STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). 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 record reviews and physician, responsible party and staff interviews the facility failed to notify the physician when attempts to	F 157	Preparation and submission of this plan of correction constitutes my written allegation	8/24/15

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

Electronically Signed | 08/26/2015

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

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F 157	Continued From page 1 administer intravenous fluids were unsuccessful and failed to notify a responsible party that a new medication to treat dementia was being used for 1 of 3 sampled residents (Resident # 3). The findings included: 1. Resident #3 was admitted to the facility on 02/21/15 with diagnoses which included Alzheimer's disease, kidney disease, chronic pain, type 2 diabetes, high cholesterol, heart disease, difficulty swallowing, dehydration and Clostridium Difficille (C-Diff) a bacterial infection in the intestines that causes infectious diarrhea. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/18/15 indicated Resident #3 was severely impaired in cognition for daily decision making and required limited assistance with eating. A review of a physician's order dated 05/13/15 indicated intravenous (IV) fluids of normal saline at 100 ml per hour for 2 liters of fluids (2,000 ml). A review of a physician's order sheet dated 05/13/15 at 4:30 PM indicated peripherally inserted central catheter (PICC) insertion related to difficult IV sticks (unsuccessful) and encourage oral fluid intake. A review of a nurse's progress note dated 05/14/15 at 6:55 AM by Nurse #3 revealed Resident #3 did not have IV access when she arrived for her shift at 11:00 PM on 05/13/15. The notes further indicated she attempted twice to start the IV but was unsuccessful and would report to oncoming nursing staff. A review of a nurse's progress note dated	F 157	of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. F 157: Notify of Changes: It is the policy of this facility to inform the patient, consult with the patient¿s physician and notify the patient¿s legal representative or an interested family member when there is an accident, a significant change in the patient¿s physical, mental or psychosocial status, a need to alter treatment significantly , a decision to transfer or discharge patient from the facility. Facility will also notify the patient and patient¿s legal representative or interested family member when there is a change in room or roommate assignment and if there is a change in Patient Rights under Federal or State law. Resident # 3 no longer resides in this facility and was discharged prior to the complaint survey of 8/6/15. Resident # 3 was sent to hospital for evaluation 5/20/15. For other residents with the potential to be affected by this cited deficiency under the supervision of the Director of Nurses a 100% audit was completed	

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F 157	Continued From page 2 05/14/15 at 2:39 PM by Nurse #4 indicated IV not placed at this time and Mobilex (mobile x-ray) was scheduled to arrive by 4:30 PM. During an interveiw on 08/06/15 at 2:07 PM with Nurse #3 she confirmed she was the day shift nurse from 7:00 AM until 3:00 PM on 05/13/15 and provided care to Resident #3. She stated she remembered Resident #3 did not eat or drink a lot and explained she recalled a conversation with a Nurse Practitioner (NP) who no longer worked at the facility about IV fluids for Resident #3. She stated the NP said she wanted to give Resident #3 IV fluids of normal saline but she did not write an order for them and did not say how much IV fluid to give or how fast to give them. Nurse #3 stated she should have asked the NP about flow rate and amount of fluids to give and should have written it as a verbal order but she didn't because she thought the NP would write an order for it. She stated she reported to Nurse #2 who worked on second shift from 3:00 PM to 11:00 PM what the NP had said and she thought Nurse #2 got orders for the IV but later heard that attempts were made to start the IV but they were unsuccessful. Nurse #2 was no longer employed at the facility and was unable to be reached for an interview. During a telephone interview on 08/06/15 at 3:59 PM with Nurse #6 she confirmed she worked night shift from 11 PM to 7:00 AM and was assigned to care for Resident #3. She stated she could not recall details about IV fluids but after review of her nurses progress note dated 05/14/15 she stated she only attempted to try and stick Resident #3 twice. She further stated Nurse #2 had not reported she called the physician on	F 157	to review orders since 5/13/15 to ensure no other IV fluid order concerns. Since the order of 5/13/15 for IV fluids for resident #3, only 1 other IV fluid was identified. The order for IV fluids was received 8/10/15 and no concerns for this order were identified. The Director of Nurses on 8/07/15 in-serviced licensed Nurses of the facility policy to notify physicians, the responsible party, or family member for significant change of condition or medication as defined in the federal regulation. To enhance currently compliant operations and prevent further recurrence of this cited deficiency, under the supervision of the Director of Nurses the following systems have been placed: audits of all nurse narrative notes, and new orders have been reviewed 5 days per week to ensure physician and or responsible party/family member is notified of significant orders for medication and care changes. Reviewing the daily progress notes report and orders within a specified duration report a 100% audit is completed Monday through Friday to ensure notification of significant change is ongoing to both the physician and responsible party/family member. Further the Director of Nurses has created a quality assurance audit tool placed at each nurse¿s station. Licensed nurses were in-serviced to complete this audit tool when an RP/family member is notified for a change as per state and	

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F 157	Continued From page 3 call when she couldn't get the IV started on the 3:00 PM to 11:00 PM shift on 05/13/15. Nurse #6 verified she did not call the on call physician to let them know the IV had not been started but thought she had reported to the day shift nurse during the change of shift report. During an interview on 08/06/15 at 4:21 PM with Nurse #4 she explained she was not assigned to care for Resident #3 on 05/14/15 but was asked by a nurse to start an IV on Resident #3. She stated she tried but Resident #3's veins were collapsing so the Director of Nursing (DON) tried and could not get it in. Nurse #4 verified mobile x-ray was called on 05/14/15 at 11:53 AM to insert the PICC line and they arrived at the facility on 05/14/15 at 4:30 PM. Nurse #4 also verified there were no calls to request mobile x-ray place a PICC line before 11:53 AM on 05/14/15. During an interview on 08/06/15 at 4:30 PM the DON stated it was her expectation for nursing staff to follow physician's orders to administer IV fluids and they should have called the physician on call to report they were unsuccessful with getting the IV started so additional orders could have been obtained. She explained a physician or NP was in the facility 4 days a week on Monday, Tuesday, Wednesday and Friday and there was someone on call 24 hours a day 7 days a week for nursing staff to call. During a telephone interview on 08/06/15 at 5:14 PM with the facility Medical Director he confirmed he was also Resident #3's physician. He explained there were physicians or nurse practitioners in the facility 4 days per week on Monday, Tuesday, Wednesday and Friday and there was a provider on call 24 hours a day for 7	F 157	federal regulation. Effective 8/10/15 a quality assurance program was implemented under the supervision of the Director of Nurses to monitor /audit progress notes and physician orders to ensure the physician and responsible party have been informed for significant changes in care or treatment. The Director of Nurses or designated quality assurance representative will perform the following systematic changes: review 10 nurse progress notes for content, and 10 physician orders daily Monday through Friday x1 month then 3 days per week for 4 weeks, then 10 progress notes and 10 physician orders weekly x 4 weeks, then random weekly audits to ensure compliance and follow through. Any concerns/deficiencies are immediately addressed and corrected on the spot with the staff member involved. The findings of these quality assurance audits are documented and submitted at the quarterly quality assurance committee meeting for further review and corrective action. The Director of Nursing is responsible for monitoring, follow up, and compliance.	

