

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155819	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2016
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 SOUTH DIXON ROAD KOKOMO, IN 46902
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00191230.</p> <p>Complaint IN00191230-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F309.</p> <p>Survey dates: February 1 and 2, 2016</p> <p>Facility number: 013153 Provider number: 155819 AIM number: 201254360</p> <p>Census bed type: SNF: 49 NF: 7 Residential: 30 Total: 86</p> <p>Census payor type: Medicare: 36 Medicaid: 7 Other: 13 Total: 56</p> <p>Sample: 4</p> <p>These deficiencies reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The submission of this Plan of Correction does not indicate an admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Wellbrooke of Kokomo. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p> <p>The provider respectfully requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>Quality Review was completed by 21662 on February 9, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a Physician was notified of abnormal vital signs for 2 of 4 residents whose vitals sign results were reviewed. (Residents B and C)</p> <p>Findings include:</p> <p>1. Resident B's record was reviewed on 2/2/16 at 10:54 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, hypertension and cerebrovascular disease.</p> <p>A Physician progress note, dated 12/24/15, indicated the resident had a history of multiple cerebrovascular accidents (strokes).</p> <p>The resident's vital sign documentation in the facility computer system indicated the following blood pressures (BP) on the following dates and times were documented in red on the computer screen and the Physician was not notified:</p> <p>1/4/16 at 9:14 a.m.--180/103 (high) 1/8/16 at 9:12 p.m.--168/106 (high) 1/13/16 at 9:49 p.m.--170/116 (high) 1/13/16 at 11:20 p.m.--170/116 (high) 1/21/16 at 7:51 a.m.--141/103 (high)</p>			F 0157	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</p> <p>Wellbrooke of Kokomo practice is to notify Physicians of abnormal vital signs. Resident B's Physician will be notified of abnormal vital signs. Resident C is no longer a Resident of the facility.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p><i>A Physician Notification Audit of Abnormal Vital Signs</i> (Attachment A) conducted and all other residents were assessed, interventions were put in place and nurses notified Physician of abnormal vital signs.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee re-educate the nurses on the following guideline:</p>		03/03/2016

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	<p>1/22/16 at 10:30 a.m.--160/107 (high)</p> <p>There was no documentation, which could be located in the resident's record to indicate the Physician had been notified of these elevated blood pressures. The facility was asked to provide documentation to indicate the physician was notified and they were unable to provide that documentation.</p> <p>2. Resident C's record was reviewed on 2/1/16 at 1:58 p.m. Diagnoses included, but were not limited to, hypothermia (low body temperature), diabetes mellitus type 2, hypotension, atrial fibrillation and chronic systolic (congestive) heart failure.</p> <p>A Physician progress note, dated 12/5/15, indicated Resident C had recently been admitted to the hospital after going to the Emergency Room with complaints of fatigue and she was admitted to the hospital with hypothermia as one of her diagnoses.</p> <p>The resident's vital sign documentation in the facility computer system indicated the following blood pressures and temperatures on the following dates and times were documented in red on the computer screen and the physician was not notified:</p>		<p>Vital Signs Guidelines (Attachment B)</p> <p>Physician Notification of Dianostic Testing (Attachment C)</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>Physician Notification Audit of Abnormal Vital Signs (Attachment A)</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>12/2/15 at 1:56 a.m.--94/60 (low)</p> <p>12/4/15 at 8:42 a.m.--94.1 F (Fahrenheit) (low)</p> <p>12/5/15 at 3:54 p.m.--95.8 F (low)</p> <p>12/10/15 at 11:53 p.m.--93.1 F (low)</p> <p>12/14/15 at 12:26 a.m.--92.5 F (low)</p> <p>12/14/15 at 10:15 p.m.--94.4 F (low)</p> <p>12/17/15 at 11:17 p.m.-91.4 F (low)</p> <p>12/18/15 at 11:22 p.m.--92.2 F (low)</p> <p>12/22/15 at 5:46 p.m.--94.5 F (low)</p> <p>12/23/15 at 7:50 p.m.--90/50 (low)</p> <p>12/23/15 at 10:43 p.m.--90/50 (low)</p> <p>12/31/15 at 3:58 p.m.--93.7 F (low)</p> <p>1/2/16 at 3:58 p.m.--94.3 F (low)</p> <p>1/5/16 at 11:26 p.m.--90.7 F (low)</p> <p>1/15/16 at 1:28 p.m.--94.5 (low)</p> <p>The resident's vital sign documentation in the computer on the Medication Administration Records, dated December 2015 and January 2016, indicated the resident's blood pressure medications on the following dates and times were either held by the nurse or refused by the resident due to the resident's blood pressures being low and the physician was not notified:</p> <p>12/5/15 at 8:01 p.m.--88/52 (Metoprolol held)</p> <p>12/8/15 at 8:26 a.m.--93/45 (Lisinopril & Metoprolol)</p> <p>12/8/15 at 9:17 p.m.--82/53 (Metoprolol)</p> <p>12/13/15 at 9:11 a.m.--99/61 (Lisinopril</p>			

