DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185314	A. BUILDING ____ B. WING ____	C 10/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	115 PIONEER TRACE FLEMINGSBURG, KY 41041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An Abbreviated/Partial Extended Survey investigating Complaint #KY00023779, Complaint #KY00023821, and Complaint #KY00023879 were initiated on 09/15/15 and concluded on 10/02/15. Complaint #KY00023779, Complaint #KY00023821, and Complaint #KY00023879, were substantiated with deficiencies cited. Immediate Jeopardy (IJ) was identified on 09/24/15 at 42 CFR 483.10 Notification of Change, F-157; 42 CFR 483.20 Services by Qualified Professionals, F-282; 42 CFR 483.25 Quality of Care F-309; 42 CFR 483.25 Hydration F-327; 42 CFR 483.75 Clinical Records, F-514 all at a Scope and Severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F-309, and 42 CFR 483.25 Hydration F-327. The Immediate Jeopardy was determined to exist on 09/11/15 and the facility was notified of the Immediate Jeopardy on 09/24/15. Additional deficiencies were also cited at 42 CFR 483.15 Dignity, F-241 at a Scope and Severity of a "D", and 42 CFR 483.65 Infection Control, F-441 at a Scope and Severity of a "D".

Resident #2 was placed on the hydration list on 09/12/15, due to not meeting his/her estimated fluid needs for the past twenty-four hours. On 09/11/15, Resident #2 was assessed to have a temperature of 101.1 degrees Farenheit and the Physician was notified and orders were received for Zithromax (antibiotic medication) for a Upper Respiratory Infection. Although the resident received the Zithromax medication on 09/11/15 at 5:00 PM, there was no documented evidence the resident received the Tylenol (medication for pain and fever reducer) for the temperature as ordered. Interviews revealed on 09/11/15,

2015

2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	10/28/15

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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between 8:00 PM and 10:00 PM, Resident #2's temperature was obtained, however, not documented until 09/12/15 at 12:38 AM as one-hundred and two (102) degrees Farenheit when the nurse also documented the resident had wheezes and Rhonchi (abnormal breath sounds) to the bilateral lungs. The resident was not administered the as needed (PRN) Tylenol until approximately 12:38 AM, which was over two (2) hours after his/her temperature was obtained. Although the resident had an increased temperature of 102 degrees F, and interviews with Certified Nursing Assistants (CNA's) revealed the resident had decreased urine output throughout second (2nd) shift on 09/11/15 and no urine output on 09/12/15 on the third (3rd) shift, between the times of 1:00 AM, 3:00 AM, and 5:00 AM, and the nurse was notified, there was no documented evidence the Physician was notified of the increased temperature or the decreased and lack of urine output. In addition, there was no documented evidence the resident was assessed or continuously monitored by staff. Interview with Licensed Practical Nurse (LPN) #1, the nurse assigned to the resident from 09/11/15 from 6:00 PM until 09/12/15 at 6:00 AM, revealed she last checked the resident on 09/12/15 at approximately 12:30 AM to 1:00 AM when she completed a treatment to the resident's buttocks, but did not check on the resident again until approximately 6:00 AM. Resident #2 was found on 09/12/15 at approximately 6:00 AM to be unresponsive in respiratory distress. The resident was transferred to the hospital on 09/12/15 and arrived at the hospital emergency room at 6:57 AM unresponsive with a documented one-hundred and six point seven (106.7) degree rectal temperature and was admitted to the Critical Care Unit (CCU) at the local Hospital and

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placed on a ventilator with diagnoses of Dehydration, Pneumonia, and Sepsis. Resident #2 expired on 09/21/15 related to complications of his/her increased temperature, dehydration, and sepsis.

An acceptable credible Allegation of Compliance was received on 10/02/15, alleging removal of the Immediate Jeopardy on 09/30/15. The State Survey Agency verified the Immediate Jeopardy was removed as alleged on 09/30/15, prior to exit on 10/02/15, with remaining non-compliance at 42 CFR 483.10 Notification of Change, F-157; 42 CFR 483.20, Services by Qualified Professionals, F-282; 42 CFR 483.25 Quality of Care, F-309; 42 CFR 483.25 Hydration, F-327; and, 42 CFR 483.75 Clinical Records, F-514 all at a Scope and Severity of a "D", while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

F 157 SS=J 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

F 157

Resident #2 was transferred to hospital on 9/12/2015 and did not return to facility. On 9/25/2015, DON reviewed Resident #9 medical record for necessity for notification of change. Medical Record review revealed no further requirement for notification of change on 9/25/2015.

Beginning the night of 9/24/2015 and ending on 9/25/2015, Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited

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treatment), or a decision to transfer or discharge the resident from the facility as specified in §483.12(a)

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

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member

This REQUIREMENT is not met as evidenced by.
Based on interview, record review and review of facility policy, it was determined the facility failed to have an effective system in place to ensure the Physician and/or legal representatives were notified when there was a significant change in the resident's physical status or a need to alter treatment significantly for two (2) of nine (9) sampled residents (Residents #2 and #9).

Resident #2 did not meet his/her Estimated Fluid Need (EFN) on 09/03/15, 09/05/15, 09/07/15, 09/09/15, and 09/11/15, and on 09/11/15 at 5:16 PM, Resident #2 spiked a fever of 101.1 degrees Farenheit (F). The Physician was notified and the resident was started on Zithromax (antibiotic medication) for an Upper Respiratory Infection. On 09/11/15 between 8:00 PM and 10:00 PM the resident was assessed to have a further

F 157 100 percent of resident clinical records pertaining to notification of change. No evidence found that any other residents adversely affected by notification of change. On 9/24/2015, Administrator and DON reviewed facility policies regarding change in resident status and notification of change for compliance of Federal regulations. It was determined that facility policy had been followed regarding notification of change related to Resident #2's fluid intake on 9/11/2015. Facility policy "Notification of Change" updated to include facility requirements when notification of change is to occur and who staff is to notify on 9/25/2015 by Administrator. On 9/21/2015, Administrator and Medical Director created Abnormal Vital Signs policy, which instructs staff on definition of abnormal vital signs, actions nurses should take when abnormal vital signs obtained, and when to notify physician, resident, and/or responsible party/POA.

24 out of 26 nurses were educated on updated Notification of Change policy and new Abnormal Vital Signs

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increased temperature of 102 degrees F; however, there was no documented evidence the Physician was notified of the 102 degree temperature. Staff interviews revealed Resident #2 who was a "heavy wetter" and normally incontinent of urine every two (2) hours; had no urinary output during rounds on 09/12/15 at 1:00 AM, 3:00 AM, and 5:00 AM. Additionally, the resident was receiving routine Lasix (a medication to increase the excretion of water from the body) Lasix (diuretic) forty (40) milligrams (mg's) twice a day for Essential Hypertension. Staff interviews further revealed Resident #2 was showing signs and symptoms of dehydration including decreased or no urine output, dry chapped lips, fever, weakness, and limited food and liquid intake. However, there was no documented evidence the resident was closely monitored and no documented evidence the physician was notified of the resident's signs and symptoms of dehydration

On 09/12/15, at approximately 6:00 AM, Resident #2 was observed to be unresponsive, in respiratory distress with a temperature of one 102.2 degrees F. axillary. Resident #2 was transferred to the hospital Emergency Room (ER), on 09/12/15 at 6:57 AM and on arrival had a rectal temperature of 106.7 degrees F, was unresponsive, had mottled skin (blood vessel changes in the skin that cause a patchy appearance), agonal respirations (gasping labored breathing), capillary refill time of eight (8) seconds, laboratory values which indicated severe dehydration, and his/her soft palate and uvula were like "sand paper" Resident #2 was admitted to the Critical Care Unit (CCU) at the Hospital and placed on a ventilator due to diagnoses of Dehydration, Pneumonia, and

F 157 policy on dates 9/24/2015 through 9/29/2015 by DON, ADON, Staff Development Coordinator, and QAPI Nurse. Education was conducted in small group sessions with open conversation and question and answer period at the end to test knowledge and understanding of the policies. The nurses that did not receive education will not provide direct care until education on Abnormal Vital Signs policy and Notification of Change policy has been received. Furthermore, these policies have been added to the facility's orientation program which is conducted prior to new nurses providing direct care in the facility beginning with next orientation on 9/28/2015. This facility does not utilize Agency staffing. On 9/24/2015, Administrator reviewed facility policies with DON, ADON, Staff Development Coordinator and QAPI Nurse to ensure thorough understanding and knowledge of Federal regulations pertaining to notification of change prior to education of staff.

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F 157	Continued From page 5 Sepsis. Resident #2 expired on 09/21/15. Additionally, although the facility faxed the Physician related to Resident #9 having edema to his/her right leg on 09/25/15, after the resident's Power of Attorney (POA) told nurses she was concerned about the resident's leg (on 09/24/15 and 09/25/15), there was no documented evidence the facility called the physician to follow up on the fax. On 09/27/15, the resident's POA notified the Physician of the resident's right leg edema. An Echo/Vascular Ultrasound was completed on 09/28/15, which revealed Resident #9 was positive for a Deep Vein Thrombosis (DVT), blood clot. The facility's failure to have an effective system in place to ensure the Physician and legal representatives were notified when there was a significant change in the resident's physical status or a need to alter treatment significantly has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/24/15, and was determined to exist on 09/11/15. The facility was notified of the Immediate Jeopardy on 09/24/15 The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/02/15 with the facility alleging removal of the Immediate Jeopardy on 09/30/15. The State Survey Agency validated removal of the Immediate Jeopardy, on 09/30/15, as alleged prior to exit on 10/02/15, with remaining non-compliance in the area of 42 CFR 483.10 Resident Rights, F-157 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic change.	F 157	Staff Development Coordinator, QAPI Nurse, MDS staff, and Charge Nurses, began auditing 100 percent nurse documentation daily, including weekends, to monitor staff compliance with facility policy regarding notification of changes in resident status. This audit will continue until next QAPI meeting on 11/16/15, in which audit results will be reviewed and the committee will determine need for continued daily 100 percent audits. All issues identified with regards to these policies will be immediately addressed with individual staff responsible and results of audits presented to QAPI Committee for review and process improvement if necessary. The QAPI Committee consists of Administrator, DON, ADON, Social Worker, Maintenance Director, Medical Director, Activities Director, Housekeeping/Laundry Supervisor, and Dietary Manager. The QAPI Committee meets monthly. 10/30/15

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The findings include:

Review of the facility's policy, titled "Notification of Change in Residents' Condition", revised on 08/03/15, revealed, staff should immediately inform the resident, consult with the resident's physician, and if known; notify the resident's legal representative when there was a change in the resident's status/condition. Continued review revealed, in the event of a resident's status change, the nurse would assess the situation, notify the attending physician, provide necessary care, notify the responsible party, document in the resident's medical record and follow up as indicated.

1. Review of Resident #2's medical record revealed, the facility admitted the resident on 02/10/15 with diagnoses which included Parkinsonism, Dysphagia Unspecified, Leukemia, Diabetes Mellitus, and Cerebral Infarction with Paralysis Agitans.

Review of the Comprehensive Care Plan revised 02/16/15, revealed Resident #2 had the potential for fluid deficit related to diuretic use with a goal stating the resident would be free of symptoms of dehydration and maintain moist mucous membranes, and good skin turgor. The interventions included; monitoring vital signs as ordered/per protocol and record, notify the Physician of significant abnormalities, monitor/document/report to Physician signs and symptoms of dehydration: i.e. decreased urine output, cracked lips, fatigue/weakness, fever, dry/sunken eyes and furrowed tongue.

Review of the Nutrition Risk Assessment, dated

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02/20/15, completed by the facility's Dietitian revealed Resident #2's estimated fluid needs (EFN) were two thousand and fifty (2050) to two thousand, four hundred and sixty (2460) cubic centimeters (cc) per day.

Review of the "Follow-Up Question Report" (form used to total fluid intakes), revealed Resident #2 did not meet the estimated fluid needs (EFN) of two thousand and fifty to (2050) to two thousand and four hundred and sixty (2460) milliliters (ml's) per day on 09/03/15, 09/05/15, 09/07/15 09/09/15; and, on 09/11/15. The resident's total fluid intakes were as follows 09/03/15 - 1940 cc 09/05/15 - 1680 cc, 09/07/15 - 2205 cc 09/09/15 - 1220 cc, and 09/11/15 - 1500 cc.

Although, the resident did not have three (3) consecutive days without meeting the EFN in order for staff to notify the Physician of the resident's hydration status as per policy staff interviews revealed the resident was having changes in nutrition/hydration status and they were having difficulty getting the resident to eat and drink. However, there was no documented evidence the resident's Physician was notified of the resident change in condition.

Interview on 09/17/15 at 1:40 PM, with Certified Nursing Assistant (CNA) #5, revealed the week prior to the resident's hospitalization, she observed the resident had a dry mouth, sores on the outside of his/her mouth which she soaked with warm water and a washcloth to clean the "stuff" off the resident's lips.

Interview on 09/17/15 at 10:50 AM, with CNA #4 revealed the resident was cheeking (pocketing) food, had complaints of mouth pain, and the

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resident's lips were dried and chapped. CNA #4 stated he notified Registered Nurse (RN) #4 of these changes with Resident #2.

Interview with CNA #3, on 09/17/15 at 10:50 AM, revealed he worked the week Resident #2 became sick, 09/07/15 through 09/10/15. He stated he observed the resident was more combative than normal and it was difficult to feed him/her, also the resident did not want to eat and it was difficult to "get" fluids in him/her. CNA #3 stated the resident would "cheek" his/her food and would not swallow.