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days a week. He stated when orders were given for IV fluids for Resident #3 he expected for nursing staff to let him know or the on call physician know if they could not start them so they could discuss a contingency plan such as to provide other oral fluids or other options to hydrate her to make her veins more prominent or to discuss need to send to the emergency room for evaluation. He further stated communication could have been improved to treat Resident #3's dehydration.

2. Resident #3 was admitted to the facility on 02/21/15 and discharged on 05/20/15. Resident #3's diagnoses included Diabetes Mellitus type 2, Alzheimer's disease and others. A Minimum Data Set (MDS) dated 05/18/15 specified the resident had severely impaired cognition. Resident #3's demographic sheet specified she had a Responsible Party (RP).

Review of Resident #3's physician's orders revealed:

- A physician's order dated 05/05/15 noted by Nurse #2 to start Exelon patch (to treat dementia)

Further review of the medical record revealed there was no documentation that Resident #3's RP was notified of the change.

On 08/06/15 at 1:00 PM the Director of Nursing (DON) was interviewed and reported that nurses were expected to notify residents' responsible parties of medication changes either verbally or by calling and that the notification was to be documented in the medical record. The DON explained that when a new physician's order was received, the nurse that received the order was

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F 157	Continued From page 5 responsible for notifying the RP of the change. She added that if the nurse was unable to notify the RP by end of shift then the nurse should have the next shift nurse to notify. Nurse #2 was no longer employed at the facility and unable to be reached for an interview. On 08/14/15 at 11:30 AM Resident #3's RP was interviewed on the telephone and reported that she was not notified of Resident #3's Exelon patch being ordered by the physician. She explained that she observed a patch on Resident #3's body and asked a nurse what the patch was and the nurse stated that it was to treat Alzheimer's Disease and added that the patch had been in place for a while. The RP stated she spoke with other family members and they were not aware of the new order.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR 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 record reviews and physician and staff interviews the facility failed to assess a resident who was dehydrated when attempts to administer intravenous fluids were unsuccessful for 1 of 3 residents sampled for dehydration. (Resident	F 309	F 309: Provide care/services for highest wellbeing. It is the policy of this facility that each patient receives and this facility will provide the necessary care and the	8/24/15

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F 309	Continued From page 6 #3). The findings included: Resident #3 was admitted to the facility on 02/21/15 with diagnoses which included Alzheimer's disease, kidney disease, chronic pain, type 2 diabetes, high cholesterol, heart disease, difficulty swallowing, dehydration and Clostridium Difficille (C-Diff). A review of the most recent quarterly Minimum Data Set (MDS) dated 05/18/15 indicated Resident #3 was severely impaired in cognition for daily decision making and required limited assistance with eating. A review of a progress note for nutritional needs dated 05/12/15 at 4:48 PM by a former dietary manager revealed Resident #3 ' s oral intake remained very poor due to resident consuming 25 percent or less on most occasions. The notes indicated Resident #3 needed maximum encouragement at meals and recommended that Resident #3 be assisted with all meals by nursing staff to increase oral intake. A review of a physician's order dated 05/13/15 indicated intravenous (IV) fluids of normal saline at 100 ml per hour for 2 liters of fluids (2,000 ml). A review of a physician's order sheet dated 05/13/15 at 4:30 PM indicated peripherally inserted central catheter (PICC) insertion related to difficult IV sticks (unsuccessful) and encourage oral fluid intake. A review of a progress note for nutritional needs dated 05/13/15 at 5:22 PM by a former dietary manager indicated family was concerned	F 309	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 facility will ensure that the patient obtains optimal improvement or does not deteriorate within the limits of a patient¿s right to refuse treatment, and within the limits of recognized pathology and the normal aging process. Resident #3 was discharged from the facility prior to the complaint survey of 8/6/15. Resident #3 was sent to hospital for evaluation on 5/20/15. Because other residents who have a previous history for dehydration, are dependent for care or who require extensive assistance with nutritional and hydration assistance are at risk for this cited deficiency, under the supervision of the Director of Nursing, a 100% audit was done for each resident who triggers on the census and condition reports as extensive assistance or dependence for nutritional and hydration needs was completed 08/24/15 by the Regional Nurse Consultant to ensure resident needs are assessed to maintain their highest level of wellbeing. The Director of Nurses further retrained the licensed nurses, and aides for the facility policy to provide services to maintain a resident¿s highest wellbeing specifically hydration on 8/07/2015. Retrained staff for assessing hydration, signs, symptoms dehydration, and monitoring fluid intake to maintain hydration and communicating concerns	

