STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARLINGTON GARDENS CARE CENTER	**3688 NYE AVENUE RIVERSIDE, CA 92505**

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 -** Minimal harm or potential for actual harm **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, for one of three sampled residents (Resident A), received necessary care consistent with professional standards of practice, when the licensed staff failed to check the resident's blood sugar when the resident was found unresponsive and during an emergency code (emergency situation that require resuscitation and interventions). Resident A had a history of [REDACTED]. This failure had the potential to result in unidentified critical medical issues and/or unmet medical needs. Findings: On [DATE], at 9:29 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].). The resident was sent out to the acute care hospital on [DATE]. The progress notes, dated [DATE], at 9:48 a.m., indicated, At 0910 (9:10 a.m.) resident noted to be unresponsive by LVN (licensed vocational nurse), RN (registered nurse) called and assessed. Blood sugar noted to be 36 (mg/dl), Subq (subcutaneous- administered under the skin) [MEDICATION NAME] (medication used to treat low blood sugar) given & 911 called . Fire dept (department) arrived @ 0925 (9:25 a.m.) with resident still unresponsive and diaphoretic . The general acute care hospital (GACH) notes, dated [DATE], indicated, .presented as a transfer .with altered mental status . He was difficult to arouse and was found that his blood sugar was low. He was given IV (intravenous- administered into the veins) [MEDICATION NAME] (medication given by injection to treat low blood sugar). He was diagnosed with [REDACTED]. Patient will be transferred to ICU (intensive care unit) for q1h (hourly) glucose (blood sugar) monitoring . The GACH physician consultation notes, dated [DATE], indicated, .admitted to the hospital with [REDACTED].he is on insulin (medication used to treat elevated blood sugar levels) that was reported that he was on [MEDICATION NAME] (long-acting insulin) and Humalog (rapid-acting insulin). Here in the hospital, he is not on any insulin and he is requiring highly concentrated [MEDICATION NAME] to correct his [DIAGNOSES REDACTED]. Currently, he is on D10 (10% [MEDICATION NAME] injection) running at 40 ml/h (milliliters per hour) and he is receiving juices for low glucose numbers in addition to [MEDICATION NAME] 50%. The resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The progress notes, dated [DATE], at 1:01 p.m., indicated, Patient(')s blood sugar was 56 (mg/dl). Gave juice with sugar . checked sugar again went to 57 (mg/dl). NP (nurse practitioner) made aware. Symptomatic with cool skin. Fed patient lunch, blood sugar is now 84. Will continue to monitor . The progress notes, dated [DATE], at 1:19 p.m., indicated, New orders from NP .DC (discontinue) [MEDICATION NAME] (rapid-acting insulin) . The progress notes, dated [DATE], at 6:46 a.m., indicated, .Per (name of NP) d/c any insulin orders. No insulin orders noted . A physician's orders [REDACTED]. The resident's vital signs report for [DATE] indicated fluctuations with the resident's blood sugar levels: - [DATE], at 5:47 a.m. = 72 mg/dl; - [DATE], at 5:35 p.m. = 78 mg/dl; - [DATE], at 5:47 a.m. = 73 mg/dl; - [DATE], at 10:15 p.m. = 166 mg/dl; - [DATE], at 10:13 p.m. = 163 mg/dl; - [DATE], at 6:09 a.m. = 70 mg/dl; - [DATE], at 4:28 a.m. = 76 mg/dl; - [DATE], at 4:21 p.m. = 77 mg/dl; - [DATE], at 5:56 p.m. = 167 mg/dl; - [DATE], at 6:11 p.m. = 79 mg/dl; - [DATE], at 5:47 a.m. = 170 mg/dl; - [DATE], at 10:01 a.m. = 188 mg/dl; - [DATE], at 4:40 a.m. = 79 mg/dl; - [DATE], at 5:57 a.m. = 79 mg/dl; - [DATE], at 5:33 a.m. = 77 mg/dl; - [DATE], at 4:26 p.m. = 74 mg/dl; - [DATE], at 6:29 a.m. = 75 mg/dl; - [DATE], at 5:45 a.m. = 73 mg/dl; - [DATE], at 9:58 p.m. = 198 mg/dl; - [DATE], at 5:08 p.m. = 176 mg/dl; - [DATE], at 4:07 p.m. = 159 mg/dl; The progress notes, dated [DATE], at 6:53 a.m., indicated, Called to room at 0523 (5:23 a.m.). Noted dark brown emesis (matter that has been vomited) on upper shirt. Unresponsive. No respirations. No pulse. Full code status (primary goal of prolonging life by all medically effective means) noted. Initiated CPR (cardiopulmonary resuscitation- medical procedure involving repeated compression of a patient's chest, performed in an attempt to restore the blood circulation and breathing of a person who has suffered [MEDICAL CONDITION]) with the assistance of 2 other staff members and called 911. Paramedics arrived at 0535 (5:35 a.m.). Continued CPR with paramedic oversight. Paramedics called an end to CPR at 0601 (6:00 a.m.). Unable to appreciate vital signs . The progress notes, dated [DATE], at 7:42 a.m., indicated, At