Interview on 09/16/15 at 1:00 PM with the resident's POA revealed he had informed RN# 4 on 09/06/15 and 09/08/15 that they were concerned about the resident not eating and drinking well, and, looking like he/she felt bad and he wanted the Physician to see Resident #2 Review of the facility's Twenty-Four (24) Hour Report dated 09/08/15, revealed a note stating the resident's son, who was the POA wanted the Physician to assess the resident. However, review of the Nurse's Notes dated 09/06/15 and 09/08/15 revealed no documented evidence the resident's Physician was notified of the family's request to contact the physician.

Interview on 09/24/15 at 1:01 PM, with RN #4 revealed she had written the notation on the twenty-four (24) hour report; however, she had failed to ensure the Physician was contacted

Review of the Nurse's Notes dated 09/11/15 at 5:16 PM, completed by RN #4, revealed Resident #2 had a fever of 101.1 F, and crackles (abnormal lung sounds) were noted in the lungs. Per the Note, the Physician was notified and

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orders were received for Zithromax (antibiotic medication).

On 09/12/15 at 12:35 AM, staff documented on the Vital Sign Log, Resident #2 had a temperature of 102 F. Interview with CNA #10 on 09/22/15 at 5:11 PM, and CNA #11 on 09/23/15 at 8:27 AM revealed they worked with CNA #9 the evening of 09/11/15 and thought CNA #9 obtained the vital signs. CNA #9 and CNA #11 stated the vital signs were usually obtained between 8:00 PM and 10:00 PM. However, interview with CNA #9 on 09/22/15 at 4:43 PM revealed he could not recall if he obtained the vital signs the evening of 09/11/15. Staff interviews revealed it was unclear what time the resident's vital signs were obtained on the evening of 09/11/15.

Interview with Certified Nursing Assistant (CNA) #7, on 09/22/15 at 3:44 PM, revealed Resident #2 was not eating or drinking and had only taken in about five-hundred and sixty (560) cc from 2:00 PM on 09/11/15 through 09/12/15 at 6:00 AM, for the two (2) shifts in which she worked. She stated Licensed Practical Nurse (LPN) #1 was informed of the resident's decreased fluid intake. However, record review revealed no documented evidence the resident's Physician was notified of the resident's decreased fluid intake.

Interview with CNA #10, on 09/22/15 at 5:11 PM, revealed she worked the night of 09/11/15 from 2:00 PM until 10:00 PM. She stated she helped CNA #8 with changing Resident #2 and the resident did not have much urine output that shift. She stated the resident was a "heavy" wetter, and low urine output was not normal for him/her. Further interview revealed, the resident was not "combative" or "fighting" with her when she went

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to change him/her which was unusual. CNA #10 stated it was almost like the resident, "did not have much fight left in (him/her)." CNA #10 stated she reported these changes to LPN #1, but she did not know if LPN #1 assessed the resident.

Review of Resident #2's Flowsheet, revealed on 09/12/15, Resident #2 had not urinated at the 1:00 AM, 3:00 AM or 5:00 AM rounds. Interview on 09/22/15 at 3:40 PM, with CNA #7, revealed she reported to LPN #1 that the resident was not urinating and wasn't making any noise, was stiff and difficult to roll over, pale, and had sunken cheeks.

However, there was no documented evidence LPN #1 continued to monitor and/or assess the resident on 09/12/15 and no documented evidence the Physician was notified of the resident's increased temperature of 102 degrees F and signs and symptoms of dehydration even though the nurse was informed the resident was not urinating, was pale, weak and had sunken cheeks.

Interview with Licensed Practical Nurse (LPN) #1 on 09/24/15 at 5:50 PM, revealed on 09/11/15, she was given the resident's vital signs which indicated he/she had a temperature of 102 degrees F. LPN #1 stated she gave the resident two (2) 500 milligram (mg) of Tylenol. She stated she checked the resident's temperature again at approximately 12:30 AM, on 09/12/15, and his/her temperature was 99.0 F. However, LPN #1 stated she did not check on the resident anymore until 09/12/15 at approximately 6:00 AM, when she noticed the resident had no movement and was found mottled. Per interview, LPN #1 stated

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had not been notified by the CNAs that the resident had not urinated throughout the night, she found out through shift report. LPN #1 stated the resident was having signs and symptoms of dehydration; however, she "missed it" and failed to notify the Physician.

Further interview on 09/17/15 at 10:50 AM with CNA #3 revealed at approximately 6:30 AM on 09/12/15, he took the resident's temperature under the resident's arm and it was 102.2 degrees F. CNA #3 stated the resident was found to be in respiratory distress, and was sweating.

Record review revealed Emergency Services was called and the resident was transferred to the local Hospital.

Review of Resident #2's Emergency Room Notes, dated 09/12/15, revealed upon arrival at the Emergency Room (ER) the resident was assessed to have a rectal temperature of 106.7 degrees F, respiratory rate of sixty-eight (68) breaths per minute, was unresponsive, had mottled skin, (changes in the blood vessels under the skin that causes a patchy appearance) agonal respirations, (an abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, accompanied by strange vocalizations). Further review, revealed the resident had a capillary refill time of eight (8) seconds. (normal capillary refill time less than two (2) seconds and prolonged capillary refill time may be a sign of shock which could indicate dehydration and decreased peripheral perfusion)

Review of the laboratory values upon presentation to the ER, revealed; sodium 174

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(reference range 135-145), Potassium 4.1 (reference range 3.5-5.0) Blood Urea Nitrogen (BUN) 75 (reference range 7-20 test to measure the amount of nitrogen in the blood in order to evaluate kidney function). Creatinine 4.0 (reference range 0.6-1.2 -test to evaluate kidney function). The resident was admitted to the Cardiac Care Unit (CCU) for treatment and monitoring for diagnoses of Septic Shock with Hypotension, Pneumonia, Dehydration, and Acute Renal Failure. On 09/15/15, the resident was referred to Hospice and expired on 09/21/15

Interview on 0919/15 at 6:30 AM, with the ER Physician, revealed the resident had severe dehydration. Further interview, revealed the resident had a rectal temperature of 106.7 degrees F and looked septic and dehydrated The ER Physician stated the resident suffered brain damage which was multifaceted related to the sepsis, dehydration and increased temperature which he stated was completely avoidable. The ER Physician stated if the resident's Physician had been contacted when the resident's temperature was 102 degrees F. then an increase in temperature could have been avoided.

Interview on 09/23/15 at 11:40 AM with the On-call Physician for Resident #2 on the evening of 09/11/15 and 09/12/15, revealed he had received no phone call regarding Resident #2's increased temperature He stated if he had been notified he could have most likely prevented the temperature from going up by transferring Resident #2 to the ER for further evaluation and to have blood work drawn.

Interview on 09/17/15 at 10:30 AM with Resident

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F 157	Continued From page 13 #2's Physician revealed he considered a 102 degree F temperature a change in condition and the physician should have been notified. He stated the resident's high temperatures contributed to the resident's dehydration and cerebral injury. He further revealed if he had been notified of the increased temperature, the resident would have been sent to the ER. Continued interview with the Physician revealed the cerebral injury was partially related to the fever and this could have been prevented if the Physician been notified when the resident's temperature was noted to have increased to 102 degree F. Interview on 09/24/15 at 3:59 PM with the Staff Development Coordinator (SDC) revealed if a resident had decreased fluid intake and signs and symptoms of dehydration, the Physician should be notified of the change. She further stated if a resident had an increased temperature, decreased fluids and decreased urine output the physician would need to be notified immediately Interview on 09/24/15 at 4:23 PM with the Assistant Director of Nursing (ADON) revealed her expectation was when a resident had an increased temperature, decreased fluid intake and decreased urination, staff would contact the physician and send the resident to the ER. She stated, an increased temperature did increase the risk for dehydration and by not contacting the Physician she felt the situation with Resident #2 was neglect. Also, she stated LPN #1 should have further informed the Physician that Resident #2 needed to be sent to the ER. The ADON stated she considered a 102 degrees F temperature to be a significant change of condition in a resident.	F 157		

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Interview on 09/24/15 at 5:27 PM, with the Director of Nursing (DON) revealed she considered a temperature of 102 degrees F a "significant change of a resident's condition" and her expectation was for the resident's Physician to be notified and the resident's responsible party to be notified of any change in condition as well

Interview on 09/24/15 at 6:46 PM, with the Administrator revealed he would expect with a change of condition the nurses should have monitored closely and contacted the physician with the change in the resident's condition.

2. Review of Resident #9's medical record revealed the facility admitted the resident on 05/15/13 with diagnoses which included Urinary Tract Infection, Dementia, Depressive Disorder, Insomnia, Orthostatic Hypotension, and Alzheimer's Disease. Review of Resident #9's Quarterly Minimum Data Set (MDS) Assessment dated 08/11/15, revealed the facility assessed the resident to score three (3) out of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating the resident was severely cognitively impaired.

Review of the Nurse's Note completed by RN #5 dated 09/25/15 at 6:48 PM, revealed the Resident's Daughter was concerned about the resident's right leg, particularly his/her calf. The Note stated there was two (2) plus edema from the right ankle to the mid-thigh and measured thirty-nine (39) centimeters (cms) in circumference at the Anterior Tibial Tuberosity. Per the Note, the Daughter stated she had noticed the resident's leg was swollen for a few days but that "today" it was obviously bigger.

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Further review of the Note, revealed the nurse completed an assessment on the resident while he/she was in the bed. The Note stated, the Physician was faxed and the oncoming nurse was given a full report, will continue to monitor

Review of the Facsimile (fax) Transmission to Resident #2's Primary Care Physician (PCP) dated 09/25/15, revealed the resident had two (2) plus (+) edema to the right leg from the ankle to the mid thigh. Continued review of the fax, revealed it was documented that this was "abnormal" for the resident. Further review of the Fax Transmission revealed there was no redness noted and although it was not "warm" it was warmer than the left leg.

Review of the Nurse's Note completed by LPN #9, dated 09/26/15 at 10:16 PM, revealed Resident #9 continued to have three (3) plus (+) pitting edema to the right leg. Per the Note the resident had complaints of pain when deep pressure was applied. According to the Note, Tylenol was given at bedtime to ease discomfort. Further review of the Note, revealed the fax was on the board for the Physician. Review of the Nurse's Note, completed by RN #5, on 09/27/15 at 2:39 PM, revealed the resident was assessed (this morning) before getting out of bed. Per the Note, the resident's right leg still had two (2) plus (+) edema with shiny skin and slight warmth. Further review of the Note, revealed the On-call Physician ordered a doppler ultrasound. Continued review of the Note revealed staff was awaiting for a call back to schedule the procedure. The Note stated the family was in the front lobby, and the nurse would continue to monitor.

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Review of the Ultrasound Echo/Vascular Form, dated 09/28/15, revealed Resident #9 was positive for a Deep Vein Thrombosis (DVT) blood clot.

Review of the Nurse's Note completed by RN #5, on 09/28/15 at 4:41 PM, revealed there was an order for Xarelto (anticoagulant blood thinner used to prevent the formation of blood clots) regarding the positive doppler ultrasound on 09/28/15. Review of Physician's Orders dated 09/28/15 revealed new orders for Xarelto Tablet fifteen (15) milligrams two (2) times a day related to Acute Venous Embolism and Thrombosis of deep vessels of proximal lower extremity for twenty-one (21) days.

Observation of Resident #9, on 10/01/15 at 4:36 PM, revealed the resident was sitting in the hallway in his/her Gerichair, with lego pieces in front of him/her on his/her lap table.

Interview with Resident #9's Daughter/Power of Attorney (POA), on 10/01/15 at 9:15 AM, revealed she had concerns about Resident #9's right leg being swollen and she had notified Licensed Practical Nurse (LPN) #8, on 09/24/15. She stated LPN #8 told her that "they would watch the leg." However, there was no documented evidence in the Nurse's Notes, the POA had expressed concern related to the resident's right leg. Continued interview with the resident's POA revealed she talked to RN #5, on 09/25/15, the next day. She stated she was informed by RN #5, that there was nothing in the Nurse's Notes related to the POA expressing concern about the resident's leg, but she told her, "We will watch it." Resident #9's POA stated she thought her loved one might have had a blood clot, so she was

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persistent about alerting staff about his/her condition. The POA stated the resident did not see a Physician until 09/27/15. She stated, another Primary Care Physician (PCP) #25 was in the facility to see other residents and she (POA) approached PCP #25 to assess the resident. Continued interview with Resident #9's POA, revealed the resident had a blood clot and was now on blood thinners to resolve it. Resident #9's POA reported she felt the staff was "unconcerned" about the needs of her loved one

Interview with Certified Nursing Assistant (CNA) #10, on 10/01/15 at 6:27 PM, revealed she worked with Resident #9. CNA #10 stated Resident #9's family visited the facility often. CNA #10 further revealed she saw the resident's POA tell LPN #8 and RN #5, she thought something was different with the resident's leg. She further stated, LPN #8 stated she would document the family had a concern and LPN #8 asked staff to reposition the resident. Per interview, CNA #10 stated she recalled RN #5 taking measurements because the resident's daughter was still concerned about the resident's leg. Further interview with CNA #10, revealed she heard the daughter say to staff and to another family member that she thought the resident had a blood clot. CNA #10 stated she thought this had been reported to the Physician.