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F 309	Continued From page 7 regarding Resident #3's condition and poor oral intake. The notes revealed family stated Resident #3 was extremely dehydrated and she was too weak to even hold a drink glass which was also observed by the former dietary manager during her visit with the resident. The notes further indicated Resident #3 had IV fluids ordered. A review of a nurse's progress note dated 05/14/15 at 6:55 AM by Nurse #3 revealed Resident #3 did not have IV access when she arrived for her shift at 11:00 PM on 05/13/15. The notes further indicated she attempted twice to start the IV but was unsuccessful and would report to oncoming nursing staff. A review of a laboratory report dated 05/14/15 indicated Resident #3's Blood Urea Nitrogen (BUN) was high at 50 (normal range 5-25) and Creatinine was high at 1.8 (normal range 0.6-1.3). BUN and Creatinine blood tests were done to see how well the kidneys were working. A review of a care plan with a focus statement of nutritional needs indicated in part to offer adequate fluid intake. A section labeled intervention which was updated 05/14/15 indicated IV fluid 100 ml per hour for 2 liters of fluid. A review of a psychiatric consult note dated 05/14/15 indicated Resident #3's family reported she had been very dehydrated and reported there was an IV hanging in the room but it was not started due to difficulty getting IV started in veins. The notes indicated Resident #3's mental status exam revealed motor activity was sluggish and a section labeled care treatment plan indicated staff	F 309	with dietary manager as indicated. Upon admission to the facility each new resident is assessed by the Dietary Manager for hydration needs utilizing the full dietary assessment questionnaire in the electronic healthcare record. Each resident is assessed by a licensed nurse on the date of admission for hydration concerns based on physical assessment, hospital labs if available, discharge summary, and diagnosis from hospital. To enhance current compliant operations and under the supervision of the Director of Nurses, Licensed nurses were retrained to thoroughly assess resident skin turgor, oral mucosa, and review available hospital labs upon admission to the facility and prn for significant change in condition. Resident hydration is further assessed using the MDS 3.0 quarterly. Nurse aides were re-educated for the importance of documentation of fluid intake during meals and prn in the electronic medical record and informing the nurse when a resident has a decrease in the amount of liquids the resident usually consumed during the shift. Effective 08/21/15 a quality assurance program was implemented under the supervision of the director of nurses to monitor residents identified for risk of fluid concerns: The Director of Nurses and Certified Dietary Manager meet weekly for 3 months to review residents identified at risk for dehydration to ensure interventions are immediately placed and care plans and care guides are updated. These residents are identified pulling data from the electronic record reports and	

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and family voiced concerns about dehydration.

A review of a nurse's progress note dated 05/14/15 at 2:39 PM by Nurse #4 indicated IV not placed at this time and Mobilex (mobile x-ray) was scheduled to arrive by 4:30 PM.

A review of a physician's progress notes dated 05/15/15 indicated Resident #3 was able to walk and feed self a week ago but was now bed bound and would drink if encouraged. The notes indicated Resident #3's skin was dry and had poor turgor (degree of elasticity of skin and when there was moderate to severe hydration a portion of the skin that was pinched up remained elevated and only slowly returned to its flat position). A section labeled assessment and plan indicated to monitor closely for signs of deterioration in condition.

A review of a progress note for nutritional needs dated 05/19/15 at 4:47 PM by a former dietary manager indicated she spoke with Resident #3's family and they expressed concerns about Resident #3 ' s intake and requested when anyone came in the room they should offer Resident #3 drinks of water.

The stated Resident #3 had been very weak and needed maximum encouragement and assistance. A review of a nurse's progress note dated 05/19/15 at 10:52 PM indicated Resident #13 complained of stomach upset and vomited a small amount of liquid and ginger ale was offered.

A review of nurse's progress notes dated 05/20/15 at 10:15 AM indicated Resident #3 was transferred by emergency medical services to the hospital for evaluation of a large mass on right

monitoring documentation of physician and nurse progress notes. The Director of nursing is responsible for compliance and will document and submit findings to the quarterly quality assurance committee for further review and corrective action.

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side of abdomen.

During an interveiw on 08/06/15 at 2:07 PM with Nurse #3 she confirmed resident assessments and changes in a resident's condition were supposed to be documented in the nurses notes. She stated nursing staff were expected to assess residents on their shift. She explained Resident #3 could feed herself but she was very slow, did not eat or drink a lot and needed encouragement. She stated she recalled the NP ordered Resident #3 to have IV fluids but they were unsuccessful at getting the IV started and she did not recall doing any nursing assessments for dehydration for Resident #3. She stated she reported to Nurse #2 who worked on second shift from 3:00 PM to 11:00 PM and she thought Nurse #2 got orders for an IV and later she heard that attempts were made to start the IV but they were unsuccessful.

Nurse #2 was no longer employed at the facility and was unable to be reached for an interview.

During a telephone interview on 08/06/15 at 3:59 PM with Nurse #6 she confirmed she worked night shift from 11 PM to 7:00 AM. She stated she remembered she was assigned to care for Resident #3 but could not recall details about the resident because it had been too long ago. She stated after review of her progress notes she could not get Resident #3 ' s IV started but she did not recall doing an assessment of Resident #3's hydration because if she had she would have documented it in her nurse's notes.

During an interview on 08/06/15 at 4:30 PM the DON stated she stated it was her expectation for nursing staff to assess residents during their assigned shift. She explained there had been a

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F 309	Continued From page 10 lot of staff turnover and improvement was needed with nursing assessment skills. During a telephone interview on 08/06/15 at 5:05 PM with Nurse #5 she verified she worked second shift from 3:00 PM to 11:00 PM. She explained she remembered Resident #3 but she was not assigned to provide care to Resident #3. She stated Nurse #2 was assigned to Resident #3 and she told her she had tried to start an IV for Resident #3 but she couldn't get the IV in because Resident #3's veins were rolling. She further stated Nurse #2 did not ask her to try to start Resident #3's IV and she did not assess Resident #3's level of hydration. During a telephone interview on 08/06/15 at 5:14 PM with the facility Medical Director he confirmed he was also Resident #3's physician. He stated he expected nursing staff to assess resident's condition and to call him or the physician on call when there was an acute change in condition. He further stated he expected when IV fluids were ordered for Resident #3 he expected for nursing staff to let him or the on call physician know if they could not start them so they could have discussed a contingency plan such as to provide other oral fluids or other options to hydrate her to make her veins more prominent or to discuss need to send to the emergency room for evaluation.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		8/24/15

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F 323	Continued From page 11 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to keep water temperature at safe levels for 3 of 3 residents' rooms, in a visitor bathroom and in a hallway sink. The findings included: On 08/06/15 at 10:30 AM an observation of the hot water in the visitor bathroom at the intersection of the 700 and 800 Halls revealed the water was too hot to touch and had steam rising from the sink. On 08/06/15 at 10:45 AM the Maintenance Director was interviewed and reported that he tried to keep the hot water at/around 116 degrees Fahrenheit. He explained that every Monday he randomly checked the water temperatures in residents' rooms. He specifically said that concerns had been identified on the 500, 600, 700 and 800 Halls. He added that the plumbing company was at the facility last week to address hot water concerns. The Maintenance Director reported that each resident room was equipped with its own sink and shower and that the temperature levels would be the same. He added that the facility did have shower rooms with bath tubs but the residents did not use those rooms since they had their own private baths. The Maintenance Director used a calibrated	F 323	F 323: Free of accidents hazards/supervision/devices: This facility believes the patient environment should remain as free from accident hazards as is possible and that each patient receives adequate supervision and assistance devices to prevent accidents ¿ The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices assistive devices to each patient to prevent avoidable accidents. No residents were injured, nor had any residents, families, or staff voiced concerns that water temperatures were too hot. All residents have the potential to be affected by this cited deficiency. To achieve compliance for this cited deficiency. The plumber adjusted the water temperature and the temperature high level is set within the range of 100 - 116 degrees. Signage placed on the boiler by the plumber that read ¿Do not adjust mixing valve. Keep set at 120 degrees Fahrenheit, thanks plumber:¿ was removed by the Maintenance Director	

