Interview with the Administrator on [DATE] at 11:20 a.m. revealed RN A had originally been on the 2pm-10pm shift when they had learned of her probation in (MONTH) (YEAR). He stated RN A then switched to the night shift in December. He stated he was under the impression RN A would be on the same 4 on 2 off schedule (work four days and they are off for two days) as the other RN on night shift, so she could provide supervision. He stated because of their mistake, RN A worked over 20 night shifts since (MONTH) without another RN supervising her according to her probation terms. Review of the facility's Change in Resident's Condition or Status Policy revised in (MONTH) (YEAR) reflected the following: The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. An accident or incident involving the resident .d. A significant change in the resident's physical/emotional/mental conditions . A 'significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . Review of the facility's undated Abuse/Neglect policy reflected the following: Definition of 'Neglect' 'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Signs of/Actual Neglect . 6. Inadequate provision of care . 9. Leaving someone unattended who need supervision. An Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator and DON were informed of the IJ on [DATE] at 1:40 p.m. and a Plan of Removal was requested at that time. The facility's Plan of Removal accepted on [DATE] reflected: Staff will be in-serviced by Corporate Director of Clinical Operations on [DATE] on neglect policy, and to never leave a resident unattended during an emergency. Current staff will be in-serviced today, both day and evening. Night, weekend, and PRN staff will be in-serviced prior to shift. No one will work without having received information. The Plan of Removal will be used for in-service. One hundred percent audit was completed on [DATE] on all residents requiring blood glucose monitoring. Orders were reviewed for high/low parameters and notification of MD Clinical staff were in-serviced by Corporate Director of Clinical Operations on [DATE] on change in resident's condition or status policy. If a resident is found in distress, the charge nurse will notify the resident's attending physician and DON. The nurse will make detailed observations and gather pertinent information utilizing the SBAR assessment. Corporate Director of Clinical Operations in-serviced nursing staff on [DATE] on best nursing practice of using [MEDICATION NAME] injection. If resident continues to be unresponsive after 15 minutes of injection, EMS will be called for additional intervention. Competency checks will be performed on staff for the above in-services on [DATE] and [DATE]. Change in condition policy will be included in all orientations going forward, with included post-test. DON will monitor SBAR assessments that are written for a resident change in condition. Nurse who demonstrated poor judgment during the episode in question was suspended and terminated on [DATE]. Monitoring the Plan of Removal: Interviews with CNA G, LVN H, and CNA B on [DATE] at 10:05 p.m. through 10:30 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident is was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in conditions and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interviews with LVN J, LVN K, LVN L, CNA M, CNA N, CNA O, and CNA P on [DATE] between 1:00 p.m. through 2:00 p.m. revealed they had been in-serviced before their shift regarding change in conditions, what to do when a resident was unresponsive and abuse/neglect. They all revealed they had to complete a quiz regarding the in-services. They all revealed they were to contact the Administrator immediately with any allegation of abuse or neglect. They were able to give examples of changes in condition and what to do if they recognized a change in condition. They also were able to state they would not leave an unresponsive resident and to treat it as an emergency. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they believed the immediate jeopardy occurred because RN A left a resident alone who was unresponsive and in a state of emergency and did not notify the physician. RN A did not call 911 when the [MEDICATION NAME] did not work. The Administrator stated they should have caught the situation but RN A had not documented the incident correctly. When asked what they would do differently to prevent another IJ, the Administrator stated they would no longer hire nurses who were on probation with the board of nursing. The DON stated they started doing SBAR forms (forms used by nurses when a change in condition is noted) and she would review them all. They both revealed they had been in-serviced over the abuse/neglect policy and reportable events. On [DATE], the Immediate Jeopardy (IJ) was removed. On [DATE] at 4:15 p.m., DON and the Corporate Director of Operations were informed the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. Review of the list of diabetic residents from the DON and dated [DATE] reflected there were 25 diabetic residents on Halls 100, 200, and 300 where RN A had worked.