Interview with RN #5, on 10/02/15 at 11:39 AM, revealed the resident's family informed her the resident's leg was swollen more than normal. She stated the resident's POA asked her if she knew about her concern, since she reported it to LPN #8 the day before, on 09/24/15. RN #5 stated she had not, adding LPN #8 "quit" the job. RN #5 reported she measured the resident's leg,

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when the POA asked her about the resident's leg, and both of his/her legs looked swollen. RN #5 stated she told the nursing staff to monitor and watch the resident's leg. She further stated she faxed the concern to the resident's PCP, and passed on the information to LPN #9. She stated the system was for the nurse to fax the concern to the Physician and put the copy of the Fax on the board at the nurse's station, and the subsequent shift was to follow up and call the Physician if there was no reply from the physician per fax. RN #5 stated she would have thought the oncoming nurse, LPN #9, would have called the resident's PCP if she had not heard from the PCP. Continued interview with RN #5 revealed if left undetected a blood clot could lead to death.

Interview with LPN #9, on 10/02/15 at 12:33 PM, revealed RN #5 relayed the information to her, regarding the resident's leg. LPN #9 stated she would notify the PCP for any changes in the resident's condition, but the primary communication was to Fax the physician. She stated, the information was already reported to the resident's PCP, via Fax, thus she did not have to call the PCP.

Attempted interview with LPN #8, on 10/02/15 at 12:34 PM, a message was left with no returned call.

Interview, on 09/24/15 at 5:27 PM and 10/02/15 at 1:44 PM, with the Director of Nursing (DON) revealed staff had communicated with the PCP by way of "Fax" since she has been the DON. She stated the concern with communicating by Fax, was that if the PCP office was closed or if staff was off for a day or two (2), then the staff who completed the original Fax would need to

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contact the physician. The DON stated she had educated the staff on calling the physician if there was any change of condition with the residents. She stated she was working with the physicians to devise an updated way of communication between the nurses and the physicians in order to ensure the Physicians were aware of the needs of the residents.

Interview on 09/24/15 at 6:46 PM, with the Administrator revealed his expectations was for the nurse to follow the "Notification of Change in Residents' Condition" policy. Interview further revealed he would expect with a change of condition the nurses would monitor closely and contact the physician.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/02/15 which alleged removal of the IJ effective 09/30/15. Review of the AOC revealed the facility implemented the following.

1. On 09/21/15, the Administrator and Medical Director created the Abnormal Vital Signs policy which instructed staff on the definition of abnormal vital signs, actions nurses should take when abnormal vital signs were obtained, and when to notify the physician, resident, and/or responsible party/Power of Attorney (POA).

2. On 09/24/15, the Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse reviewed facility policies regarding change in resident status, notification of change, documentation, hydration, charting, and care plans for compliance of Federal regulations to ensure thorough understanding and knowledge prior to education of staff. It was determined,

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facility policy had been followed regarding notification of change related to Resident #2's fluid intake on 09/11/15. The facility policy "Notification of Change" was updated to include facility requirements when notification of change was to occur and who staff was to notify on 09/25/15 by the Administrator. The Administrator and DON determined the facility Charting and Care Plan policies were in compliance with Federal Regulations. It was identified, the facility had three (3) policies governing hydration; all policies were reviewed and the Administrator and DON determined one (1) of the policies met federal regulations compliance. The "Hydration and Nutrition" updated on 09/25/15, by the Administrator, would be used as the facility's only policy on hydration.

3 Twenty-four (24) out of twenty-six (26) nurses were educated on updated "Notification of Change" the new "Abnormal Vital Signs", "Hydration and Nutrition", and "Charting" policies on dates 09/24/15 through 09/29/15 by the DON, ADON, Staff Development Coordinator, and QAPI nurse. Additionally, education also included following the residents' plan of care related to signs and symptoms of dehydration, documentation regarding hydration and nutrition, and contacting physician with change in status (for example abnormal vital signs, signs and symptoms of dehydration). Certified Nurse Aides (CNAs) were not involved in this training even though they may obtain vital signs, it was solely the nurses' responsibility to monitor and assess the residents vital signs and hydration status. Education was conducted in small group sessions with open conversation and question and answer period at the end to test knowledge and understanding of the policies. The nurses that

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did not receive education would not provide direct care until education on Abnormal Vital Signs policy and Notification of Change policy had been received. Furthermore, these policies had been added to the facility's orientation program which was conducted prior to new nurses providing direct care in the facility beginning with next orientation on 09/28/15.

On 09/25/15 and 09/27/15, the Staff Development Coordinator made rounds through the facility daily, including weekends, and on all shifts to question all nurses about the "Notification of Change and Resident Status Changes", "Abnormal Vital Signs", "Residents' Plan of Care", and "Hydration" policies. These rounds also included communicating with the facility during night shift and asking staff questions regarding notification of change, abnormal vital signs, and residents' plan of care

4 Beginning the night of 09/24/15 and ending on 09/25/15, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) Staff Development Coordinator, and (QAPI) Nurse audited one-hundred (100) percent of resident clinical records pertaining to notification of change. No evidence was found that any other residents were adversely affected by notification of change.

5 Beginning the night of 09/24/15 and ending 09/25/15, the Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited one-hundred (100) percent of resident clinical records pertaining to care plan interventions related to dehydration/fluid volume deficit. Evidence revealed all current resident care plans implemented correctly related to

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dehydration. MDS staff reviewed the plan of care for all current residents and updated to include the "daily estimated fluid need" for each resident. On 09/25/15, the DON added question to Electronic Medication Administration Record (EMAR) for all residents. "Did resident meet estimated daily fluid intake?"

6. Beginning the night of 09/24/15 and ending on 09/25/15, the Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited one-hundred (100) percent of the residents clinical records daily, including weekends, to ensure staff was compliant with the Charting policy and accurate clinical documentation.

7. Starting 09/25/15, and ongoing the DON with the assistance from the ADON, Staff Development Coordinator, QAPI Nurse, MDS staff, and Charge Nurses, began auditing one-hundred (100) percent nurse documentation daily, including weekends, to monitor staff compliance with facility policy regarding notification of changes in resident status, abnormal vital signs, documentation of physician notification, hydration and nutrition logs and care plan interventions. This audit would continue until Immediate Jeopardy abated. All issues identified with regards to these policies would be immediately addressed with individual staff responsible.

8. On 09/25/15, and ongoing the DON began auditing one-hundred (100) percent of the residents' charts daily, including weekends, to ensure plan of care related to dehydration and notification of change was followed for residents who triggered on the "Nutrition and Hydration

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Log." The DON audited, with the help from the ADON, Staff Development Coordinator, QAPI Nurse, MDS Staff, and Charge Nurses, included inspection of Hydration and Nutrition logs, vital signs obtained, lab values obtained which was checked against nurse documentation if abnormal vital signs or lab values obtained and/or change of resident hydration status noted. The audit would continue until Immediate Jeopardy was abated. The DON would immediately address all issues regarding staff compliance with resident plan of care with individual staff and present audit findings to QAPI Committee for review and process improvement if necessary

The Nutritionally at Risk (NAR) Committee would review all residents that trigger for "nutritionally at risk" for hydration status weekly and would make appropriate interventions as necessary. The NAR Committee consists of the DON, ADON, MDS Coordinator, Dietary Manager, Staff Development Coordinator, and QAPI Nurse. The DON would address all issues related to hydration and nutrition, care plans, documentation, and notification of changes with staff immediately and present audit findings to the QAPI Committee monthly 9. Results of audits (nurse documentation and staff compliance with residents' plan of care) would be addressed daily with individual staff and audit findings would be presented to the QAPI Committee for review and process improvement at least monthly as necessary. The QAPI Committee consists of the Administrator, DON, ADON, Social Worker, Maintenance Director, Medical Director, Activizes Director, Housekeeping/Laundry Supervisor, and Dietary Manager. The QAPI Committee meets monthly with the Medical Director attending the QAPI meeting quarterly. The next QAPI meeting

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was scheduled for 10/02/15.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Review of the "Abnormal Vital Signs", created 09/21/15, revealed there were parameters set, regarding a resident's blood pressure, pulse, and temperature in which the physician should be notified to due a change in the resident's change in condition.

Interview with the Administrator, on 10/02/15 at 1:44 PM, revealed the Medical Director (MD) stopped by his office on 09/21/15 to discuss the concern regarding Resident #2. The Administrator revealed he acknowledged to the Physician the facility did not have a policy to address when the physician should be notified regarding a change in resident's condition. He revealed, in regards to a resident's temperature staff would obtain the resident's temperature rectally and would notify the physician if out of the set parameters. The Administrator reported the Physician agreed with the policy.

Interview with the Physician, on 10/08/15 at 11:00 AM, revealed he discussed Resident #2's case with the Administrator. The Physician revealed he thought the physician should have been notified with a temperature of one-hundred and two (102) and it warranted an Emergency Room (ER) visit, especially since the resident was on antibiotics. He reported he came up with some reasonable numbers, through his expertise and practice, that would assist the staff with notifying the physician.

2. Review of the facility's policies revealed the

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facility kept the "Charting" revised 07/30/15, "Care Plan" reviewed 01/06/15, and "Notification of Change", dated 08/03/15, policies. The facility added a "cheat" sheet to go along with the "Notification of Change in Residents' Condition." The "cheat" sheet was titled, "Notification of Change When to Document?", created 09/25/15.

Interview with the Administrator, DON, and ADON on 10/02/15 at 1:44 PM, revealed, when he and the staff reviewed the policies, they thought the policies they had in place complied with the Federal Regulations. Continued interview with the Administrator revealed they, thought it would be helpful to have a "cheat" sheet to go along with the "Notification of Change in Residents' Condition" to assist the staff with knowing what to look for when there was a change in a residents' condition.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed she was part of assisting with the policy review and new updated policies.

Review of the facility's "Hydration and Nutrition" Policy, revised 09/25/15 revealed there was no change from the original policy provided.

Interview with the Administrator, DON, and ADON on 10/02/15 at 1:44 PM revealed the facility had three (3) policies related to Hydration. The Administrator reported he was not aware of the three (3) different policies. Continued interview with the Administrator revealed they have removed the other two (2) polices and added a revision date to the "Hydration and Nutrition" policy because this one superceded the other policies.

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3. Review of the In-Service Training Sheet, dated 09/24/15, 09/25/15, and 09/29/15, revealed staff signed they were in-serviced on Abnormal vital signs, Hydration, Documentation, Notifying Physician and Power Of Attorney (POA) of changes in condition, Notifying physician of any Significant Changes, following the care plan, and educated staff on the F-Tags the facility received.

Review of the Nurses Training Manual, revised 06/05/15, revealed the updated policies were added for orientation of new hires.

Interviews with Registered Nurse (RN) #1 on 10/01/15 at 8:30 PM, RN #5 on 10/02/15 at 11:40 AM, Licensed Practical Nurse (LPN) #6 on 10/01/15 at 7:07 PM, LPN #2 on 10/02/15 at 9:50 AM, and LPN #7 on 10/02/15 at 10:50 AM, revealed they were all in-serviced on the Abnormal Vital Signs policy, Hydration, Documentation, Notification of the Physician and Power of Attorney of changes of condition. Additionally, they added the information was stored at the nurses station for their reference

Review of the documentation provided by the Staff Development Coordinator revealed she provided staff with follow-up questions, on 09/25/15, 09/26/15, and 09/27/15, to what was in-serviced to the staff. The Staff Development Coordinator had a series of questions in which she asked staff about the required information.

Interviews with Registered Nurse (RN) #1 on 10/01/15 at 8:30 PM, RN #5 on 10/02/15 at 11:40 AM, Licensed Practical Nurse (LPN) #2 on 10/02/15 at 9:50 AM, and LPN #7 on 10/02/15 at 10:50 AM, revealed they were asked questions from the Staff Development Coordinator

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regarding what they were in-serviced on.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed she took all of the information from the policies and created a questionnaire in which she asked staff how much they knew about Hydration, Care Plans, Notification, Change in a Resident's Condition, Documentation, and the F-Tags cited. She stated she did not have a sign-in sheet, but documented the names and times of the individuals she spoke with. The SDC stated she questioned staff on every shift, including weekends. The SDC revealed the auditing would be ongoing and reported the Hydration for the residents have improved, adding "there were less residents on the Hydration List.

4. Review of the auditing tools used to audit one-hundred (100) percent of the residents clinical records were reviewed and the records were reviewed from 09/24/15 through 10/02/15

Interview with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on 10/02/15 at 1:44 PM, revealed reports were pulled from the Point Click Care (PCC) system which provided them information on each resident. The information contained were critical labs and abnormal vital signs. The DON revealed she reviewed the information and contacted the physician when residents were "triggered" for critical labs. The Administrator added the nurses notes were also reviewed to see if they added anything regarding the lab results. Additionally, the DON revealed she looked at all of the resident's vital signs manually to see if there were any residents with abnormal vital signs. The DON reported she checked the nursing documentation and ensured the physician was

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notified on the results. No issues were identified

5. Review of Resident's Charts, Resident's #3, #4, #5, #6, #7, #8, Unsampled Resident's A and B, revealed their care plans were updated to dehydration/fluid volume deficit. The resident's Estimated Fluid Need(EFN) was added to the resident's care plan with interventions in place. Resident #1 was out of the facility, thus his/her chart was not updated.

Interview with the Administrator, DON, and ADON, on 10/02/15 at 1:44 PM, revealed the Minimum Data Set Coordinator (MDS) reviewed all of the residents care plans to make sure their EFN numbers were updated. Additionally, the DON reported she added a question to the resident's Electronic Medication Administration Record (EMAR) which asked staff if the resident met their EFN for the day. She revealed if the resident had not then this would prompt nurse to document interventions made to ensure the resident reached his/her EFN

Interview with the MDS Coordinator, on 10/02/15 at 4:10 PM, revealed she updated the resident's care plan to include EFN. She revealed the residents were already care planned for risk of dehydration and how to recognize the signs and symptoms of dehydration.