approximately 0523 CNA (certified nursing assistant) notified LVN that patient was unresponsive, upon assessment patient has dark brown emesis on shirt, non responsive to physical and verbal stimuli, no respirations or pulse, RN supervisor was immediately notified . There was no documented evidence the facility staff checked the resident's blood sugar level when the resident was found unresponsive or during the emergency code. On [DATE], at 2:28 p.m., LVN 1 was interviewed regarding Resident A and stated the resident was alert with periods of confusion as his baseline. She stated at 5:23 a.m., CNA 1 called for help to check on Resident A. She stated the resident was not breathing at that time and CPR was initiated. When asked if the resident's blood sugar was checked by any facility staff during that time, she stated she doesn't remember if it was done. On [DATE], at 11:40 a.m., the Director of Nursing (DON) was interviewed regarding Resident A, and stated he worked as the registered nurse supervisor during that time. He stated the resident was diabetic and was receiving [MEDICAL TREATMENT] treatments three times a week. He stated on [DATE], at 5:23 a.m., the resident was observed without pulse or respirations and had emesis on his chest. He confirmed there was no documentation of the resident's blood sugar when he was found unresponsive and stated the resident's blood sugar was not checked by any facility staff during the emergency code. When asked if facility staff would check the resident's blood sugar during an emergency code, he stated, .not all the time .there are times blood sugar (levels are) not being checked during a code . The facility's policy and procedure titled, Nursing Care of the Resident with Diabetes Mellitus, dated [DATE], was reviewed and indicated: Diabetes is a disorder in which there is relative or absolute lack of insulin, which results in elevated blood sugar .and lack of energy for cellular function. Symptoms Associated with Diabetes: [MEDICAL CONDITION] (blood sugar above target levels). Early signs and symptoms of [MEDICAL CONDITION] may include .polydipsia (increase thirst) .headache .lethargy (sleepiness or fatigued) . Diabetic ketoacidosis (DKA- a life-threatening problem that affects people with diabetes) . loss of consciousness; and/or .coma .[DIAGNOSES REDACTED] .signs and symptoms of [DIAGNOSES REDACTED] usually have a sudden onset and may include the following . weakness . restlessness . pale, cool, moist skin . (more severe) stupor (a state of near-unconsciousness or insensibility), unconsciousness and/or convulsions; and .coma (deep state of prolonged unconsciousness in which a person cannot be awakened; fails to respond normally to painful stimuli, light, or sound). .Management of [DIAGNOSES REDACTED] . For symptomatic and unresponsive residents with [DIAGNOSES REDACTED] . immediately administer oral glucose paste to the [MEDICATION NAME] mucosa (lining of the cheeks and the back of the lips), intramuscular (injection administration into a muscle) [MEDICATION NAME], or IV 50% [MEDICATION NAME] . If resident remains unresponsive, call 911 . From the Journal of Emergency Medical Services (JEMS), in its article titled, Recognizing & Treating [DIAGNOSES REDACTED], [MEDICAL CONDITION] & Other Diabetes-related Health Problems, dated [DATE], it indicated: .Diabetic emergencies account for ,[DATE]% of EMS (Emergency Medical Services) calls. EMS is likely to encounter two types of diabetic emergencies: [DIAGNOSES REDACTED] and diabetic ketoacidosis, with [DIAGNOSES REDACTED] being the most common. Both are potentially life-threatening . Glucometer

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

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) readings have been found to be both safe and accurate in the prehospital setting, providing that the glucose strips have been properly stored. The central nervous system relies entirely on glucose as its energy source. If glucose levels fall, the brain is affected and a change in mental status occurs. [DIAGNOSES REDACTED] is defined as a serum (blood) glucose level below 70 mg/dL. Normal blood glucose is between ,[DATE] mg/dL. [DIAGNOSES REDACTED] is the most common endocrine emergency. If glucose continues to be unavailable, a change in the patient's mental status results. Patients become confused, experience headache, and then progress into semiconsciousness and unconsciousness, progressing rapidly to brain damage . [DIAGNOSES REDACTED] can also occur in the non-diabetic patient. It's important to consider [DIAGNOSES REDACTED] as the cause of unconsciousness in all patients . [DIAGNOSES REDACTED] is a medical emergency that must be treated immediately. An initial blood glucose reading may confirm suspicion of [DIAGNOSES REDACTED] .