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F 323	Continued From page 12 digital thermometer and random residents' bathrooms were checked that revealed the following: a. On 08/06/15 at 10:51 AM room 601's bathroom sink water temperature was measured by the Maintenance Director and reached a temperature of 118.4 degrees Fahrenheit. The Maintenance Director was interviewed about the water temperature and stated 118 degrees was too hot. The Resident #4 residing in room 601 was interviewed and reported that she did not have problems with the water being too hot in her bathroom. During the observation, The Maintenance Director explained that all the rooms along the 600 would have water temperature at 118 degrees. b. On 08/06/15 at 10:53 AM room 701's bathroom sink water measured 119.8 degrees Fahrenheit. The Maintenance Director reported that the temperature was too hot. Room 701 was occupied at the time but the resident was unable to be interviewed. The Maintenance Director explained that the rooms on the 700 hall would also have water temperatures close to 119 degrees. c. On 08/06/15 at 10:56 room 403's bathroom sink water measured 119.3 degrees Fahrenheit. The Maintenance Director reported that the temperature was too hot. d. On 08/06/15 at 11:07 AM the wall-mounted sink on access hall available to residents was checked and the hot water measured 119 degrees Fahrenheit. The Maintenance Director reported that the water was too hot.	F 323	08/06/15 during the complaint survey. Under supervision of the Maintenance Director water temperatures are checked and recorded daily. Immediate adjustments are made to correct any identified concerns for hot water temps. The plumber was recalled to facility on 08/11/15 when water temp concerns were identified. The mixing valve was changed out during this maintenance visit. Under the supervision of the Maintenance Director water temps are recorded each shift daily for 2 weeks, then water temps are recorded 5 days per week for 4 weeks then 3 days weekly for 4 weeks then weekly ongoing per protocol. Any identified concerns are immediately addressed by the Maintenance Director. The Administrator and Assistant Maintenance Director are trained to shut water off in the facility in the event water temperatures concerns are identified (this is a new backup system. Training was performed by the Maintenance Director on 8/07/15). All concerns are presented to the quarterly quality assurance committee for review and further corrective action if needed. The administrator is responsible for compliance.	

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During the observations the Maintenance Director reported that he did not check the temperature of the hot water in the visitor bathrooms because residents did not use the areas.

On 08/06/15 at 11:10 AM observations were made of the facility's boiler room that revealed one boiler was used to heat the facility and the kitchen area. The mixing valve of the boiler unit was set to 120 degrees Fahrenheit and noted to have a cardboard sign that read "Do not adjust mixing valve. Keep set at 120 (degrees Fahrenheit), thanks Plumber." The Maintenance Director was interviewed about the sign and he explained that he was told to keep the valve set to 120 degrees Fahrenheit and that he should not be making adjustments to the mixing valve because of the new unit's warranty. The Maintenance Director confirmed that the mixing valve was set too high and that all the hot water in the facility would be 120 degrees Fahrenheit. He added that when he noticed the water was too hot he would go to unoccupied rooms, turn the hot water on to allowing the water to flow, emptying the hot water stored in the holding tank causing the water to be cooled. The Maintenance Director stated that he had not had staff or residents complain about the temperature of the hot water.

On 08/06/15 at 11:20 AM the Maintenance Director shared water temperature logs that revealed the weekly water temperatures were within acceptable ranges. The Maintenance Director explained that on occasionally prior to measuring the hot water temperature he would allow the water to run causing the hot water to be diluted then he checked the temperatures to make sure they were within an acceptable range.

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F 323	Continued From page 14 On 08/06/15 at 11:25 AM the Administrator was interviewed and reported that he was not aware of concerns with water temperatures. On 08/06/15 at 12:50 PM the Administrator used a calibrated digital thermometer to check the hot water of the 700 and 800 hall visitor bathroom sink that after the Maintenance Director had allowed the water to run to lower the temperature of the water in the building. The water measured 118.2 degrees Fahrenheit. On 08/06/15 at 1:30 PM nurse aide (NA) #1 assigned to the 500 and 600 Halls was interviewed and reported that she had not observed concerns with the hot water being too hot. She also stated that residents had not complained. On 08/06/15 at 1:35 PM NA #2 assigned to the 700 and 800 Halls was interviewed and stated she did not have concerns with the hot water being too hot and that residents had not voiced concerns. The NA stated that she always checked the water before allowing a resident to get wet and would ask them if the temperature was okay. She also stated that if the water was too hot she notify the nurse immediately. On 08/06/15 at 3:05 PM the Plumber was on site to assess the mixing valve. The Plumber was interviewed and stated that he had told the Maintenance Director not to make adjustments to the mixing valve. He added that he had been to the facility 4 times in response to hot water concerns. On 08/06/15 the Plumber determined that the mixing valve was stuck and needed to be replaced.	F 323		

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F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain a Dietitian consult for weight loss as ordered by the physician and waited 7 days before implementing nutritional interventions for a resident that lost 11.5 % of her body weight in one month for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/21/15 and discharged on 05/20/15. Resident #3's diagnoses included Diabetes Mellitus type 2, Alzheimer's disease, clostridium difficile and others. A Minimum Data Set (MDS) dated 05/18/15 specified the resident had severely impaired cognition, required extensive assistance with activities of daily living and had experienced significant weight loss and the weight loss was not the result of a physician prescribed diet. Review of Resident #3's weights revealed she	F 325	F 325: Maintain nutritional status unless unavoidable: It is the policy of this facility to assess patients who experience significant unplanned or undesired weight loss or weight gain, and insidious weight loss and to follow recommendations and orders for Dietician consults, and supplements as indicated. Resident #3 was discharged from the facility prior to the complaint survey of 8/6/15. Resident #3 was sent to hospital for evaluation on 5/20/15. For other residents with the potential to be affected by this cited deficiency, under the supervision of the director of nurses the following has been achieved: 100% audit of all orders since May 13, 2015 completed to ensure all consult orders had been transcribed and scheduled in the electronic health record under consults. Further the Director of	8/24/15