6. Review of resident's charts. Resident's #3, #4, #5, #6, #7, #8, Unsampled Resident's A and B, revealed no issues were noted.

Interview with the Administrator, on 10/02/15 at 1:44 PM, revealed he went over the charting policy with the nurses. He reported the policy was vague, but specific enough to guide the

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nursing staff of what was expected with charting on a resident.

7. Review of the Auditing tool for nutrition, hydration, vital signs, care plans and physician notification dated 09/24/15 to 10/01/15, revealed when concerns were noted they were addressed immediately

Interview with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 10/02/15 at 1:44 PM, revealed they reviewed the Twenty-Four Hour Report and all of the nursing documentation. Continued interview with the DON revealed changes were made accordingly. The DON revealed if there was a concern then they would address the concern with the staff member.

Interview with the SDC, on 10/02/15 at 3:49 PM revealed she made sure the Physician was notified if the resident's were on the Hydration Log book for three (3) consecutive days and ensured the information was charted.

8. Review of resident's charts, Resident's #3, #4 #5, #6, #7, #8, Unsampled Resident's A and B, revealed they did not trigger on the Hydration Log. Review of Nursing notes revealed they were updated accordingly.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed every morning she would make rounds in the building to check the Hydration/Nutrition Book to see if it was completed by staff. She reported she would ensure the EFN note and the Nutrition note was added to the residents progress note.

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Review of the audit form for Nutrition and Hydration dated 09/24/15 through 10/01/15, revealed residents who triggered for hydration in 09/24/15 did not trigger for hydration on 10/01/15.

Interview with the Administrator, DON and ADON, on 10/02/15 at 1:44 PM, revealed the Nutritionally at Risk (NAR) committee was already looking at residents who were Nutritionally at Risk, residents who were having a weight loss against medical advice. The DON revealed the NAR committee would now also look at residents who were also at risk for dehydration. The DON revealed, if a resident was nutritionally at risk and was also on the list for dehydration, even if it was one time, they would assess the resident for further interventions. The Administrator revealed, since auditing the residents who were at risk for dehydration, there were fewer residents who triggered for Hydration which indicated what they were doing was working.

Interview with the Staff Development Coordinator, on 10/02/15 at 3:49 PM, revealed the NAR Committee was including Hydration along with Nutritionally at Risk residents for observation and interventions. She revealed the nurses would still document resident's who did not meet their Estimated Fluid Needs (EFN) for the day and would contact the Physician when they were on the list for three (3) consecutive days, unless the resident was showing sign and symptoms of dehydration in which case the physician would be notified immediately.

9. Interview with the Administrator, DON, and ADON on 10/02/15 at 1:44 PM, Social Service Director on 10/02/15 at 3:32 PM, Staff Development Coordinator on 10/02/15 at 3:49

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PM, Medical Director on 10/08/15 at 11:00 AM, Activity Director on 10/02/15 at 3:36 PM, Housekeeping Supervisor on 10/02/15 at 3:18 PM, and Maintenance Director on 10/02/15 at 3:28 PM, revealed they had a QAPI meeting on 10/02/15 in which the results of audits and the Federal/State Deficiencies was discussed.

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to promote care in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his/her individuality for one (1) of nine (9) sampled residents (Resident #1)

Resident #1 was placed in the hallway for approximately two (2) days without a call light and privacy

The findings include

Review of the facility's policy, revised 06/20/15, revealed fifteen (15) residents would be assured of at least visual privacy in multi-bed rooms. Continued review of the Policy revealed each resident would be treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and

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F 241 Resident #1 was returned to room on 8/31/15 by housekeeping staff. DON spoke with resident, who stated no complaints of dignity or privacy at that time.

Beginning the night of 9/24/2015 and ending on 9/25/2015, Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited 100 percent of resident clinical records pertaining to notification of change. No evidence found that any other residents adversely affected by notification of change. On 9/24/2015, Administrator and DON reviewed facility policies regarding change in resident status and notification of change for compliance of Federal regulations. It was determined that facility policy had been followed regarding notification of change related to Resident #2's fluid intake on 9/11/2015. Facility policy

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care for his/her personal needs.

Review of the letter provided by the City, regarding "Bed Bug Infestation", dated 08/29/15, revealed the Code Enforcement Office was notified on 08/28/15, of potential bed bug infestation at the facility. Continued review revealed bed bugs were found in Resident #1's room and the room was completely stripped. Further review, revealed the adjacent rooms and rooms across the hall were checked, with no bed bugs found. Continued review revealed the follow-up inspection was performed by the City's Code Enforcement Inspector and all the residents were cleared to return to their rooms on 08/29/15.

Review of Resident #1's medical record revealed the facility admitted the resident on 03/28/15, with diagnoses which included Congestive Heart Failure, Diabetes, and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/15/15, revealed the facility assessed the resident resident to have a Brief Interview of Mental Status (BIMS) score of fourteen (14) out of fifteen (15) indicating the resident was cognitively intact.

Interview with Resident #1, on 09/16/15 at 4:30 PM, and on 09/17/15 at 3:46 PM, revealed he/she was placed at the end of the hallway for about a day and a half. He/she stated the facility was treating his/her room for bed bugs. Resident #1 stated, he/she did not like being in the hallway because he/she did not get the "privacy" he/she would normally get if he/she was in his/her room. Resident #1 stated, she complained to staff, but they did not do anything about it, stating "They act as though they don't want to be bothered with you." The resident stated she was given a

F 241 "Notification of Change" updated to include facility requirements when notification of change is to occur and who staff is to notify on 9/25/2015 by Administrator. On 9/21/2015, Administrator and Medical Director created Abnormal Vital Signs policy, which instructs staff on definition of abnormal vital signs, actions nurses should take when abnormal vital signs obtained, and when to notify physician, resident, and/or responsible party/POA.

18 of 19 nurses and 33 of 35 certified nurse aids received education on dignity and privacy during the dates of 10/1/15 and 10/27/15 by Staff Development Coordinator. Education was conducted in small group sessions with open conversation and question and answer period at the end to ensure knowledge and understanding of resident dignity and privacy. The staff that did not receive education will not provide direct care until receipt of education on resident dignity and privacy by Staff Development Coordinator. Furthermore, this education has been added to the facility's continuing

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"curtain", but it did not cover everything. Resident #1 further stated "I felt less than everyone else." Additional interview with the resident revealed, he/she was not supplied a call light, thus he/she could not receive help when he/she needed it and staff did not check on him/her very often.

Interview with Certified Nursing Assistant (CNA) #17, on 09/17/15 at 5:59 PM, revealed when she reported to work on Saturday, 08/29/15 from 6:00 AM to 2:00 PM, the resident's door was closed and the resident was placed at the end of the hallway. She stated the resident had his/her oxygen machine, a wheelchair, chair, and a bedside table. Continued interview with CNA #17 revealed, if the resident was sitting directly behind the sectional (curtain on wheels), you could not see him/her. She stated, it was her understanding the night shift nurse notified Administration and was told to leave the resident in the hallway. CNA #17 stated this would have been a dignity concern for the resident because he/she was a modest person and often liked to be by himself/herself.

Interview with the Code Enforcement Inspector, on 09/18/15 at 11:05 AM, revealed when the facility had a problem with bed bugs, they would notify him. He restated he came to the facility on 08/28/15 related to a concern about bed bugs, but the housekeeping staff was still cleaning out Resident #1's room. Continued interview with the Code Enforcement Inspector, revealed he told staff he would return to the facility to inspect the room once the housekeeping staff had completed clearing out the room. Further interview with the Code Enforcement Inspector, revealed he returned to the facility on 08/29/15, and cleared the room for the resident to return to his/her

F 241 education program which is conducted annually for all staff providing direct care in the facility.

QAPI Nurse began auditing residents weekly on 10/7/15 using a survey of resident rights and dignity. This survey allows residents to identify dignity and privacy issues. The weekly audits consist of a 40 resident sample generated by facility QAPI program. All issues identified in survey process will be immediately investigated for resolution and results presented to QAPI Committee for review and process improvement if necessary. The QAPI Committee consists of Administrator, DON, ADON, Social Worker, Maintenance Director, Medical Director, Activities Director, Housekeeping/Laundry Supervisor, and Dietary Manager. The QAPI Committee meets monthly.

10/30/15

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room. The Code Enforcement Inspector stated, he did not remember who he notified about the resident's room being cleared, but stated it was someone who worked the front office.

Interview with CNA #15, on 09/17/15 at 3:10 PM, revealed she worked Sunday night, 08/30/15 on third shift, 10 PM to 6 AM. She stated Resident #1 was in the back corner of the hallway, with a sectional. Continued interview with CNA #15, revealed she talked to the resident who reported to her, that he/she had been in the hallway since Saturday, 08/29/15. CNA #15 stated she asked Registered Nurse (RN) #1 why the resident was not in one of the empty beds, stating, "The resident had no call light and the only way he/she could get to staff was by yelling." She stated RN #1 informed her, "She did not know why the resident did not have a room." CNA #15 stated she talked to the resident who informed her that he/she did not know why his/her roommate got a room and he/she did not. CNA #15 stated, she assisted with moving the resident to a different room, regardless of what RN #1 or the Director of Nursing (DON) thought, during her shift. CNA #15 stated, it was a dignity concern for the resident because he/she was "embarrassed" and "upset". She stated, when she talked to the resident the resident told her, "They forgot about me" and then asked, "What did I do wrong?"

Interview with Registered Nurse (RN) #1, on 09/18/15 at 7:00 AM, revealed she could not recall the date of the incident, due to it not being documented; however, she was told by Licensed Practical Nurse (LPN) #2, that Resident #1 had bed bugs in his/her room and they were to to remove the resident and his/her roommate from their room. RN #1 stated she instructed the

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CNAs to give the resident a shower and to dress him/her in clothes that did not originate from his/her room, per the Administrator's instructions RN #1 stated, all the resident's clothes were bagged and the resident remained in a gown until his/her clothes went through laundry. RN #1 stated, housekeeping took awhile to finish cleaning the resident's room so the person from the Health Department, who was at the facility to clear the room left, stating he would be back the next day. She stated CNA #15 was to move the resident into an available room that shift. RN #1 stated she thought it might have been a dignity concern because "No one should have to sit in the hallway, they should be provided a room in which they paid for." However, in the case of Resident #1, RN #1 stated the resident was provided privacy by being placed behind the sectional. Additionally, RN #1 stated Resident #1 was someone who valued having a room with little to no social interaction outside of his/her room.

Interview with the Social Service Director, on 09/18/15 at 3:04 PM, revealed staff should document any room changes and should have done so with Resident #1. Continued interview with the Social Service Director revealed she was informed about Resident #1's incident on 08/31/15, during morning meeting. She stated the resident being left in the hallway could be a dignity concern because someone could have watched as the resident changed clothes or the resident's needs may not have been met, regarding toileting. She stated, "Yes, most definitely it was a dignity concern."

Interview with the Director of Nursing (DON), on 09/18/15 at 3:53 PM, revealed Resident #1 was

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placed in the hallway on 08/28/15, around 5:00 PM. She revealed the Code Enforcement Inspector cleared some of the facility's rooms but not all of them. She stated, to her knowledge, Resident #1's room had not been cleared over the weekend. The DON stated, when she reported to the facility on Monday morning 08/31/15 around 5:00 AM, the resident was still seated at the end of the hallway with a sectional and she located a room for the resident. Continued interview with the DON revealed she was not aware the resident was placed at the end of the hallway with a sectional and stated, "I was less than thrilled." The DON reported this was a dignity concern, adding, "No one should be left in the hallway for any length of time." The DON stated the incident should have been documented and she was working with staff with documentation concerns.

Interview with the Administrator, on 09/18/15 at 4:19 PM, revealed it was his expectation for staff to notify the resident's Physician and Power of Attorney (POA), when there was a change in the residents' rooms. Additionally, he stated staff should have documented the room changes and documented the incident, stating, "documentation was very important." Further interview with the Administrator, revealed he was notified, on 08/29/15 that Code Enforcement had not yet reported to the facility. He stated it was his understanding, Code Enforcement did not report to the facility on 08/29/15, and he instructed staff to place the resident in an empty bed. The Administrator stated, he attempted to contact Code Enforcement on 08/30/15, around 5:45 PM, and it went to voice mail. Further interview with the Administrator, revealed he was not aware the resident spent approximately two (2) days in the

Resident #2 was transferred to hospital on 9/12/2015 and did not return to facility.

Beginning the night of 9/24/2015 and ending on 9/25/2015, Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited 100 percent of resident clinical records pertaining to care plan interventions related to dehydration/fluid volume deficit. Evidence revealed all current resident care plans implemented correctly related to dehydration. On 9/24/2015 and 9/25/2015, MDS staff reviewed the plan of care for all current residents and updated to include the "daily estimated fluid need" for each resident. On 9/24/2015, Administrator and DON reviewed facility policies regarding change in resident status, notification of change

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hallway and should have been made aware. Continued interview with the Administrator, revealed it would have been his expectation that RN #1 would have listened to his direction and placed the resident in the empty bed and monitored the situation. Additionally, the Administrator reported this was a dignity issue for the resident.