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	<p>& Metroprolol held) 12/19/15 at 9:25 a.m.--98/58 (Resident refused Lisinopril & Metroprolol) 12/19/15 at 7:45 p.m.--90/58 (Resident refused Metroprolol) 12/20/15 at 7:44 a.m.--96/50 (Lisinopril & Metroprolol held)</p> <p>There was no documentation, which could be located in the resident's record to indicate the Physician had been notified of the low blood pressures or low temperatures. The facility was asked to provide documentation to indicate the physician was notified and they were unable to provide that documentation.</p> <p>During an interview on 2/2/16 at 1:50 p.m., the Interim Director of Nursing (DON) indicated the red vital sign numbers on the vital sign page in the computer indicated those vital signs were out of normal range for that resident. They were either too high or too low. She indicated those vital sign numbers would be taken to morning meeting and discussed with the team to determine if there needed to be new orders obtained for the resident. She indicated if the vital sign numbers were unusually high or low for a resident, she expected the nurse to retake that vital sign and if that number was correct, then she expected the nurse to notify the Physician with the vital sign</p>			

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	<p>result.</p> <p>During an interview on 2/2/16 at 2:03 p.m., LPN #2 indicated (name of Physician) knew about Resident C's low temperature and he had indicated to continue with the same treatment that she was receiving, so she did not call him every time the resident's temperature was low.</p> <p>During an interview on 2/2/16 at 5:10 p.m., RN #1 indicated she did not call Resident C's Physician every time her BP or temperature was low or in the red zone on the vital sign chart in the computer because all the nursing staff knew "verbally" when (name of Physician) wanted to be called about his residents vital signs. She indicated he would not want to be called for a low systolic BP unless it was below 90 if he did not have call parameters ordered for the resident already.</p> <p>During an interview on 2/2/16 at 5:44 p.m., the Interim DON indicated the facility was going to have to sit down and collectively discuss the vital signs that showed up on the computer screen in red as vital signs out of the normal ranges because those vitals depended on the resident and their diagnoses whether they were actually abnormal for that resident</p>			

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F 0282 SS=D Bldg. 00	<p>or not and when they needed to be called to the Physician if there were no parameters ordered already. She indicated these residents' Physician had a protocol to call for systolic blood pressures over 180, but not for anything about the diastolic blood pressures, temperatures or low blood pressures.</p> <p>A current policy titled "Vital Signs Guidelines" revised on 12/2007, provided by the Medical Records staff person on 2/2/16 at 4:39 p.m., indicated "... Procedure... 4. The physician will be notified of a significant change in vitals...."</p> <p>This Federal Tag relates to complaint IN00191230.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to administer a resident's antibiotic in a timely manner for 1 of 4 residents reviewed for following the resident's plan of care. (Resident C)</p>	F 0282	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo practice is to administer a resident's antibiotic in a timely manner. Resident C did receive</p>	03/03/2016

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	<p>Findings include:</p> <p>Resident C's record was reviewed on 2/1/16 at 1:58 p.m. Diagnoses included, but were not limited to, hypothermia (low body temperature), diabetes mellitus type 2, hypotension, atrial fibrillation and chronic systolic (congestive) heart failure.</p> <p>The resident's Medication Administration Record (MAR) dated January 2016, indicated she had an order, dated 1/15/16, for Levaquin (Levofloxacin) (an antibiotic medication) 500 milligrams by mouth daily scheduled between 12:00-2:00 p.m. The MAR indicated the first dose of Levaquin was given on 1/15/16 between the scheduled time of 12:00-2:00 p.m.</p> <p>The progress notes indicated the following: 1/9/16 at 10:13 a.m.--"Resident's bilateral lower extremities are edematous, red, and warm to touch with scattered blisters on bilateral lower legs...." 1/13/16 at 2:31 p.m.--"Writer assessed residents bilateral lower extremities and noted skin was moist and draining with open blister to right lower extremity measuring 1 x 0.5. Noted scant serosang</p>		<p>their antibiotic the next dose.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: A Following Physician Antibiotic Orders Audit (Attachment D) was conducted and no other Residents were affected.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee re-educate the nurses on the following guideline: Specific Medication Administration Procedure /Preparation & General Guidelines (Attachment E) How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Following Physician Antibiotic Orders Audit (Attachment D) The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>(watery/bloody) drainage present to old dressing. Writer noted another open blister to right lower extremity measuring [sic] 0.5 x 0.6. Noted scant serosang drainage. One open blister to left lower extremity measuring 0.8 x 0.6. Moderate serosang drainage...."</p> <p>1/13/16 at 3:15 p.m.--"Resident complaining of increased pain and swelling in bilateral lower extremities. Bilateral extremities continue to be red, edematous, and slightly warm with areas on bilateral legs increased in size...."</p> <p>1/14/16 at 1:30 p.m., (Recorded as a late entry on 1/15/16 at 3:01 p.m.)--"Writer assessed bilateral lower extremities and noted that legs are swollen, red, and warm to touch... Writer attempted to contact [name of Physician] but had to leave a message. Awaiting return phone call at this time."</p> <p>1/14/16 at 2:45 p.m., (Recorded as a late entry on 1/15/16 at 2:16 p.m.--[Name of Physician] called back with new order noted to start Levaquin 500 mg PO [by mouth] QD [every day] times 10 days for treatment of cellulitis...."</p> <p>1/15/16 at 2:30 p.m.--"Temp 94.5 ax [axillary]. ATB [antibiotic] therapy started for treatment of cellulitis to BLE's</p>			