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F 325	Continued From page 16 weighed: 02/21/15 135.6 pounds (lbs) 03/05/15 133.2lbs 04/02/15 129.4lbs 05/07/15 114.5lbs Further review of Resident #3's medical revealed Resident #3 was ordered by the physician to receive a mechanical soft diet. On 04/03/15 the nurse practitioner (NP) ordered "Magic Cup" (a fortified ice cream) to be given with meals for 2 weeks due to anorexia. On 04/08/15 a second order was written to give "Magic Cup" with meals for 2 weeks due to anorexia. During this time Resident #3 was diagnosed with a urinary tract infection (UTI) and started on antibiotics. A document titled "Monitoring Assessments Report" for 04/01/15 through 05/20/15 specified Resident #3 received the fortified ice cream 3 times a day for 10 days starting on 04/08/15 through 04/17/15. According to the "Monitoring Assessments Report" the resident consumed ~75% of the ice cream. There was no documentation that Resident #3 received the Magic Cup as ordered on 04/03/15 through 04/07/15. Review of the medical specified that on 04/20/15 Resident #3 was diagnosed with clostridium difficile (C-diff) and started on antibiotics to treat the infection. On 05/05/15 the NP reviewed Resident #3 after completing antibiotics for the C-diff and documented in the progress note that Resident #3 continued to have decreased by mouth intake of food. The NP documented that Resident #3	F 325	Nursing or designee informs the Certified Dietary Manager for nutritional consults. A communication box has been placed at each nurse¿s station for communication of nursing to dietary so the Certified Dietary Manager is informed for nutrition consults and dietary changes. The Certified Dietary Manager or dietary designee retrieves communication slips from the nurse¿s station 7 days per week. Dietary staff and licensed nurses were in-serviced for this additional process 8/24/15. 100% audit for all supplement orders completed to ensure they are accurately scheduled under monitoring assessments, in order to record the amount of the supplement intake. Under the supervision of the Director of Nurses, all licensed nurses were in-serviced to enter all supplement orders for nutrition under the monitor assessment tab of the electronic record. All new residents are weighed within 48 hours of admission and weekly x 4 week¿s total, then monthly if no significant weight concerns are identified. Residents identified on the significant weight loss report are placed on weekly weights, the family/RP and MD are informed. Other interventions are scheduled as ordered by the physician. The care plan and care guide are revised by a licensed nurse or Certified Dietary Manager to reflect weight concerns and nutritional needs. This is an ongoing process and required to monitor each resident weight per state and federal regulation.	

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F 325	Continued From page 17 had lost weight from 135.6 pounds to 129.4 pounds and ordered weekly weights, Remeron (an antidepressant medication that can stimulate appetite) and a "Dietitian" consult. Review of Resident #3's medical record revealed that Resident #3 was not assessed by a Registered Dietitian (RD) after the 05/05/15 order. On 05/07/15 Resident #3's weight was 114.5 pounds; an 11.5% loss of body weight from 04/02/15. On 05/12/15 Resident #3 was reviewed by the facility's Dietary Manager (DM) for weight loss and anorexia. The DM documented that Resident #3's intake was very poor and that the resident consumed 25% or less on most occasions. The DM also documented that the weight loss was likely associated with C-diff and poor intake and recommended Magic Cup three times a day with meals and finger foods when possible and to continue to monitor. Review of Resident #3's medical record, there was no order for the Magic Cup on 05/12/15 and the Magic Cup was not indicated on the "Monitoring Assessments Report." On 05/13/15 the DM documented in Resident #3's medical record that she met with Resident #3's family due to concerns with the resident's condition and poor intake. The DM documented that she informed the family of the recommendations she made. The DM's progress note specified the resident was "extremely dehydrated and was too weak to hold a glass" and that Resident #3 had tested positive for C-diff	F 325	Under supervision of the Director of Nurses and the Certified Dietary Manager the following systematic changes were implemented to prevent recurrence: communication box at each nurse station. In-service of additional process to dietary and licensed nurses. Effective 08/24/15 a quality assurance program was implemented as above under the supervision of the Director of Nurses. The Director of Nurses is responsible for compliance and documents and submits concerns identified to the quality assurance committee quarterly for further review and corrective action.	

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again.

Further review of Resident #3's medical record revealed that no additional changes were made to the resident's nutrition regimen.

On 05/18/15 the NP reviewed Resident #3 for significant weight loss and documented in the progress note that the resident's appetite had been extremely poor but had improved over the weekend from encouragement of family and staff. The NP ordered a high calorie fortified supplement to be given three times a day by the nurse.

On 05/20/15 Resident #3 was sent to the Emergency Department for evaluation of an abdominal mass. Resident #3 was admitted to the hospital and did not return to the facility.

The NP was no longer employed by the facility and unable to be interviewed.

The DM was no longer employed by the facility and unable to be interviewed.

On 08/06/15 at 2:00 PM the facility's consultant Registered Dietitian (RD) was interviewed and explained that she was in the facility twice a month for 12 hours. The RD reported that during her visits she reviewed tube fed residents, residents with pressure ulcers and residents with significant weight loss. She stated that she was notified of such residents by the DM. The RD added that if a Dietitian consult was ordered by the physician then she would also be responsible for completing the consult during her twice a month visits but that if the consult was ordered when she was not due to visit then the facility's

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F 325	Continued From page 19 Corporate RD would do the consult. The RD stated that it would be the DM's responsibility to notify her of a Dietitian consult. She added that in May she visited the facility on 05/05/15 and 05/20/15. The RD was unaware of a consult ordered for Resident #3 on 05/05/15 while she was in the facility and the RD stated that she did not review Resident #3 for significant weight loss on her visit to the facility on 05/20/15 because she met Resident #3 leaving the facility on a stretcher. On 08/06/15 at 2:40 PM the facility's Corporate RD was interviewed and reported that a physician ordered "Dietitian" consult did not mean a Registered Dietitian had to review the resident because the term "Dietitian" was used "loosely." The Corporate RD explained that when a consult was ordered a "pink slip" was delivered to the dietary manager and that the DM could attempt to assess the resident; but if in reviewing the medical record the DM felt the issue was "more than they could handle" then he/she should contact the Consultant RD or Corporate RD. The Corporate RD stated that when a Dietitian consult was made she expected it to be addressed as quickly as possible. The Corporate RD did not comment on the 7 day delay of assessing Resident #3's weight loss after the consult was ordered. The facility provided Resident #3's tray card that reflected she was to receive Magic Cups with meals but there was no monitoring of the supplement.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		8/24/15