F 282 SS=J 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.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility policy, it was determined the facility failed to have an effective system to ensure services were provided in accordance with each resident's written Comprehensive Plan of Care for (1) of nine (9) residents (Resident #2)

The facility developed a care plan for Resident #2 stating the resident had the potential for fluid volume deficit related to diuretic use with a goal stating the resident would be free of dehydration. The interventions included monitor/document/report to the Physician as needed for signs/symptoms of dehydration. However, there was no documented evidence the care plan was followed for Resident #2 related to monitoring vital signs and notifying the Physician of significant abnormalities, and monitoring, documenting and reporting to the Physician signs

F 241 and hydration. It was identified that facility had three policies governing hydration; all policies were reviewed and Administrator and DON determined one of the policies met federal regulations compliance. This Hydration and Nutrition policy

F 282 updated, as only facility policy on hydration, on 9/25/2015 by Administrator. Facility policy "Notification of Change" updated to include facility requirements when notification of change is to occur and who staff is to notify on 9/25/2015 by Administrator.

24 out of 26 nurses were educated on following the plan of care on dates 9/24/2015 through 9/29/2015 by DON, ADON, Staff Development Coordinator, and QAPI Nurse. Education included following residents' plan of care related to signs and symptoms of dehydration, documentation regarding hydration and nutrition, and contacting physician with change in status (i.e. abnormal vital signs, signs and symptoms of dehydration). Education was conducted in small group sessions with open conversation and

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and symptoms of dehydration.

Interview and record review revealed the facility assessed Resident #2 to have an elevated temperature on 09/11/15 at 5:15 PM of 101.1 degrees Fahrenheit (F), and, on 09/11/15 between 8:00 PM and 10:00 PM of 102 degrees F. Further review of the clinical record revealed Resident #2, who was normally a "heavy wetter" had no urinary output during rounds on 09/12/15 at 1:00 AM, 3:00 AM, and 5:00 AM. Although the resident was having increased temperatures and staff interviews revealed the resident was showing signs and symptoms of dehydration including decreased or no urine output, dry chapped lips, fever, weakness, and limited food and liquid intake, there was no documented evidence staff provided ongoing assessments of the resident in order to monitor for signs and symptoms of dehydration, and, there was no documented evidence the physician was notified of the signs and symptoms of dehydration as per the Care Plan.

On 09/12/15 at approximately 6:00 AM, Resident #2 was assessed to have a temperature of 102.2 degrees F axillary and was unresponsive, and in respiratory distress. The resident was transferred to the hospital on 09/12/15 and arrived at 6:57 AM. Resident #2 presented with a rectal temperature of 106.7 degrees F, was unresponsive, had mottled skin (blood vessel changes in the skin that cause a patchy appearance), agonal respirations (gasping labored breathing), laboratory values which indicated severe dehydration, and his/her soft palate and uvula were "like sand paper". Resident #2 was admitted to the Critical Care Unit (CCU) at the local Hospital and placed on a

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question and answer period at the end to test knowledge and understanding of the policies. The nurses that did not receive education will not provide direct care in facility until educated on following plan of care. Certified Nurse Aides were not involved in this training even though they may obtain vital signs, it is solely the nurses' responsibility to monitor and assess resident vital signs and hydration status. Furthermore, these policies have been added to the facility's orientation program which is conducted prior to new nurses providing direct care in the facility beginning with orientation on 9/28/2015. On 9/24/2015, Administrator reviewed facility policies with DON, ADON, Staff Development Coordinator and QAPI Nurse to ensure thorough understanding and knowledge of Federal regulations pertaining to resident care plans prior to education of staff.

DON began auditing, on 9/25/2015, 100 percent of resident charts daily, including weekends, to ensure plan of care related to dehydration and

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ventilator with diagnoses of Dehydration, Pneumonia, and Sepsis. Resident #2 expired on 09/21/15 related to complications of increased temperature, dehydration, and sepsis.

The facility's failure to provide services by qualified persons in accordance with each resident's written plan of care has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/24/15, and was determined to exist on 09/11/15. The facility was notified of the Immediate Jeopardy on 09/24/15.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/02/15 with the facility alleging removal of the Immediate Jeopardy on 09/30/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged, on 09/30/15, prior to exit on 10/02/15, with remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment, F-282 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic change

The findings include:

Review of the facility's policy titled "Resident Care Plan", revised 05/01/09, revealed the services provided or arranged by the facility will meet professional standards. Qualified persons will provide services in accordance with each resident's written plan of care.

Review of the facility's policy, titled "Dietary Intake Log", reviewed 08/03/15, revealed the purpose of the policy was to track residents' nutrition and

F 282 notification of change was followed for residents who triggered on "Nutrition and Hydration Log." DON audit, with help from ADON, Staff Development Coordinator, QAPI Nurse, MDS staff, and Charge Nurses, included inspection of Hydration and Nutrition logs, vital signs obtained, lab values obtained which was checked against nurse documentation if abnormal vital signs or lab values obtained and/or change of resident hydration status noted. This audit will continue daily until next QAPI Committee meeting on 11/16/15, in which results will be evaluated and committee will determine if 100 percent daily auditing would continue. DON will immediately address all issues regarding staff compliance with resident plan of care with individual staff and present audit findings to QAPI Committee for review and process improvement if necessary. The QAPI Committee consists of Administrator, DON, ADON, Social Worker, Maintenance Director, Medical Director, Activities Director, Housekeeping/Laundry Supervisor, and Dietary Manager. The QAPI Committee meets monthly.

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hydration. Continued review of the policy revealed there was a record kept daily (completed on night shift) of those residents who did not meet their daily fluid requirements. Once the resident was on the list for three (3) consecutive days the physician must be notified. When notifying the physician; staff should include the resident;s symptoms, poor skin turgor, dry mucous membranes, concentrated urine, and decreased urine output.

Review of Resident #2's clinical record revealed, the facility admitted the resident on 02/10/15 with diagnoses including Secondary Parkinsonism, Dysphagia Unspecified, Leukemia, Secondary Diabetes Mellitus, Confusional Arousals and Paralysis Agitans.

Review of the Comprehensive Plan of Care, revised 02/16/15, revealed the resident had the potential for fluid deficit related to diuretic use with a goal stating the resident would be free of symptoms of dehydration and maintain moist mucous membranes, and good skin turgor. The interventions included monitoring vital signs as ordered/per protocol and record, notify the Physician of significant abnormalities, and monitor/document/report to the Physician signs and symptoms of dehydration: decreased urine output, cracked lips, fatigue/weakness, fever dry/sunken eyes and furrowed tongue

Review of the Nutrition Risk Assessment, dated 02/20/15, completed by the facility's Dietitian revealed Resident #2's estimated fluid need (EFN) was two thousand and fifty (2050) to two thousand, four hundred and sixty (2460) cubic centimeters (cc) per day.

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Review of the Quarterly Minimum Data Set (MDS), dated 08/04/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of seven (7) which indicated severe cognitive impairment. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance of two (2) for bed mobility, transfer, ambulation, dressing, toilet use and personal hygiene. Further review of the MDS, revealed the facility assessed the resident as requiring supervision and assistance of one (1) person for eating, and, as frequently incontinent of bowel and bladder.

Review of the Physician's Orders, dated September 2015 revealed the resident was ordered Atenolol Tablet (medication used to control blood pressure which contains a diuretic) twenty-five (25) mgs give three (3) tablets by mouth once a day (ordered 07/23/15) related to Essential Hypertension Benign and Lasix (diuretic) forty (40) milligrams (mgs) twice a day for Essential Hypertension. Further review revealed Resident #2 was ordered Lasix forty (40) mgs once a day on 02/13/15 and an order was received to increase the Lasix to forty (40) mgs twice a day on 07/22/15

Review of the "Follow-Up Question Report" (form used to total fluid intakes), revealed Resident #2 did not meet his/her estimated fluid needs (EFN) of 2050 to 2460 cc per day on 09/3/15, 09/05/15, 09/07/15, 09/09/15, and 09/11/15. The fluid intakes were recorded as follows: 09/03/15 -1940 cc, 09/05/15 - 1680 cc, 09/07/15 - 2205 cc, 09/09/15 - 1220 cc, and 09/11/15 - 1500 cc

Although, Resident #2 did not have three (3) consecutive days without meeting the EFN in

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order for staff to notify the Physician of the resident's hydration status, staff interviews revealed the resident was having changes in nutrition/hydration status and, they were having difficulty getting the resident to eat and drink. Additionally, staff interviews revealed the resident was having behavior changes, weakness and was showing signs and symptoms of dehydration including dry mouth, and dried and chapped lips. Further record review and staff interview revealed the resident was having little or no urine output and increased body temperatures on 09/11/15 and 09/12/15.

Interview on 09/17/15 at 10:50 AM, with Certified Nursing Assistant (CNA) #4 revealed on 09/07/15 Resident #2 was cheeking food, had complaints of mouth pain, and the resident's lips were dried and chapped. CNA #4 stated he notified Registered Nurse (RN) #4 of these changes with Resident #2. However, there was no documented evidence the Physician was notified and no documented evidence the resident was monitored for signs and symptoms of dehydration, as per the Care Plan.

Interview with CNA #8, on 09/22/15 at 4:15 PM, revealed she noticed a decline in Resident #2 when she worked the 2:00 PM to 10:00 PM shift on 09/10/15. She stated the resident was refusing to eat and drink, which the resident would never do, adding "(He/She) drank and ate pretty well." CNA #8 stated, she notified Licensed Practical Nurse (LPN) #1.

Interview with CNA #11, on 09/23/15 at 8:27 AM, revealed the resident had gotten to the point were he/she stopped eating and drinking and within the last week prior to hospitalization, was pocketing

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his/her food. She stated the resident was normally pretty independent with his/her liquids, but had gotten to the point where staff needed to hold the resident's cup for him/her. CNA #11 stated she reported these changes to Registered Nurse (RN) #4, who told her to keep an eye on the resident and make sure he/she got fed

Interview with CNA #3, on 09/17/15 at 10 50 AM, revealed he worked the week the resident became sick, 09/07/15 through 09/10/15. He stated Resident #2 was more combative than normal and was difficult to feed. CNA #3 stated the resident did not want to eat and it was difficult to "get" fluids in him/her. CNA #3 further stated he reported this to the Speech Language Therapist (SLP) and RN #4

Interview on 09/23/15 at 10 11 AM, with the SLP revealed on 09/11/15 while assisting Resident #2 with lunch in the dining room, the SLP noticed the resident was leaned over in the chair and looked as if he/she did not feel well. Further interview revealed the SLP informed RN #4 of the resident's condition

Review of the Nurse's Notes, dated 09/11/15 at 5:16 PM, completed by RN #4, revealed Resident #2 had a fever of 101.1 F, and crackles (abnormal lung sounds) were noted in the resident's lungs and the physician was notified, and orders were received for Zithromax (antibiotic medication). However, there was no documentation of the resident's decreased fluid intake.

Interview on 09/16/15 at 5:20 PM, with RN #4 revealed on 09/11/15, she observed the resident had not felt well; she had not reviewed the

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resident's fluid intake because no one had reported any issues. However, interview with the CNAs revealed they had reported a change in the resident's fluid intake to RN #4. Per interview, RN #4 obtained Resident #2's temperature around 5:00 PM and discovered he/she had a fever, she contacted the Physician and obtained orders. However, the RN failed to notify the Physician of the resident's decreased fluid intake

On 09/12/15 at 12:35 AM, staff documented on the Vital Sign Log, Resident #2 had a temperature of 102 degrees F. Interview with CNA #10 on 09/22/15 at 5:11 PM, and CNA #11 on 09/23/15 at 8:27 AM revealed they worked the evening of 09/11/15 and they thought CNA #9 obtained the vital signs, stating vital signs were usually obtained between 8:00 PM and 10:00 PM Interview with CNA #9 on 09/22/15 at 4:43 PM revealed he could not recall if he obtained the vital signs the evening of 09/11/15. Staff interviews revealed it was unclear exactly what time the resident's vital signs were obtained on the evening of 09/11/15.

Interview with CNA #7, on 09/22/15 at 3:44 PM, revealed Resident #2 became a "feeder" earlier that week because the resident was not eating or drinking and had only taken in 500 ccs from 2:00 PM to 10:00 PM on 09/11/15, and sixty (60) ccs from 10:00 PM to 6:00 AM 09/11/15 through 09/12/15. However, there was no documented evidence the Physician was notified of the fever, or of the resident's decreased fluid intake, as per the Care Plan.

Interview with CNA #10, on 09/22/15 at 5:11 PM, revealed she worked the night of 09/11/15 from 2:00 PM until 10:00 PM and assisted CNA #8 with

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Resident #2's incontinence care, stating the resident did not have much urine output during that shift. CNA #10 stated it was almost like the resident, "did not have much fight left in (him/her)." CNA #10 stated she reported this to LPN #1, but she did not know if LPN #1 assessed the resident afterwards.

Review of Resident #2's record Flowsheet, revealed on 09/12/15, Resident #2 had not voided at the 1:00 AM, 3:00 AM or 5:00 AM rounds.

Interview on 09/22/15 at 3:40 PM, with CNA #7, revealed she reported to LPN #1 that the resident wasn't making any noise, was stiff and difficult to roll over, pale and had sunken cheeks.

Review of the resident's medical record revealed no documented evidence LPN #1 continued to monitor and/or assess the resident on 09/12/15. There was no documented evidence the Physician was notified of the resident's increased temperature of 102 degrees F, and/or the signs and symptoms of dehydration, even though the nurse was informed the resident was not urinating, was pale, weak and had sunken cheeks, per the resident's plan of care.