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9)
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one (Resident #1) of 11 residents reviewed neglect. 1. The Administrator and DON failed to provide an RN to supervise RN A, as ordered by the Board of Nursing, who could have intervened and provided emergency care to Resident #1. On one of the shifts when she was not supervised by another RN, RN A failed to carry out her duties as described in her job description when she failed to initiate emergency support measures as appropriate and protect residents from harm and failed to recognize an emergency situation and take appropriate action. RN A failed to contact the physician, stay with Resident #1 or contact EMS when the resident's blood sugar was low, and the resident did not respond to [MEDICATION NAME] and was unresponsive. Forty minutes after Resident #1 was found she was transferred to the hospital on [DATE]. She remained unresponsive and was placed on life support. Resident #1 did not become responsive again and expired on [DATE] after being taken off life support. 2. The Administrator and DON failed to implement the Abuse/Neglect policy and Change in Condition Policy when they failed to identify neglect by RN A and failed to investigate when Resident #1 experienced a significant change in condition related to her blood sugar and level of consciousness. The incident was recorded on the 24 hour report and was discussed in the morning meeting, which was attended by the DON and Administrator. An Immediate Jeopardy was identified on [DATE] as beginning on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. This failure placed the 25 diabetic residents who resided on Hall 100, 200, and 300 where RN A worked at risk of serious physical harm, injury, and/or death. Findings included: Review of RN A's license on the Board of Nursing website on [DATE] at 12:45 p.m. reflected RN A's nursing license was on probation. Review of the Agreed Order from the Texas Board of Nursing reflected on or about [DATE], while employed at the same facility, she failed to initiate cardio-pulmonary resuscitation (CPR) after finding a resident unresponsive with no respirations or pulse and instead went to check his code status. RN A's conduct resulted in an unnecessary delay in care and was likely to injure the resident, including possible demise from lack of timely interventions and appropriate nursing care. Review of the Agreed Order from the Texas Board of Nursing reflected RN A was to be supervised by another RN who is on the premises. The supervising RN was not required to be on the same unit or ward, but should be on facility grounds and readily available to provide assistance and intervention if necessary. Review of RN A's employee file reflected a Notification of Employment dated [DATE] and signed by the Corporate Director of Clinical Services which stated the following: I have received a complete copy of the Order of the Board and am aware of the stipulations placed on this license by the Texas Board of Nursing. I agree to notify the Board's office and provide information to the Board regarding this nurse's resignation or termination. Review of the staff schedule and sign in sheet since [DATE] reflected RN A worked 24 10pm-6am shifts, including [DATE], without another RN in the building and readily available for supervision. Further review of the sign in sheets revealed RN A had worked on Halls 100, 200, and 300. Review of RN A's job description signed on [DATE] by RN A reflected the following: Initiates emergency support measures . Emergency situations are recognized and appropriate action is instituted. Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they were aware RN A was on probation and was to be under the supervision of another RN. The Administrator stated he was the Administrator of the building during the prior incident with RN A when she did not perform CPR on another resident. He stated he was willing to give her a second chance. The DON stated RN A could always call her for advice but she was not on facility grounds as her supervision the night of the incident. Interview with the Administrator on [DATE] at 11:20 a.m. revealed RN A had originally been on the 2pm-10pm shift when they had learned of her probation in (MONTH) (YEAR). He stated RN A then switched to the night shift in December. He stated he was under the impression RN A would be on the same 4 on 2 off schedule (work four days and they are off for two days) as the other RN on night shift, so she could provide supervision. He stated because of their mistake, RN A worked over 20 night shifts since (MONTH) without another RN supervising her according to her probation terms. Review of Resident #1's closed record revealed an MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year old female who was admitted to the facility on [DATE]. Her admitting [DIAGNOSES REDACTED]. Resident #1 required extensive assistance of two people for activities of daily living. Review of her Care Plan dated [DATE] reflected there was not a care plan regarding her diabetes. Review of Resident #1's (MONTH) physician's orders [REDACTED]. [DATE]: Inject 20 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 30 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Inject 40 units of [MEDICATION NAME] ,[DATE] insulin subcutaneously once a day. [DATE]: Give 500 mg of [MEDICATION NAME] (medication used to help control and lower blood sugars) twice a day by mouth. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of Resident #1's nurse's note documented by RN A on [DATE] at 3:14 a.m. reflected Resident #1 became unresponsive to stimuli. Skin was cool to touch and clammy. Resident #1 had frothy secretions coming out of her mouth. Head was repositioned to prevent aspiration. FSBS (Finger Stick Blood Sugar) was taken and was noted to be 21 mg/dl. Resident #1's vital signs were noted to be the following: 95.8 temperature, 79 heart rate, 20 respirations per minute, and her blood pressure was ,[DATE]. Continue to monitor closely. According to https://medlineplus.gov/ency/article/ 6.htm, obtained on [DATE], Low blood sugar is a condition that occurs when the body's blood sugar (glucose) decreases and is too low. Blood sugar below 70 mg/dL (3.9 mmol/L) is considered low. Blood sugar at or below this level can be harmful. Review of Resident #1's MAR for (MONTH) (YEAR) reflected the following order: Inject 1 mg of [MEDICATION NAME] intramuscularly as needed for low blood sugar (if blood sugar is less than 60 and resident is unresponsive) which had a start date of [DATE] at 3:10 a.m. and had been put on the MAR by RN A. There was not a signed physician's orders [REDACTED]. Review of Resident #1's (MONTH) (YEAR) Medication Administration Record [REDACTED]. Review of [MEDICATION NAME]'s Information page for physicians accessed at http://uspl.lilly.com/[MEDICATION NAME]/[MEDICATION NAME].html#pi on [DATE] at 12:49 p.m. reflected the following: [MEDICATION NAME] is indicated as a treatment for [REDACTED]. If the response is delayed .emergency aid should be sought so that [MEDICATION NAME] (route other than oral which is usually either intramuscularly, subcutaneous, or intravenous) glucose can be given. Review of Resident #1's nurse's note documented by RN A on [DATE] at 4:40 a.m. reflected Resident #1 remained unresponsive to stimuli, and her eyes appeared to be rolled back after being given [MEDICATION NAME] at 3:15 a.m. FSBS rechecked at 3:25 a.m. and noted to be at 40 and at 3:45 a.m. at 59. Resident #1 did not arouse to sternum rub. EMS (Emergency Medical Services) was notified at 3:55 a.m. When paramedics arrived to facility, IV was started in left arm and [MEDICATION NAME] at 10% hung and infused. Resident #1 was transferred to the stretcher and taken to ambulance at 4:30 a.m. to be transported to the ER. The notes also reflected the RN was unable to contact the resident's family. No additional vital signs were recorded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676212	A. BUILDING _____ B. WING _____	04/11/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLEGE PARK REHABILITATION AND CARE CENTER	1715 MARTIN DR WEATHERFORD, TX 76086

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) Review of Resident #1's Emergency Department Admission reflected her date of admission was [DATE]. The record reflected Resident #1 arrived to the emergency roiagnom on [DATE] at 4:48 a.m. Resident #1 presented with decreased responsiveness and possible cause was listed as low blood sugar. Resident #1 was intubated on [DATE] at 5:08 a.m. and was put on a ventilator to assist with breathing and was admitted to the ICU. Review of the Hospital's Physician Notes reflected that on [DATE], Resident #1 was still on the ventilator and had been off sedation for 24 hours but remained unresponsive and the family requested terminal extubation (The withdrawal of mechanical ventilation from critically ill patients who are not expected to survive without respiratory support.) Resident #1 was discharged from the hospital on [DATE] with hospice services. Resident #1 remained unresponsive and her prognosis was poor. Interview with Resident #1's family on [DATE] at 10:30 a.m. revealed Resident #1 expired on [DATE]. He stated she never woke up after the low blood sugar incident, so he made the difficult decision to take her off life support and take her home. He stated Resident #1's blood sugar went low every once in a while, but it had never gotten as low as 21. Interview with RN A on [DATE] at 11:43 a.m. revealed on [DATE] around 3:15 a.m CNA B told her Resident #1 was not acting right. She stated she went down to Resident #1's room and found her unresponsive and cold and clammy. She stated she took Resident #1's vital signs and knew she was a diabetic so she took her blood sugar. Resident #1's blood sugar was 21. She stated she realized the resident was hypoglycemic (when a resident has low blood sugar). She stated she knew the resident had an order for [REDACTED].#1's room at that time, even though the resident was still unresponsive. RN A stated she came back about ten minutes later and rechecked her blood sugar and it was 40. She stated she left the room at that time and Resident #1 was still unresponsive at that time. She stated she came back about 20 minutes later and took her blood sugar again and it was 59. She stated the resident was still unresponsive so she decided at that point she should send Resident #1 to the hospital. RN A revealed she called 911 and went back to the room and stayed with the resident until the paramedics arrived. She stated the resident remained unresponsive and when EMS arrived, the paramedics started an IV but Resident #1 was still completely unresponsive. RN A stated EMS transferred Resident #1 to the stretcher and the resident started to groan, but other than that she was still out of it. RN A stated she never called the physician during the 45 minutes between finding the resident unresponsive and sending her to the hospital. RN A stated she left a message for the doctor after Resident #1 was sent to the hospital. She stated she did not remember notifying the DON or any administrative staff about the incident, but she did record the incident on the 24 hour report for the upcoming shift. RN A stated if she could go back and change things, she would have given the [MEDICATION NAME] and after a few minutes when it had not worked, she would have called 911. She stated she also would have called the doctor sooner to see what he wanted her to do. She stated she did not know why she waited so long to call 911, but she cannot go back and change it. Interview with CNA B on [DATE] at 10:30 p.m. revealed she was RN A's aide the night of the incident on [DATE]. She revealed she came into work around 10:00 p.m. and started her initial rounds. She said she remembered Resident #1's family was still there and Resident #1 was alert and talking. She stated Resident #1's family left a little after midnight. When she began her second round around 1:30 a.m. she noticed Resident #1 was very pale and had some white stuff coming from her mouth. CNA B stated she went to get RN A and asked her to go assess Resident #1 because something was not right. RN A told her she would go look at Resident #1 in a minute. CNA B continued on her rounds with other residents and went back to check on Resident #1 around 2:00 a.m. CNA B stated Resident #1 was still very pale and appeared to be unconscious because she was not waking up. She asked RN A to go look at Resident #1 again and RN A went down to Resident #1's room and looked at the resident but did not take vital signs or anything. RN A told her she had the situation handled, so she went back to care for other residents. CNA B went back to check on Resident #1 again around 2:30 a.m. and noticed Resident #1 was still pale and was not waking up. CNA B asked RN A what was going on with the resident and RN A told her that Resident #1 was going to be okay but to just keep an eye on her. At that point, she went and got CNA C to go look at Resident #1 with her. CNA B stated the time was probably around 3:00 a.m. CNA B and CNA C went down to check on the resident and she was still the same way. Resident #1 was unresponsive, pale, and still frothing at the mouth. CNA B revealed they asked LVN D to come and look at the resident, because RN A was not helping. At that point, RN A got up with them and went down to look at the resident. RN A told LVN D to not go into the room. RN A took Resident #1's vital signs and said her blood sugar was really low. RN A told her (CNA B) she had it handled, so she finished her rounds. CNA B revealed after a while, probably close to 4:00 a.m., she finally saw the paramedics arrive. She stated Resident #1 looked exactly the same. She was still unresponsive and finally around 4:30ish, the paramedics told RN A that it was just better if they took Resident #1 to the hospital. Attempt to interview LVN D was made on [DATE] at 10:44 a.m. but LVN D's phone number was not working. Interview with LVN E on [DATE] at 11:40 a.m. revealed she was one of the other nurses the night of the incident. She revealed LVN D told her CNA B had asked her to go look at Resident #1 because she was looking bad and RN A told her she had it handled. LVN E stated she remembered CNA B coming up to the desk, a little after midnight, a few times throughout the night asking RN A to go look at Resident #1. LVN E stated RN A never let them know what was going on with her residents and ignored aides' concerns regularly. Interview with the DON on [DATE] at 11:43 a.m. revealed she knew Resident #1 had been sent to the hospital, but did not remember why. Once she reviewed RN A's nurse's notes, she stated RN A should not have waited so long to call emergency services. She stated RN A should have called 911 when she found Resident #1 completely unresponsive. The DON stated she did not investigate the incident or ask RN A what happened. She revealed they had not done any in-services with staff regarding changes in conditions or blood sugar checks since the incident. Interview with ADON F on [DATE] at 1:15 p.m. revealed the ADON over RN A's hall that night was no longer employed with the facility, but ADON F did remember the other ADONs and the DON discussed the reason for discharge of Resident #1 the next day during morning meeting. An Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator and DON were informed of the IJ on [DATE] at 1:40 p.m. and a Plan of Removal was requested at that time. The facility's Plan of Removal accepted on [DATE] reflected: Administration staff were in-serviced on proper reporting guidelines on [DATE] by Corporate Director of Clinical Operations. One hundred percent audit was completed on [DATE] on all residents requiring blood glucose monitoring. Orders were reviewed for high/low parameters and notification of MD. Nurse who demonstrated poor judgment during the episode in question was suspended and terminated on [DATE]. Monitoring the Plan of Removal: Interview with the Administrator and DON on [DATE] at 2:45 p.m. revealed they believed the immediate jeopardy occurred because RN A left a resident alone who was unresponsive and in a state of emergency and did not notify the physician. RN A did not call 911 when the [MEDICATION NAME] did not work. The Administrator stated they should have caught the situation but RN A had not documented the incident correctly. When asked what they would do differently to prevent another IJ, the Administrator stated they would no longer hire nurses who were on probation with the board of nursing and they no longer had any nurses on probation. The DON stated they started doing SBAR forms (forms used by nurses when a change in condition is noted) and she would review them all. They both revealed they had been in-serviced over the abuse/neglect policy and reportable events. Review of the DON, LVN D, LVN E, and LVN Q's employee files revealed they were not on probation with the board of nursing. On [DATE], the Immediate Jeopardy (IJ) was removed. On [DATE] at 4:15 p.m., DON and the Corporate Director of Operations were informed the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at severity level of actual harm and a scope of isolated because the facility was still monitoring the implementation of the Plan of Removal. Review of the list of diabetic residents from the DON and dated [DATE] reflected there were 25 diabetic residents who resided on Hall 100, 200, and 300.