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F 327	Continued From page 20 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews the facility failed to provide a resident sufficient fluids to maintain hydration and failed to administer intravenous fluids for dehydration as ordered by a physician for 1 of 3 residents sampled for dehydration. (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/21/15 with diagnoses which included Alzheimer's disease, kidney disease, chronic pain, type 2 diabetes, high cholesterol, heart disease, difficulty swallowing, dehydration and Clostridium Difficille (C-Diff) a bacterial infection in the intestines that causes infectious diarrhea. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/18/15 indicated Resident #3 was severely impaired in cognition for daily decision making and required limited assistance with eating. A review of a laboratory report dated 04/23/15 indicated Resident #3's Blood Urea Nitrogen (BUN) was normal at 17 (normal range 5-25) and Creatinine was normal at 1.1 (normal range 0.6-1.3). BUN and Creatinine blood tests were done to see how well the kidneys were working. A review of a progress note dated 05/05/15 by a Nurse Practitioner who no longer worked at the facility indicated Resident #3 continued	F 327	F 327: Sufficient fluid to maintain hydration: This facility has a policy which reveals the facility must provide each patient with sufficient fluid intake to maintain proper hydration and health. The intent of this policy is to assure that the patient receives sufficient amount of fluids based on individual needs to prevent dehydration. Resident #3 was discharged from the facility prior to the complaint survey of 8/6/15. Resident #3 was sent to hospital for evaluation on 5/20/15. Resident # 3 did have a PICC line inserted on 5/14/15 and received IV fluids via this route. Resident was assessed on the full dietary assessment 2/24/15 for hydration needs by the registered dietician. For other residents with the potential to be affected by this cited deficiency the following has been achieved: 100% audit of all Physician orders since 5/13/15. One IV order was revealed, written on 8/10/15 and no concerns were identified. This IV was scheduled in the electronic record as ordered with intake scheduled hourly for 100cc¿s/hour x 1 liter of fluid. This resident received the IV as ordered. All new admissions have hydration needs assessed by the Certified Dietary Manager utilizing the full dietary	

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F 327	Continued From page 21 decreased oral intake. A review of a facility document titled "Monitoring Assessment Report" for daily fluid intake revealed: 05/05/15: 0 milliliters (ml) for breakfast, 50 ml for lunch and 90 ml for dinner for a daily total of 140 ml. 05/06/15: 0 ml for breakfast, 240 ml for lunch and 360 ml for dinner for a daily total of 600 ml. 05/07/15: 120 ml for breakfast, 360 ml for lunch and 240 ml for dinner for a daily total of 720 ml. 05/08/15: 240 ml for breakfast, 360 ml fluid intake for lunch and 240 ml fluid intake for dinner for a daily total of 840 ml. 05/09/15: 120 ml for breakfast, 25 ml for lunch and 100 ml for dinner for a daily total of 245 ml. 05/10/15: 120 ml for breakfast, 120 ml for lunch and 100 ml for dinner for a daily total of 340 ml. 05/11/15: 0 ml breakfast, 240 ml for lunch and 100 ml for dinner for a daily total of 340 ml. A review of a progress note for nutritional needs dated 05/12/15 at 4:48 PM by a former dietary manager revealed Resident #3's oral intake remained very poor due to resident consuming 25 percent or less on most occasions. The notes indicated Resident #3 needed maximum encouragement at meals and recommended that Resident #3 be assisted with all meals by nursing staff to increase oral intake. There was no assessment of the estimated fluid needs for Resident #3. A review of a facility document titled "Monitoring Assessment Report" for daily fluid intake revealed on 05/12/15: 0 ml for breakfast, 240 ml for lunch and 240 ml for dinner for a daily total of 480 ml.	F 327	assessment questionnaire within 5 days of admission. Licensed nurses are trained to evaluate resident hydration based on physical appearance, skin turgor, oral mucosa, dry eyes, mental status change, and clinical labs 08/07/15. Licensed nurses were trained by Legacy pharmacy IV nurse on July 1 and 2, 2015 for IV therapy, including hyperdermaclysis. To enhance the current compliant operations and under the direction of the Director of Nurses on 08/07/15 all Licensed nursing staff were in-serviced of importance and professional standard of practice for initiating orders and follow through for calling and documenting the physician when the order cannot be completed i.e: starting IV¿s. Direct care staff were in serviced for documenting oral fluid intake and importance of maintaining hydration needs for each resident 8/7/15. Effective 8/10/15 a quality assurance program was implemented under the supervision of the Director of Nurses to monitor /audit progress notes and physician orders to ensure that physician orders are initiated as ordered. Audit 10 nurse progress notes for content, and 10 physician orders daily Monday through Friday x1 month then 3 days per week for 4 weeks, then 10 progress notes and 10 physician orders weekly x 4 weeks, then random weekly audits to ensure compliance and follow through. Any concerns/deficiencies are immediately addressed and corrected on	

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F 327	Continued From page 22 A review of a physician's order dated 05/13/15 indicated intravenous (IV) fluids of normal saline at 100 ml per hour for 2 liters of fluids (2,000 ml). A review of a physician's order sheet dated 05/13/15 at 4:30 PM indicated peripherally inserted central catheter (PICC) insertion related to difficult IV sticks (unsuccessful) and encourage oral fluid intake. A review of a progress note for nutritional needs dated 05/13/15 at 5:22 PM by a former dietary manager indicated family was concerned regarding Resident #3's condition and poor oral intake. The notes revealed family stated Resident #3 was extremely dehydrated and she was too weak to even hold a drink glass which was also observed by the former dietary manager during her visit with the resident. The notes further indicated Resident #3 had IV fluids ordered. There was no assessment of the estimated fluid needs for Resident #3. A review of a facility document titled "Monitoring Assessment Report" dated 05/13/15 for daily fluid intake revealed 120 ml for breakfast, 240 ml for lunch and 240 ml for dinner for a daily total of 600 ml. A review of a facility document titled "Monitoring Assessment Report" dated 05/13/15 at 6:24 PM indicated 150 ml IV intake was given. A review of a nurse's progress note dated 05/14/15 at 6:55 AM by Nurse #3 revealed Resident #3 did not have IV access when she arrived for her shift at 11:00 PM on 05/13/15. The notes further indicated she attempted twice to start the IV but was unsuccessful and would	F 327	the spot with the staff member involved. The findings of these quality assurance audits are documented and submitted at the quarterly quality assurance committee meeting for further review and corrective action. The Director of Nursing is responsible for monitoring, follow up, and compliance.	