Interview with LPN #1, on 09/24/15 at 5:50 PM, revealed on 09/11/15 she was given the resident's vital signs which indicated he/she had a temperature of 102 degrees F and she administered two (2) 500 milligram (mg) of Tylenol. LPN #1 stated she checked the resident's temperature again at approximately 12:30 AM, on 09/12/15, and it was 99.0 degrees F. LPN #1 further stated she did not check on the resident anymore until 09/12/15 at approximately 6:00 AM, when she noticed the

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resident had no movement. LPN #1 further stated she was not told the resident had not urinated throughout the night by the CNAs and only found out the resident had not urinated during the two (2) hour rounds when the subsequent shift reported to her the resident had not urinated. She stated it would have been important to have known the resident had little to no urine output because she would have monitored and assessed the resident more closely. She stated she was aware the resident was on the list for decreased fluids and his/her blood sugar was high. Further interview revealed the facility did not advise her of the resident's care plan, therefore she did not know she needed to follow the care plan.

Further interview on 09/17/15 at 10:50, with CNA #3 revealed on 09/12/15 at approximately 6:30 AM he took the resident's temperature under his/her arm and the temperature was 102.2 degree F. CNA #3 stated the resident was in respiratory distress, and was sweating.

Review of the Nurse's Note completed by LPN #3, dated 09/12/15 at 6:40 AM, revealed Resident #2 was found in distress, and unresponsive. According to the Note, the resident's skin was clammy, cool to touch and there was mottling to the bilateral lower and upper extremities, chest, neck and ears. Emergency Services (911) was called to transfer the resident to the hospital Emergency Room.

Review of Resident #2's Emergency Room Notes, dated 09/12/15, revealed upon arrival at the Emergency Room (ER), the resident presented with a rectal temperature of 106.7 degrees F. The resident's laboratory values

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were documented as: Sodium 174 (reference range 135-145). Potassium 4.1 (reference range 3.5-5.0) Blood Urea Nitrogen (BUN) 75 (reference range 7-20 test to measure the amount of nitrogen in the blood in order to evaluate kidney function). Creatinine 4.0 (reference range 0.6-1.2 -test to evaluate kidney function). The resident was admitted to the Cardiac Care Unit for treatment and monitoring with diagnoses of Septic shock with Hypotension, Pneumonia, Dehydration, and Acute Renal Failure. Review of the Electroencephalogram (EEG), dated 09/14/15 revealed Resident #2 had severe generalized slowing, suggesting diffuse cerebral dysfunction. On 09/15/15, Resident #2's family made the decision to consult Hospice for comfort measures. The resident expired on 09/21/15.

Interview on 09/23/15 at 11:40 AM with the On-call Physician for Resident #2 on the evening of 09/11/15 and 09/12/15, revealed he did not receive a phone call regarding Resident #2's increased temperature and if he had been notified he would have transferred the resident to the ER for further evaluation and to have blood work drawn.

Interview on 09/17/15 at 10:30 AM, with Resident #2's Physician, revealed a 102 degree F temperature was a change in condition and the physician should have been notified, per the plan of care.

Interview with the Minimum Data Set Coordinator (MDS), on 09/23/15 at 2:48 PM, revealed the care plan was important for staff to follow so they would know how to work with residents. She stated if the residents should have a concern, the care plan assists the staff with addressing any

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problems and how to monitor for those problems. The MDS Coordinator stated Resident #2 was care planned for "Potential Fluid Deficient", related to his/her medications of "diuretics." She stated, if the resident was showing signs and symptoms of dehydration, then the Physician should have been notified per the resident's plan of care. She stated staff should not wait three (3) consecutive days of being on the "Hydration Log" before contacting the physician if the resident was showing signs and symptoms of dehydration. Additionally, the MDS Coordinator reported the resident's care plan related to dehydration was not followed, but should have been.

Interview on 09/24/15 at 4:23 PM, with the Assistant Director of Nursing (ADON) revealed when a resident had an increased temperature, decreased fluid intake and decreased urination staff should contact the physician per the plan of care.

Interview on 09/24/15 at 5:27 PM, with the Director of Nursing (DON), revealed LPN #1 should have re-assessed the resident and called the physician. Further interview revealed her expectation was for staff to follow the resident's care plans. She stated, "That's why we have care plans", and if the nurse did not contact the physician when Resident #2 had a significant change in temperature, then LPN #1 was not following the care plan.

Interview on 09/24/15 at 6:46 PM, with the Administrator revealed he would expect with a change of condition the nurses should have monitored more closely and contacted the physician with the change in Resident #2's condition. Further interview revealed the care

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plan was not followed related to the physician not being notified concerning Resident #2's increased temperature and signs and symptoms of dehydration. He stated staff should follow the care plan, adding "it's their plan of care."

The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/02/15, which alleged removal of the IJ effective 09/30/15. Review of the AOC revealed the facility implemented the following:

1. On 09/21/15, the Administrator and Medical Director created the Abnormal Vital Signs policy, which instructed staff on the definition of abnormal vital signs, actions nurses should take when abnormal vital signs were obtained, and when to notify the physician, resident, and/or responsible party/Power of Attorney (POA).

2. On 09/24/15, the Administrator, DON, ADON Staff Development Coordinator, and QAPI Nurse reviewed facility policies regarding change in resident status, notification of change, documentation, hydration, charting, and care plans for compliance of Federal regulations to ensure thorough understanding and knowledge prior to education of staff. It was determined facility policy had been followed regarding notification of change related to Resident #2's fluid intake on 09/11/15. The facility policy "Notification of Change" was updated to include facility requirements when notification of change was to occur and who staff was to notify on 09/25/15 by the Administrator. The Administrator and DON determined the facility Charting and Care Plan policies were in compliance with Federal Regulations. It was identified, the facility had three (3) policies governing hydration; all

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policies were reviewed and the Administrator and DON determined one (1) of the policies met federal regulations compliance. The "Hydration and Nutrition" updated on 09/25/15, by the Administrator, would be used as the facility's only policy on hydration.

3. Twenty-four (24) out of twenty-six (26) nurses were educated on updated "Notification of Change" the new "Abnormal Vital Signs", "Hydration and Nutrition", and "Charting" policies on dates 09/24/15 through 09/29/15 by the DON, ADON, Staff Development Coordinator, and QAPI nurse. Additionally, education also included following the residents' plan of care related to signs and symptoms of dehydration, documentation regarding hydration and nutrition, and contacting physician with change in status (for example abnormal vital signs, signs and symptoms of dehydration). Certified Nurse Aides (CNAs) were not involved in this training even though they may obtain vital signs, it was solely the nurses' responsibility to monitor and assess the residents vital signs and hydration status. Education was conducted in small group sessions with open conversation and question and answer period at the end to test knowledge and understanding of the policies. The nurses that did not receive education would not provide direct care until education on Abnormal Vital Signs policy and Notification of Change policy had been received. Furthermore, these policies had been added to the facility's orientation program which was conducted prior to new nurses providing direct care in the facility beginning with next orientation on 09/28/15.

On 09/25/15 and 09/27/15, the Staff Development Coordinator made rounds through the facility

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daily, including weekends, and on all shifts to question all nurses about the "Notification of Change and Resident Status Changes", "Abnormal Vital Signs", "Residents' Plan of Care", and "Hydration" policies. These rounds also included communicating with the facility during night shift and asking staff questions regarding notification of change abnormal vital signs, and residents' plan of care.

4. Beginning the night of 09/24/15 and ending on 09/25/15, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator, and (QAPI) Nurse audited one-hundred (100) percent of resident clinical records pertaining to notification of change. No evidence was found that any other residents were adversely affected by notification of change.

5. Beginning the night of 09/24/15 and ending 09/25/15, the Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited one-hundred (100) percent of resident clinical records pertaining to care plan interventions related to dehydration/fluid volume deficit. Evidence revealed all current resident care plans implemented correctly related to dehydration. MDS staff reviewed the plan of care for all current residents and updated to include the "daily estimated fluid need" for each resident. On 09/25/15, the DON added question to Electronic Medication Administration Record (EMAR) for all residents: "Did resident meet estimated daily fluid intake?"

6. Beginning the night of 09/24/15 and ending on 09/25/15, the Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse

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audited one-hundred (100) percent of the residents clinical records daily, including weekends, to ensure staff was compliant with the Charting policy and accurate clinical documentation.

7. Starting 09/25/15, and ongoing the DON with the assistance from the ADON, Staff Development Coordinator, QAPI Nurse, MDS staff, and Charge Nurses, began auditing one-hundred (100) percent nurse documentation daily, including weekends, to monitor staff compliance with facility policy regarding notification of changes in resident status, abnormal vital signs, documentation of physician notification, hydration and nutrition logs and care plan interventions. This audit would continue until Immediate Jeopardy abated. All issues identified with regards to these policies would be immediately addressed with individual staff responsible.

8. On 09/25/15, and ongoing the DON began auditing one-hundred (100) percent of the residents' charts daily, including weekends, to ensure plan of care related to dehydration and notification of change was followed for residents who triggered on the "Nutrition and Hydration Log." The DON audited, with the help from the ADON, Staff Development Coordinator, QAPI Nurse, MDS Staff, and Charge Nurses, included inspection of Hydration and Nutrition logs, vital signs obtained, lab values obtained which was checked against nurse documentation if abnormal vital signs or lab values obtained and/or change of resident hydration status noted. The audit would continue until Immediate Jeopardy was abated. The DON would immediately address all issues regarding staff compliance with

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resident plan of care with individual staff and present audit findings to QAPI Committee for review and process improvement if necessary.

The Nutritionally at Risk (NAR) Committee would review all residents that trigger for "nutritionally at risk" for hydration status weekly and would make appropriate interventions as necessary. The NAR Committee consists of the DON, ADON, MDS Coordinator, Dietary Manager, Staff Development Coordinator, and QAPI Nurse. The DON would address all issues related to hydration and nutrition, care plans, documentation, and notification of changes with staff immediately and present audit findings to the QAPI Committee monthly.

9. Results of audits (nurse documentation and staff compliance with residents' plan of care) would be addressed daily with individual staff and audit findings would be presented to the QAPI Committee for review and process improvement at least monthly as necessary. The QAPI Committee consists of the Administrator, DON, ADON, Social Worker, Maintenance Director, Medical Director, Activizes Director, Housekeeping/Laundry Supervisor, and Dietary Manager. The QAPI Committee meets monthly with the Medical Director attending the QAPI meeting quarterly. The next QAPI meeting was scheduled for 10/02/15.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Review of the "Abnormal Vital Signs", created 09/21/15, revealed there were parameters set, regarding a resident's blood pressure, pulse, and temperature in which the physician should be

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notified to due a change in the resident's change in condition.

Interview with the Administrator, on 10/02/15 at 1:44 PM, revealed the Medical Director (MD) stopped by his office on 09/21/15 to discuss the concern regarding Resident #2. The Administrator revealed he acknowledged to the Physician the facility did not have a policy to address when the physician should be notified regarding a change in resident's condition. He revealed, in regards to a resident's temperature, staff would obtain the resident's temperature rectally and would notify the physician if out of the set parameters. The Administrator reported the Physician agreed with the policy.

Interview with the Physician, on 10/08/15 at 11:00 AM, revealed he discussed Resident #2's case with the Administrator. The Physician revealed he thought the physician should have been notified with a temperature of one-hundred and two (102) and it warranted an Emergency Room (ER) visit, especially since the resident was on antibiotics. He reported he came up with some reasonable numbers, through his expertise and practice, that would assist the staff with notifying the physician.

2 Review of the facility's policies revealed the facility kept the "Charting" revised 07/30/15, "Care Plan" reviewed 01/06/15, and "Notification of Change", dated 08/03/15, policies. The facility added a "cheat" sheet to go along with the "Notification of Change in Residents' Condition." The "cheat" sheet was titled, "Notification of Change When to Document?", created 09/25/15.

Interview with the Administrator, DON, and ADON

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on 10/02/15 at 1:44 PM, revealed, when he and the staff reviewed the policies, they thought the policies they had in place complied with the Federal Regulations. Continued interview with the Administrator revealed they, thought it would be helpful to have a "cheat" sheet to go along with the "Notification of Change in Residents' Condition" to assist the staff with knowing what to look for when there was a change in a residents' condition.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed she was part of assisting with the policy review and new updated policies.

Review of the facility's "Hydration and Nutrition" Policy revised 09/25/15 revealed there was no change from the original policy provided.

Interview with the Administrator, DON and ADON on 10/02/15 at 1:44 PM revealed the facility had three (3) policies related to Hydration. The Administrator reported he was not aware of the three (3) different policies. Continued interview with the Administrator revealed they have removed the other two (2) polices and added a revision date to the "Hydration and Nutrition" policy because this one superceded the other policies.

3. Review of the In-Service Training Sheet, dated 09/24/15, 09/25/15, and 09/29/15, revealed staff signed they were in-serviced on Abnormal vital signs, Hydration, Documentation, Notifying Physician and Power Of Attorney (POA) of changes in condition, Notifying physician of any Significant Changes, following the care plan, and educated staff on the F-Tags the facility received.

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Review of the Nurses Training Manual, revised 06/05/15, revealed the updated policies were added for orientation of new hires.

Interviews with Registered Nurse (RN) #1 on 10/01/15 at 8:30 PM, RN #5 on 10/02/15 at 11:40 AM, Licensed Practical Nurse (LPN) #6 on 10/01/15 at 7:07 PM, LPN #2 on 10/02/15 at 9:50 AM, and LPN #7 on 10/02/15 at 10:50 AM, revealed they were all in-serviced on the Abnormal Vital Signs policy: Hydration, Documentation, Notification of the Physician and Power of Attorney of changes of condition. Additionally they added the information was stored at the nurses station for their reference.