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F 0309 SS=D	<p>[bilateral lower extremities]. Bilateral lower legs red, warm to touch and edematous. Has a few small blisters on bilateral legs that have opened up and are now draining. Complains of increased pain in bilateral lower extremities...."</p> <p>A current document titled "Oral Medication" revised 11/9/12, provided by the Medical Records staff member on 2/2/16 at 3:20 p.m., indicated this was the facility's oral medication Emergency drug kit list. The list indicated there was 10 tablets of Levofloxacin 250 milligrams available in the Emergency drug kit.</p> <p>During an interview on 2/2/16 at 5:07 p.m., the Medical Record staff member indicated the first dose of Levaquin, which was ordered on 1/14/16, for Resident C's cellulitis was not given until 1/15/16.</p> <p>This Federal Tag relates to complaint IN00191230.</p> <p>3.1-35(g)(2)</p>				
	483.25 PROVIDE CARE/SERVICES FOR				

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Bldg. 00	<p>HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to monitor a resident with a decreased blood sugar and blood pressure and who had previously been having loose stools while in the bathroom for 1 of 4 residents being reviewed for change of condition. (Resident C)</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 2/1/16 at 1:58 p.m. Diagnoses included, but were not limited to, hypothermia (low body temperature), diabetes mellitus type 2, hypotension, atrial fibrillation and chronic systolic (congestive) heart failure.</p> <p>A "Vitals Report" dated 2/2/16, provided by the Interim Director of Nursing (DON) on 2/2/16 at 1:15 p.m., indicated the resident's blood sugar on 12/20/16 at 6:19 a.m., was 63 mg (milligrams)/ dl (deciliter).</p> <p>The resident's Medication Administration Record (MAR), dated December 2015,</p>	F 0309	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo practice is to monitor Residents who have blood pressure and blood sugar change in condition. Resident C is no longer a Resident of the facility. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: <i>Blood Pressure and Blood Sugar Change of Condition Audit</i> (Attachment F) was conducted and all other residents were assessed and interventions were in place to address change in condition. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee re-educate the nurses on the following guideline: <i>Change in Condition Form</i> (Attachment G) How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits</p>	03/03/2016	