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report to oncoming nursing staff.

A review of a laboratory report dated 05/14/15 indicated Resident #3's Blood Urea Nitrogen (BUN) was high at 50 (normal range 5-25) and Creatinine was high at 1.8 (normal range 0.6-1.3). BUN and Creatinine blood tests were done to see how well the kidneys were working.

A review of a care plan with a focus statement of nutritional needs indicated in part to offer adequate fluid intake. A section labeled intervention which was updated 05/14/15 indicated IV fluid 100 ml per hour for 2 liters of fluid.

A review of a psychiatric consult note dated 05/14/15 indicated Resident #3's family reported she had been very dehydrated and reported there was an IV hanging in the room but it was not started due to difficulty getting IV started in veins. The notes indicated Resident #3's mental status exam revealed motor activity was sluggish and a section labeled care treatment plan indicated staff and family voiced concerns about dehydration.

A review of a nurse's progress note dated 05/14/15 at 2:39 PM by Nurse #4 indicated IV not placed at this time and Mobilex (mobile x-ray) was scheduled to arrive by 4:30 PM.

A review of a document titled Mobilex Vascular Access Insertion Documentation dated 05/14/15 at 4:30 PM revealed the indication for placement of a PICC line in Resident #3's right upper arm was for hydration.

A review of a facility document titled "Monitoring Assessment Report" dated 05/14/15 for daily fluid

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intake indicated 240 ml for breakfast, 0 ml for lunch and 90 ml for dinner for a daily total of 330 ml.

A review of a physician's progress notes dated 05/15/15 indicated Resident #3 was able to walk and feed self a week ago but was now bed bound and would drink if encouraged. The notes indicated Resident #3's skin was dry and had poor turgor (degree of elasticity of skin and when there was moderate to severe hydration a portion of the skin that was pinched up remained elevated and only slowly returned to its flat position). A section labeled assessment and plan indicated to monitor closely for signs of deterioration in condition.

A review of a nurse's progress note dated 05/15/15 at 3:00 PM indicated 500 ml saline infusion complete and locked PICC line and removed tubing from room.

A review of a facility document titled "Monitoring Assessment Report" for daily fluid intake revealed:
05/15/15: 240 ml for breakfast, 360 ml for lunch and 240 ml for dinner for a daily total of 840 ml.
05/16/15: 240 ml for breakfast, 240 ml for lunch and 90 ml for dinner for a daily total of 570 ml.
05/17/15: 240 ml for breakfast, 360 ml for lunch and 90 ml for dinner for a daily total of 690 ml.
05/18/15: 360 ml for breakfast, 480 ml for lunch and 240 ml for dinner for a daily total of 1,080 ml.

A review of a progress note for nutritional needs dated 05/19/15 at 4:47 PM by a former dietary manager indicated she spoke with Resident #3's family and they expressed concerns about Resident #3's intake and requested when anyone

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came in the room they should offer Resident #3 drinks of water. They stated Resident #3 had been very weak and needed maximum encouragement and assistance.

A review of a facility document titled "Monitoring Assessment Report" dated 05/19/15 for daily fluid intake indicated 0 ml for breakfast, 360 ml for lunch and 90 ml for dinner for a daily total of 450 ml.

A review of nurse's progress notes dated 05/20/15 at 10:15 AM indicated Resident #3 was transferred by emergency medical services to the hospital for evaluation of a large mass on right side of abdomen. During an interview on 08/06/15 at 2:07 PM with Nurse #3 she confirmed she was the day shift nurse from 7:00 AM until 3:00 PM on 05/13/15 and provided care to Resident #3. She stated she remembered Resident #3 did not eat or drink a lot and explained she recalled a conversation with a Nurse Practitioner (NP) who no longer worked at the facility about IV fluids for Resident #3. She stated the NP said she wanted to give Resident #3 IV fluids of normal saline but she did not write an order for them and did not say how much IV fluid to give or how fast to give them. Nurse #3 stated she should have asked the NP about flow rate and amount of fluids to give and should have written it as a verbal order but she didn't because she thought the NP would write an order for it. She stated she reported to Nurse #2 who worked on second shift from 3:00 PM to 11:00 PM what the NP had said and she thought Nurse #2 got orders for the IV and later heard that attempts were made to start the IV but they were unsuccessful.

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The former dietary manager no longer worked for the facility and was unable to be reached for interview.

During an interview on 08/06/15 at 2:00 PM the facility's consultant Registered Dietitian (RD) was interviewed and explained that she was in the facility twice a month for 12 hours. She stated did not review Resident #3 on her visit to the facility on 05/20/15 because she met Resident #3 leaving the facility on a stretcher.

During an interveiw on 08/06/15 at 2:07 PM with Nurse #3 explained Resident #3 could feed herself but she was very slow, did not eat or drink a lot and needed encouragement. She stated she recalled the NP ordered Resident #3 to have IV fluids but they were unsuccessful at getting the IV started and she did not recall doing any nursing assessments for dehydration for Resident #3. She further stated Resident #3 would only take sips of water when she received her medications and they usually did not document how much liquid she swallowed with her medications.

The NP was no longer employed by the facility and was unable to be reached for an interview.

Nurse #2 was no longer employed at the facility and was unable to be reached for an interview.