Review of the documentation provided by the Staff Development Coordinator revealed she provided staff with follow-up questions, on 09/25/15, 09/26/15, and 09/27/15, to what was in-serviced to the staff. The Staff Development Coordinator had a series of questions in which she asked staff about the required information.

Interviews with Registered Nurse (RN) #1 on 10/01/15 at 8:30 PM, RN #5 on 10/02/15 at 11:40 AM, Licensed Practical Nurse (LPN) #2 on 10/02/15 at 9:50 AM, and LPN #7 on 10/02/15 at 10:50 AM, revealed they were asked questions from the Staff Development Coordinator regarding what they were in-serviced on.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed she took all of the information from the policies and created a questionnaire in which she asked staff how much they knew about Hydration, Care Plans, Notification, Change in a Resident's Condition, Documentation, and the F-Tags cited. She stated she did not have a sign-in sheet, but

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documented the names and times of the individuals she spoke with. The SDC stated she questioned staff on every shift, including weekends. The SDC revealed the auditing would be ongoing and reported the Hydration for the residents have improved, adding "there were less residents on the Hydration List.

4 Review of the auditing tools used to audit one-hundred (100) percent of the residents clinical records were reviewed and the records were reviewed from 09/24/15 through 10/02/15.

Interview with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on 10/02/15 at 1:44 PM, revealed reports were pulled from the Point Click Care (PCC) system which provided them information on each resident. The information contained were critical labs and abnormal vital signs. The DON revealed she reviewed the information and contacted the physician when residents were "triggered" for critical labs. The Administrator added the nurses notes were also reviewed to see if they added anything regarding the lab results. Additionally, the DON revealed she looked at all of the resident's vital signs manually to see if there were any residents with abnormal vital signs. The DON reported she checked the nursing documentation and ensured the physician was notified on the results. No issues were identified.

5 Review of Resident's Charts, Resident's #3, #4, #5, #6, #7, #8, Unsampled Resident's A and B, revealed their care plans were updated to dehydration/fluid volume deficit. The resident's Estimated Fluid Need(EFN) was added to the resident's care plan with interventions in place. Resident #1 was out of the facility, thus his/her

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F 282	Continued From page 58 chart was not updated Interview with the Administrator, DON, and ADON, on 10/02/15 at 1:44 PM, revealed the Minimum Data Set Coordinator (MDS) reviewed all of the residents care plans to make sure their EFN numbers were updated. Additionally, the DON reported she added a question to the resident's Electronic Medication Administration Record (EMAR) which asked staff if the resident met their EFN for the day. She revealed if the resident had not, then this would prompt nurse to document interventions made to ensure the resident reached his/her EFN Interview with the MDS Coordinator, on 10/02/15 at 4:10 PM, revealed she updated the resident's care plan to include EFN. She revealed the residents were already care planned for risk of dehydration and how to recognize the signs and symptoms of dehydration. 6. Review of resident's charts, Resident's #3, #4, #5, #6, #7, #8 Unsampled Resident's A and B revealed no issues were noted. Interview with the Administrator, on 10/02/15 at 1:44 PM, revealed he went over the charting policy with the nurses. He reported the policy was vague, but specific enough to guide the nursing staff of what was expected with charting on a resident. 7. Review of the Auditing tool for nutrition, hydration, vital signs, care plans and physician notification dated 09/24/15 to 10/01/15, revealed when concerns were noted they were addressed immediately.	F 282		

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Interview with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 10/02/15 at 1:44 PM, revealed they reviewed the Twenty-Four Hour Report and all of the nursing documentation. Continued interview with the DON revealed changes were made accordingly. The DON revealed if there was a concern then they would address the concern with the staff member.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed she made sure the Physician was notified if the resident's were on the Hydration Log book for three (3) consecutive days and ensured the information was charted.

6. Review of resident's charts, Resident's #3, #4, #5, #6, #7, #8 Unsampled Resident's A and B, revealed they did not trigger on the Hydration Log. Review of Nursing notes revealed they were updated accordingly.

Interview with the SDC, on 10/02/15 at 3:49 PM, revealed every morning she would make rounds in the building to check the Hydration/Nutrition Book to see if it was completed by staff. She reported she would ensure the EFN note and the Nutrition note was added to the residents progress note.

Review of the audit form for Nutrition and Hydration dated 09/24/15 through 10/01/15, revealed residents who triggered for hydration in 09/24/15 did not trigger for hydration on 10/01/15.

Interview with the Administrator, DON and ADON, on 10/02/15 at 1:44 PM, revealed the Nutritionally at Risk (NAR) committee was already looking at residents who were Nutritionally at Risk, residents

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who were having a weight loss against medical advice. The DON revealed the NAR committee would now also look at residents who were also at risk for dehydration. The DON revealed, if a resident was nutritionally at risk and was also on the list for dehydration, even if it was one time, they would assess the resident for further interventions. The Administrator revealed, since auditing the residents who were at risk for dehydration, there were fewer residents who triggered for Hydration which indicated what they were doing was working.

Interview with the Staff Development Coordinator on 10/02/15 at 3:49 PM, revealed the NAR Committee was including Hydration along with Nutritionally at Risk residents for observation and interventions. She revealed the nurses would still document resident's who did not meet their Estimated Fluid Needs (EFN) for the day and would contact the Physician when they were on the list for three (3) consecutive days, unless the resident was showing sign and symptoms of dehydration in which case the physician would be notified immediately.

9. Interview with the Administrator, DON, and ADON on 10/02/15 at 1:44 PM, Social Service Director on 10/02/15 at 3:32 PM, Staff Development Coordinator on 10/02/15 at 3:49 PM, Medical Director on 10/08/15 at 11:00 AM, Activity Director on 10/02/15 at 3:36 PM, Housekeeping Supervisor on 10/02/15 at 3:18 PM, and Maintenance Director on 10/02/15 at 3:28 PM, revealed they had a QAPI meeting on 10/02/15 in which the results of audits and the Federal/State Deficiencies was discussed.

F 309 483.25 PROVIDE CARE/SERVICES FOR

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SS=J 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.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure each resident was assessed and monitored after a change in condition. This failure affected two (2) of nine (9) sampled residents (Residents #2 and #9).

On 09/11/15 the facility assessed Resident #2 to have a fever of 101.1 degrees Farenheit (F) and Physician's Orders were received for Zithromax (antibiotic medication), for a Upper Respiratory Infection. According to the Medication Administration Record (MAR), the resident was administered one (1) 250 milligram (mg) dose tablet of Zithromax at 5:00 PM on 09/11/15; however, there was no documented evidence Tylenol (pain reliever and fever reducer) was administered for the fever as per standing order. Staff interviews revealed on 09/11/15 between 8:00 PM and 10:00 PM the resident had a fever of 102.0 degrees F; however, there was no documented evidence the resident received Tylenol until 09/12/15 at 12:38 AM, over two (2) hours later. Review of the Nurse's Notes dated

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Resident #2 was transferred to hospital on 9/12/2015 and did not return to facility. On 9/27/15, on call MD for Resident #9 notified by phone and order received for Doppler ultrasound. Order received from Resident #9 physician ordered Xarelto 15mg twice a day for 21 days then 20mg once a day for 6 months for positive Doppler ultrasound for Deep Vein Thrombosis.

Beginning the night of 9/24/2015 and ending on 9/25/2015, Administrator, DON, ADON, Staff Development Coordinator, and QAPI Nurse audited 100 percent of resident clinical records for abnormal vital signs and changes in resident status requiring notification of change. All resident status changes and vital signs addressed appropriately as evidenced by nurse documentation of physician notification as required per federal regulations. On 9/24/2015, Administrator and DON reviewed facility policies related to hydration, notification of changes, documentation, and care plans for compliance of Federal regulations.

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09/12/15 at 12:38 AM, revealed Tylenol was administered, the resident had Rhonchi and wheezes (abnormal lung sounds) and the nurse would continue to monitor for any changes. Interviews also revealed the resident was normally incontinent of urine and a "heavy wetter"; however, the resident had no urinary output during the times of 1:00 AM, 3:00 AM, and 5:00 AM, on 09/12/15, and the nurse was notified However, there was no documented evidence the resident was continuously monitored with ongoing nursing assessments and no documented evidence the physician was notified of the increased temperature or the lack of urine output On 09/12/15, at approximately 6:00 AM, Resident #2 was noted to have a temperature of 102.2 degrees F axillary, was unresponsive, and in respiratory distress. The resident was transferred to the hospital on 09/12/15 and arrived at 6:57 AM and was assessed with a rectal temperature of 106.7 degrees Fahrenheit, was unresponsive, had mottled skin (blood vessel changes in the skin that cause a patchy appearance), agonal respirations (gasping labored breathing), capillary refill time of eight (8) seconds, labs which indicated severe dehydration, and his/her soft palate and uvula were "like sand paper". Resident #2 was admitted to the Critical Care Unit (CCU) at the local Hospital and placed on a ventilator with diagnoses of Dehydration, Pneumonia, and Sepsis. Resident #2 expired on 09/21/15 related to complications of his/her increased temperature, dehydration, and sepsis.

In addition, there was no documented evidence in the Nurse's Notes, that Licensed Practical Nurse (LPN) #8 documented Resident #9's Power of Attorney's (POA) concern related to the resident's right leg edema and no documented evidence

F 309 Administrator and DON determined that facility Charting and Care plan policies were in compliance with Federal regulations. On 9/24/2015, Administrator and DON reviewed facility policies regarding change in resident status, notification of change and hydration. It was identified that facility had three policies governing hydration; all policies were reviewed and Administrator and DON determined one of the policies met federal regulations compliance. This Hydration and Nutrition policy updated, as only facility policy on hydration, on 9/25/2015 by Administrator. Facility policy "Notification of Change" updated to include facility requirements when and how notification of change is to occur and who staff is to notify on 9/25/2015 by Administrator. On 9/23/2015 and 9/24/2015, MDS staff reviewed and updated the plan of care for all residents and updated to include the "daily estimated fluid need" for each resident. On 9/25/2015, DON added question to eMAR for all residents; "Did resident meet estimated daily fluid intake?"

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LPN #8 assessed the resident's leg after the resident's POA notified her of the edema on 09/24/15. Although the facility faxed notification to the Physician related to Resident #9's edema to the right leg on 09/25/15, the facility failed to call the physician and follow up. On 09/27/15, the resident's POA, notified the Physician of the resident's right leg edema. An Echo/Vascular Ultrasound completed on 09/28/15, revealed the resident had a Deep Vein Thrombosis (DVT), blood clot in the right leg.

The facility's failure to provide the necessary care and services related to the resident's change in medical status, has caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/24/15, and was determined to exist on 09/11/15. The facility was notified of the Immediate Jeopardy on 09/24/15.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/02/15 with the facility alleging removal of the Immediate Jeopardy on 09/30/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged, on 09/30/15, prior to exit on 10/02/15, with remaining non-compliance in the area of 42 CFR 483.25 Quality of Care, F-309 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled "Notification of Change in Residents' Condition", revised 08/03/15, revealed in an event of a significant

F 309 24 out 26 nurses were educated on facility policies pertaining to Hydration and Nutrition, Notification of Changes, Charting, Care plans, and Abnormal Vital Signs on dates 9/24/2015 through 9/29/2015 by DON, ADON, Staff Development Coordinator, and QAPI Nurse. Education was conducted in small group sessions with open conversation and question and answer period at the end to test knowledge and understanding of the policies. Certified Nurse Aides were not involved in this training, even though they may obtain vital signs, it is solely the nurses' responsibility to monitor and assess resident vital signs and hydration status. This facility does not utilize Agency nursing services. The nurses that did not receive education will not provide direct resident care in facility until education of the above has been completed. Furthermore, these policies have been added to the facility's orientation program which is conducted prior to new nurses providing direct care in the facility beginning with next orientation on 9/28/2015. On 9/24/2015,

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change in the resident's physical, mental or psychosocial status, or a need to alter treatment the nurse would assess the situation, notify the attending physician, provide necessary care, notify the responsible party, document in the resident's medical record and follow- up as indicated.

Review of the facility's policy, titled "Cardinal Symptoms", revised 07/30/15, revealed staff was to notify the charge nurse if there were any elevations in temperature or notable change in rate of pulse or respirations, or if there were any unusual variations in blood pressure. Further review revealed if staff was in doubt of the accuracy of the reading, staff should ask the charge nurse to check the vital signs

Review of Resident #2's clinical record revealed the facility admitted the resident on 02/10/15, with diagnoses which included Parkinson's Disease, Insulin Dependent Diabetes Mellitus, and Leukemia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/21/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of seven (7) which indicated severe cognitive impairment.

Review of Resident #2's Speech Therapy Treatment Note, dated 09/11/15 revealed, the Speech Language Pathologist (SLP) fed the resident lunch and noted the resident "did not feel well today", the resident had a cough throughout the meal and the nurse reported to the SLP the resident had the cough all day. Further review revealed Resident #2 did not respond to verbal cues to take drinks in between bites of food. Per the Note, the SLP fed the resident both food and

F 309 Administrator reviewed facility policies with DON, ADON, Staff Development Coordinator and QAPI Nurse to ensure thorough understanding and knowledge of Federal regulations pertain to resident care plans prior to education of staff.