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	<p>indicated she had an order for Glipizide (a medication that helped lower the blood sugar) 10 milligrams daily between 6:00 a.m.-10:00 a.m. The MAR indicated Resident C received her dose of Glipizide for that date between the scheduled time period.</p> <p>The resident's meal consumption for breakfast on 12/20/15, documented in the vitals section in the computer indicated the resident consumed 26-50% of her breakfast that day.</p> <p>The resident's MAR, dated December 2015, indicated her Metroprolol (a blood pressure medication) and Lisinopril (a blood pressure) were held by the nurse on 12/20/15 at 7:44 a.m., due to her blood pressure was 96/60.</p> <p>The resident's MAR, dated December 2015, indicated she had received Loperamide (a medication for loose stools) 2 milligrams by mouth three times a day as needed for diarrhea on these dates and times: 12/18/15 at 2:36 p.m., which was somewhat effective. 12/18/15 at 8:23 p.m., which was somewhat effective. 12/20/15 at 10:30 a.m., which the effectiveness was not determined.</p>		<p>and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Blood Pressure and Blood Sugar Change of Condition Audit ((Attachment F) The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155819	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/02/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 SOUTH DIXON ROAD KOKOMO, IN 46902		
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	<p>Resident C's progress notes indicated the following"</p> <p>12/14/15 at 12:48 p.m.--"N.O. [new order] Loperamide 2 mg TID [three times a day] as needed for diarrhea..."</p> <p>12/20/15 at 1:47 p.m.--"Res [resident] found unresponsive on commode. Drooling. Pulse 69. Resp [Respirations] 16. Res transferred back to bed with assist of 4. Res remains unresponsive. 911 called. Res being transferred to [Name of hospital] Called [Name of family member] 100/58. Pupils react slowly, equal...."</p> <p>12/20/15 at 1:52 p.m.--"EMT [Emergency Medical Technician] arrived. Bld [blood] sugar reading low. EMT gave res D50 [glucose]. Res started to come back around. Res remains hypotensive, systolic reading 70-80, EMT gave fluids, Res is currently being transferred to [Name of hospital]."</p> <p>12/20/15 at 6:26 p.m.--"Received call from [Name of Hospital] and they said they are admitting her for Hypotension and unresponsiveness...."</p> <p>A Physician's "History and Physical" report from (Name of the Hospital) dated 12/21/15, indicated the resident presented to the Emergency Room on 12/20/15.</p>				

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	<p>Her (family member) had been trying to reach her by phone since 1:00 p.m., on 12/20/15, but was unable to reach her. The family member indicated he later received a call from the facility and was told his family member was sent to the hospital. EMS (Emergency Medical Service) was called and her blood sugar was found to be low on the glucometer and she was hypotensive with systolic blood pressure in the 60's. A repeat blood sugar in the Emergency Room was 40 after being given Dextrose by the EMS. She reported she has had intermittently loose stools through her colostomy for several years, which has been a chronic issue, but had worsened recently. Resident C indicated she felt well up until that morning of 12/20/15, when she took her medications and after that she could not recall any events. The impression and plan indicated the resident had hypotension, which dehydration was suspected due to high ostomy output and recent diuresis.</p> <p>A "Patient Care Record" from (Name of Hospital) dated 12/20/15, indicated the primary impression was diabetic hypoglycemia and the secondary impression was altered level of consciousness. The narrative indicated the EMS was dispatched to the facility</p>			

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	<p>for an unconscious resident. Upon arrival to the facility, EMS found Resident C unresponsive in her bed. Staff had indicated to EMS they had assisted Resident C to the bathroom 40 minutes ago, which was not normal for her and she seemed weaker than normal. The staff indicated she was usually alert and oriented and she was able to take care of herself. The staff indicated they came to check on her and she was unconscious. Resident C was unresponsive. Her blood sugar check indicated "Lo" on the glucometer. Dextrose was given by intravenous injection and the resident became alert and oriented and was conversing normally, but she remained lethargic. Her blood pressure was 66/34. The EMS was dispatched to the facility at 1:35 p.m.</p> <p>The Emergency Department discharge instructions indicated she had diagnoses of severe dehydration and hypotension. The discharge instructions from her hospital admission had a diagnosis of hypoglycemia.</p> <p>During an interview on 2/2/16 at 1:58 p.m., CNA #3 indicated Resident C normally transferred with supervision. She indicated the resident would walk to and from the bathroom with her walker. CNA #4 indicated the resident would sit</p>			

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	<p>on the toilet until she was ready to get up, then she would pull the call light cord and the CNA's would go supervise her while she walked back to her chair or bed. CNA #3 indicated the maximum she would allow her resident to sit on the toilet before she would check on her would be 10 minutes. Both CNA's indicated they were off work on 12/20/15.</p> <p>During an interview on 2/2/15 at 2:31 p.m., RN #1 indicated the resident's vitals along with her blood sugar were done on 12/20/15 and they were good that day. She indicated the CNA's helped her get dressed that morning. She indicated she went into the bathroom to check on the resident because it was time for her medication and she was in the bathroom found somewhat responsive with her head down and when she called her name she looked up at RN #1 with a blank stare, then her head fell back down again and she did not respond. She indicated she called for help and RN #5 came into the bathroom and helped transfer the resident back into her wheelchair. RN #1 indicated as the two of them were transferring Resident C into her wheelchair she was going unconscious. She indicated it required a third staff member to get the resident back into bed. RN #1 indicated she assessed the resident</p>			

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	<p>and her blood pressure was low and 911 was called. She indicated it had probably been 20 minutes since the resident had been on the toilet without anyone checking on her, but she did her own colostomy care, so she didn't think anything about her being on the toilet for awhile.</p> <p>This Federal Tag relates to complaint IN00191230.</p> <p>3.1-37(a)</p>				