**Nursing Home Deficiency Examples Illustrating the Importance of a 24 hour RN Presence**

**Resident Receives Inadequate Treatment for Severe Pain**: A resident told the surveyor she was having severe face and jaw pain. The surveyor observed swelling and redness that extended down the right side of the resident’s face, jaw, right side of her neck, and light purple discoloration on her right ear. The resident was only able to eat 25% of her meal due to pain and had to sit up or she felt like she would choke on her saliva. The swelling and pain had been identified earlier by a licensed practical nurse (LPN), and the only intervention was Tylenol. The LPN that was the charge nurse on the night the  resident was noted with swelling and pain to the right side of her face/jaw reported that she thought it was a stopped up salivary gland. She had not contacted the physician. The LPN on the day shift the following morning said there had been nothing in the shift report notes and nothing had been said to her that morning about the pain the reident was experiencing. She said the resident complained of itching, and she noted the jaw was red and swollen. The LPN said the physician was out of town, but she left a message on the Physician Assistant (PA)'s answering machine, and the PA called back the next day and ordered the Tylenol. The PA was asked by the surveyor what she had been told about the resident's pain. She reported the staff said the resident was having pain to the side of her face. She was not told anything else and stated she would be seeing the resident next week when she made her rounds at the facility. She was not contacted about lack of pain relief. During the survey, the primary physician was out of town, so the medical director was notified and requested the resident with severe jaw and face pain be sent to his office for evaluation. She was admitted directly to the hospital from his office.

**Resident Mortality due to Inadequate Medical Emergency Response**: A resident fell in the morning and hit his head. As a precaution the physician was notified and the resident was sent to the Emergency Room to be examined. He returned to the nursing home with no new instructions. Checks to monitor blood pressure, pulse, respirations, temperature, and pupil size were conducted to identify changes related to a potential head injury from the fall. However, the frequency of the checks was not followed as established by the facility policy. The check sheet said to notify the physician immediately of signs and symptoms such as decreased consciousness, headache, lethargy, weakness, vomiting, double vision, and eye movement problems. The resident was receiving an anticoagulant medication prior to his fall to prevent formation of harmful blood clots. Lab tests reported the morning of the fall showed that the medication concentration in his blood was elevated to a critical level. The Licensed Practical Nurse (LPN) said she faxed the test results to the doctor. A Registered Nurse (RN) would have understood that critically elevated levels of anticoagulant medication combined with a potential head injury constituted a medical emergency, and would have called the physician directly. The LPN charge nurse failed to tell the LPN administering medications of the critical lab results, so the resident received another dose of the anticoagulant medicine. An RN would have directed that this medication be withheld while obtaining new instructions from the physician. The resident developed signs of confusion with rising blood pressure and complaints of headache during the night, all signs that a medical emergency was in process and that bleeding was continuing into the resident’s head. The doctor was not notified by the LPN charge nurse because, according to the LPN, “He didn’t like to be called at night unless it was an emergency. “ An RN would have realized immediately that the confusion, elevated blood pressure, and headache were danger signs and constituted a change in condition requiring immediate action needing to be communicated immediately to the physician. The second day after the fall, the doctor was notified of the resident’s change of condition and ordered a CT scan of the head. The resident was sent for a CT scan at an outpatient center 2½ hours after the order was received. An RN would have assessed the situation, realized the severity of the changes, and immediately sent the resident via an ambulance for an emergency CT scan in the ER and not in an outpatient setting. Once completed, the scan showed that the resident had significant bleeding in his brain. Because his anticoagulant level was so high, doctors at the hospital could not operate to remove the collection of blood pressing on his brain. The elevated anticoagulant level prevented his blood from clotting to stop the hemorrhage. Despite doctors’ efforts at giving the resident multiple units of blood and Vitamin K, which improves clotting time, the resident continued to bleed into his head. His family transferred him to hospice, and he died four days after his fall.