Starting on 9/25/2015 DON with the help of ADON, Staff Development Coordinator, QAPI Nurse, MDS staff, and Charge Nurses, began auditing 100 percent of resident documentation daily, including weekends, to ensure staff compliance with facility policies regarding notification of changes, hydration and nutrition logs, care plans interventions, and abnormal vital signs. This audit will continue until next QAPI Committee Meeting on 11/16/15, in which it will be determined necessity for 100 percent audit. The Nutritionally at Risk (NAR) Committee will review all residents that trigger for "nutritionally at risk" for hydration status weekly and make appropriate interventions as necessary. The NAR Committee consists of the DON, ADON, MDS

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F 309	Continued From page 65	F 309	Coordinator, Dietary Manager, Staff Development Coordinator, and QAPI Nurse. DON will address all issues related to hydration and nutrition, care plans, documentation, and notification of changes with staff immediately and present audit findings to the QAPI Committee monthly. The QAPI Committee consists of Administrator, DON, ADON, Social Worker, Maintenance Director, Medical Director, Activities Director, Housekeeping/Laundry Supervisor, and Dietary Manager.	10/30/15

drink.

Interview with the SLP, on 09/23/15 at 10:11 AM, revealed, on 09/11/15, while assisting the resident with lunch in the dining room, the SLP noticed a change in Resident #2. She reported the resident was leaned over in the chair and looked as if he/she did not feel well. Further interview with the SLP revealed, she informed Registered Nurse (RN) #4 of the resident's condition, and RN #4 replied "she did not think he/she felt well."

Review of the Nurses' Notes dated 09/11/15 at 5:16 PM completed by RN #4, revealed the resident had a fever of 101.1F, and crackles (abnormal lung sounds) were noted in the lungs. The physician was notified and orders were received for Zithromax (antibiotic medication).

Review of the Physician's Orders, dated 09/11/15 revealed orders for the Zithromax 250 milligrams (mg's) once daily for four (4) days for Upper Respiratory Symptoms and Coughing.

Interview with RN #4, on 09/16/15 at 5:20 PM, revealed on 09/11/15 she noticed the resident had not "felt well" all that day. RN #4 stated she took Resident #2's temperature at 5:00 PM, on 09/11/15, because he/she was coughing and discovered the resident had a fever. She stated she contacted the Physician and obtained orders to administer Zithromax for Upper Respiratory Symptoms and Coughing. RN #4 stated she would normally give Tylenol for a temperature of 99 degrees F; however, there was no documented evidence Tylenol was administered for the temperature.

On 09/12/15 at 12:35 AM, staff documented on

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the Vital Sign Log that the resident had a fever of 102 degrees F; however, interviews revealed this temperature was obtained between 8:00 PM and 10:00 PM on 09/11/15

Interview with Certified Nursing Assistant (CNA) #11, on 09/23/15 at 8:27 AM, revealed she was the floater on the night of 09/11/15. She stated she thought CNA #9 took the vitals for the resident the evening of 09/11/15 because the vitals were completed by the time she had gotten to the unit to assist CNA #9 between 9:00 PM and 9:30 PM.

Interview with CNA #9, on 09/22/15 at 4:43 PM, revealed he worked 2:00 PM to 10:00 PM, on 09/11/15. CNA #9 stated the nurses assign the CNAs the vital signs which were normally completed by 10:00 PM, but added he normally completed his vitals between 8:00 PM and 9:00 PM. He stated he would document the resident's vital signs on a piece of paper before handing it off to the nurse who would add the information into the computer. CNA #9 revealed he would also report any abnormal vital signs to the nurse. Further interview with CNA #9 revealed on the night of 09/11/15, he did not recall obtaining Resident #2's vital signs, adding, he could have, but did not recall.

Interview with CNA #10, on 09/22/15 at 5:11 PM, revealed she worked 09/11/15 from 2:00 PM until 10:00 PM and CNA #9 did obtain the vitals for the residents that night. She stated she assisted with changing Resident #2 and reported the resident did not have much output that night. She reported the resident was a "heavy" wetter, and was not voiding much which was not normal for him/her. Additionally, she stated the resident was

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not "combative" or "fighting" with her when she went to change him/her, which was unusual for the resident. CNA #10 stated it was almost like the resident, "did not have much fight left in him/her." CNA #10 reported she told Licensed Practical Nurse (LPN) #1, but did not know if LPN #1 assessed the resident.

Review of LPN #1 Nurse's Note, dated 09/12/15 at 12:38 AM, revealed the resident was placed on antibiotics for an upper respiratory infection and the resident had a temperature of 102 degrees F with Tylenol given for the elevated temperature. Continued review of the Note revealed the resident had wheezes and rhonchi (abnormal lung sounds) noted to bilateral lungs, no adverse reactions were noted and she would continue to observe for any changes.

Additionally, on 09/12/15 at 1:20 AM, per the Vital Sign Log, the resident's temperature was taken again and was noted to ninety-nine (99) orally.

Interview on 09/22/15 at 3:44 with CNA #7, revealed she told LPN #1, when she checked on the resident on 09/12/15 at 1:00 AM, 3:00 AM, and 5:00 AM, the resident had not urinated, which was unusual for Resident #1. She stated, when she checked on the resident at 5:00 AM, she could not reposition the resident and he/she was "hard to roll over." Continued interview with CNA #7 revealed the resident was "sweaty" and pale with his/her cheeks sunken in. CNA #7 further revealed she reported this to LPN #1, whom to her knowledge, did not address the concern.

Record review revealed no further documented evidence of continued monitoring of the resident or assessment by LPN #1 on 09/12/15 even

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though the nurse was informed the resident was not urinating, was pale, and had sunken cheeks.

Interview with LPN #1, on 09/24/15 at 5:50 PM, revealed she was told on 09/11/15, during shift report at approximately 6:00 PM, the resident was on an antibiotic for respiratory issues. She stated she had staff obtain the resident's vitals on 09/11/15 and would normally receive the vitals around 9:30 PM or 10:00 PM. Continued interview revealed she was given the resident's vital signs which indicated he/she had a temperature of 102 degrees F and she gave the resident two (2) 500 milligram (mg) of Tylenol; however, per documentation the Tylenol was not administered until 12:38 AM. Further interview with LPN #1, revealed between 12:30 AM and 1:00 AM she checked the resident's temperature again and the temperature had come down. LPN #1 stated she did not check on the resident again until approximately 6 00 AM, when she noticed the resident had no movement and was mottled The LPN (#1) stated she was not notified the resident had not voided throughout the night by the CNAs; however, interviews with CNA #10 and CNA #7, confirmed they informed LPN #1 about the resident's decreased urine output observed throughout the two (2) hour bed changes/checks. LPN #1 stated she only found out about the resident's lack of urine output on 09/12/15 at approximately 6.00 AM; however, she could not remember which CNA told her. She stated this would have been important to know because she would have monitored and assessed the resident more closely through the night had she known the resident was not urinating

Interview on 09/17/15 at 10:50 CNA #3 revealed Resident #2 was a "heavy" wetter and was often

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wet ninety (90) percent of the time when changing him/her. CNA #3 reported he did a walk through the morning of 09/12/15 and noted the resident's eyes were closed and his/her head was elevated. CNA #3 reported, at approximately 6:30 AM, the nurses went in to Resident #2's room, although he could not remember which nurses. He recalled he took the resident's temperature under his/her arm and the temperature was 102.2 degrees F. CNA #3 stated the resident was in respiratory distress, was mottled, and observed to have been sweating.

Interview with LPN #3, on 09/23/15 at 6:20 PM, who received report from LPN #1 on the morning of 09/12/15, revealed LPN #1 did not report to her during the shift report, that the resident had decreased urine output, and/or a fever throughout the night of 09/11/15 and the morning of 09/12/15.

Review of LPN #3's Nurse's Note, dated 09/12/15 at 6:40 AM, revealed the resident was found in distress, and was unresponsive. Per the Note, the resident's respirations were fifty-six (56) (normal 12-16) labored, pulse was one-hundred and thirteen (113) (normal 60-100), blood pressure was seventy over thirty-eight (70/38) (normal range-120/80), and temperature was 102.2 axillary (normal 98.6). The resident's oxygen saturation was seventy-two percent (72%) (normal range 95-100%). Further review revealed the resident's skin was clammy, cool to touch, and there was mottling to the bilateral lower and upper extremities, chest, neck, and ears. Emergency services (911) was called to transport the resident to the hospital's Emergency Room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Review of Resident #2's Emergency Room Notes dated 09/12/15, revealed the resident arrived at 6:57 AM and upon arrival at the Emergency Room (ER), the resident was found to have a rectal temperature of 106.7 degrees F, respiratory rate of 68 breaths per minute, was unresponsive, had mottled skin, and agonal respirations, (an abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, accompanied by strange vocalizations). Record review further revealed the resident had a capillary refill time of eight (8) seconds, (normal capillary refill time reference range of less than two (2) seconds) (prolonged capillary refill time may be a sign of shock which could indicate dehydration and decreased peripheral perfusion). The laboratory values obtained at the hospital on 09/12/15 at 8:10 AM, revealed a sodium (NA) level of 174 (reference range 136-145), Blood Urea Nitrogen (BUN) level of 75 (reference range of 7-18) and Creatinine level of 4.0 (reference range of 0.6-1.3) Continued review of the ER hospital record revealed the resident was found to have a big white pill stuck in his/her throat which the ER Physician had to remove prior to the resident being intubated (a procedure by which a tube was inserted through the mouth down into the trachea, the large airway from the mouth to the lungs). Further review revealed, shortly after arrival to the ER the resident's blood pressure (B/P) was seventy-two over thirty-nine (72/39) and medication was administered intravenously (IV) to increase the resident's B/P.

Further review of the hospital record revealed the resident was admitted to the Cardiac Care Unit for treatment and monitoring with diagnoses of Septic Shock with Hypotension (low blood

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	185314	A. BUILDING _____ B. WING _____	C 10/02/2015

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pressure), Pneumonia, Dehydration, and Acute Renal Failure. On 09/14/15, Resident #2 had an Electroencephalogram (EEG), the report stated it was abnormal because of severe generalized slowing, suggesting diffuse cerebral dysfunction. On 09/15/15, the resident's family made the decision to consult Hospice for comfort measures. Resident #2 was removed from the ventilator and expired on 09/21/15.

Interview with the Emergency Room (ER) Physician, on 09/17/15 at 11:50 AM, revealed Resident #2 was unresponsive, mottled head to toe, his/her extremities were cold, he/she had irregular respirations noted, the back of his/her soft palate and uvula were "like sand paper". Additionally, one big white pill was observed stuck on his/her pharynx; however, the medication was not identified. Further interview revealed brain damage was multifaceted related to sepsis, dehydration, and a rectal core temperature of 106.7 degrees F. Continued interview with the ER Physician revealed Resident #2's condition could have "been avoided." He stated, if the resident's Primary Physician would have been contacted when the resident's temperature was 102 degrees F, then an increase in temperature could have been avoided.

Interview on 09/23/15 at 11:40 AM, with the On-call Physician for Resident #2 on the evening of 09/11/15 and 09/12/15, revealed he had received no phone call regarding Resident #2's increased temperature. Per interview, he could have most likely prevented the resident's temperature from going up, and would have sent Resident #2 to the ER for further evaluation and to have blood work completed. Interview further revealed the On-call Physician evaluated

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Resident #2 on 09/12/15 at the hospital and there was not much response.

Interview, on 09/17/15 at 10:30 AM, with Resident #2's Physician, revealed if he had been notified of the increased temperature the resident would have been sent to the ER. Continued interview with the Physician revealed he felt the continued increase in the resident's temperature could have been avoided. The Physician stated the cerebral injury was partially related to the fever and could have been prevented had the Physician been notified at 12:35 AM on 09/12/15, when the resident's temperature was noted to be 102 degrees F.

Interview with the Staff Development Coordinator (SDC)/LPN, on 09/24/15 at 3:59 PM, revealed, if a resident had a fever, decreased fluid intake, and decreased urine output the physician should have been notified immediately. The SDC further revealed she educated the nurses to check vital signs every two (2) hours if there was an observed fever. She further revealed if the fever continued to worsen, staff was to give the resident an as needed (PRN) Tylenol and notify the physician, responsible party, write a Nurse's Note, sign the Medication Administration Record (MAR), and check the resident again within one (1) hour, after administering the Tylenol, to assess the effectiveness. Further interview with the SDC revealed it would be her expectation for staff to document all interventions taken. However, record review revealed staff failed to follow this protocol.

Interview with the Assistant Director of Nursing (ADON), on 09/24/15 at 4:23 PM, revealed it was her expectation LPN #1 would have notified the

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physician when Resident #2's temperature reached 102 degrees F. Additionally, she reported LPN #1 should have further informed the physician. Resident #2 needed to be sent to the ER.

Interview with the Director of Nursing (DON), on 09/24/15 at 5:27 PM, revealed it was her expectation that the as needed (PRN) Tylenol, would have been given with Resident #2's change in condition. She stated the resident should have been re-assessed and a call should have been made to the resident's physician. Additionally, she stated the resident should have been monitored with the increased temperature every one (1) hour with documentation of the assessment in the Nurse's Notes.

Interview with the Administrator on 09/24/15 at 6:46 PM, revealed his expectation was for the nurse to follow the "Notification of Change in Residents' Condition policy." Further interview with the Administrator, revealed he would expect with a change in a resident's condition the nurses would monitor more closely and contact the physician.

2. Review of Resident #9's medical record revealed the facility admitted the resident on 05/15/13, with diagnoses which included Urinary Tract Infection, Dementia, Depressive Disorder, Insomnia, Orthostatic Hypotension, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 08/11/15, revealed the facility assessed the resident as scoring a three (3) out of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating the resident was severely cognitively impaired.