During a telephone interview on 08/06/15 at 3:59 PM with Nurse #6 she confirmed she worked night shift from 11 PM to 7:00 AM. She stated she remembered she was assigned to care for Resident #3 but could not recall details about IV fluids however, after review of her nurses progress note dated 05/14/15 she stated she only attempted an IV stick twice on Resident #3. She

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stated usually when she could not get an IV started she asked another nurse to try but she did not remember if she asked another nurse but thought she reported it to the day shift nurse during the change of shift report. She explained she did not recall doing an assessment of Resident #3's hydration but if she had she would have documented it in her nurse's notes

During an interview on 08/06/15 at 4:21 PM with Nurse #4 she explained she was not assigned to care for Resident #3 on 05/14/15 but was asked by a nurse to start an IV on Resident #3. She stated she tried but Resident #3's veins were collapsing and she could not get it in. Nurse #4 verified mobile x-ray was called on 05/14/15 at 11:53 AM to insert the PICC line and they arrived at the facility on 05/14/15 at 4:30 PM. Nurse #4 also verified there were no calls to request mobile x-ray place a PICC line before 11:53 AM on 05/14/15.

During an interview on 08/06/15 at 4:30 PM the DON stated she stated it was her expectation for nursing staff to follow physician's orders to administer IV fluids and they should attempt an IV stick for a maximum of 3 times. She further stated nursing staff should have called the physician to report the IV sticks were unsuccessful and should have requested new orders.

During a telephone interview on 08/06/15 at 5:05 PM with Nurse #5 she verified she worked second shift from 3:00 PM to 11:00 PM on 05/13/15. She explained she remembered the physician ordered IV fluids for Resident #3 but Nurse #2 who no longer worked at the facility was assigned to care for Resident #3. She stated

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F 327	Continued From page 28 Nurse #2 told her she had tried to start the IV for Resident #3 but she couldn't get the IV in because Resident #3's veins were rolling and Nurse #2 did not ask her to try to start Resident #3's IV. During a telephone interview on 08/06/15 at 5:14 PM with the facility Medical Director he confirmed he was also Resident #3's physician. He stated when orders were given he expected for nursing staff to follow them. He further stated he expected when IV fluids were ordered for Resident #3 he expected for nursing staff to let him or the on call physician know if they could not start them so they could have discussed a contingency plan such as to provide other oral fluids or other options to hydrate her to make her veins more prominent or to discuss need to send to the emergency room for evaluation.	F 327		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility's administration failed to maintain the hot water system at safe levels and failed to have a procedure to notify the Administrator when the hot water was not resolved. The Administrator was not aware of the hot water concerns in residents' rooms, a visitor	F 490	F 490: Effective administration/resident well-being: It is this facility policy to be administered in such a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	8/24/15

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F 490	Continued From page 29 bathroom or the access hall sink. The findings included: Cross refer to F 323 Based on observations, staff and resident interviews and record review the facility failed to keep water temperature at safe levels for 3 of 3 residents' rooms, in a visitor bathroom and in a hallway sink. On 08/06/15 at 11:20 AM the Administrator was interviewed and reported that he was unaware of concerns with hot water being too hot in the facility. He was also unaware that the hot water had been set to 120 degrees Fahrenheit by the plumber. He stated that weekly checks were performed by the Maintenance Director and that to his knowledge the temperatures were within acceptable ranges less than 116 degrees Fahrenheit). The Administrator added that if concerns had been identified then he would expect the Maintenance Director to notify him. On 08/06/15 at 3:05 PM the Maintenance Director was interviewed and reported that he had told the Administrator that he needed the plumbing company to come out to check the mixing valve but that he felt he could handle the situation without having to involve the Administrator since he was the Department Head.	F 490	wellbeing of each patient. This facility will be licensed under applicable State and local laws. No residents were harmed related to this cited deficiency. All residents have a potential risk to be affected by this cited deficiency. To enhance the current compliant operations In order to achieve compliance, under the direction of the Administrator, department managers were in serviced by the Administrator for facility policy for reporting all incidents immediately to the Administrator or designee. Any incident that has potential to harm a resident, visitor, or staff member is immediately reported to the Administrator for corrective intervention. Further the department heads were in-serviced by the Administrator per Federal regulation that a facility has a responsibility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, mental, and psychological well-being of each resident. Effective 8/10/15 a quality assurance program was implemented under the supervision of the Administrator to monitor and record all staff, visitor, or resident reports of concerns for safety issues that could have a potential for a negative outcome. The administrator has created a quality assurance tool to record all concerns and to ensure safe facility practice. Concerns are documented on the form on the date brought to the Administrator. Interventions are	

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F 490	Continued From page 30	F 490	immediately placed in order to prevent harm to the resident, visitor, or staff. Any concerns documented on the tool are reviewed in the quarterly quality assurance meeting for further review or corrective action. This will be an ongoing process for this facility in order to ensure continued compliance.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and physician and staff interviews the facility failed to document the initial orders for intravenous (IV) fluids, failed to document unsuccessful attempts to start an IV and failed to document a recheck of a low blood pressure and assessment of a resident for 1 of 3 residents sampled for dehydration. (Resident #3). The findings included:	F 514	F 514: Resident records complete/accurate accessible: It is the policy of this facility to maintain electronic, clinical records on each patient in accordance with accepted professional standards and practices which are: complete, accurate documented, readily accessible and systematically organized. Resident #3 was discharged from the facility prior to the complaint survey of	8/24/15

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F 514	Continued From page 31 Resident #3 was admitted to the facility on 02/21/15 with diagnoses which included Alzheimer's disease, kidney disease, chronic pain, type 2 diabetes, high cholesterol, heart disease, difficulty swallowing, dehydration and Clostridium Difficille (C-Diff) a bacterial infection in the intestines that causes infectious diarrhea. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/18/15 indicated Resident #3 was severely impaired in cognition for daily decision making and required limited assistance with eating. A review of a physician's order dated 05/13/15 indicated intravenous (IV) fluids of normal saline at 100 ml per hour for 2 liters of fluids (2,000 ml). A review of a physician's order sheet dated 05/13/15 at 4:30 PM indicated peripherally inserted central catheter (PICC) insertion related to difficult IV sticks (unsuccessful) and encourage oral fluid intake. A review of nurse's progress notes dated 05/13/15 revealed there was no documentation of unsuccessful attempts to start Resident #3 ' s IV or assessment of Resident #3 ' s condition. There was also no documentation of attempts to request placement of the PICC line. A review of nurse's progress notes dated 05/14/15 at 6:55 AM by Nurse #3 revealed Resident #3 did not have IV access when she arrived for her shift at 11:00 PM on 05/13/15. The notes further indicated she attempted twice to start the IV but was unsuccessful and would report to oncoming nursing staff. There was no documentation regarding assessment of Resident	F 514	8/6/15. Resident #3 was sent to hospital for evaluation on 5/20/15. Resident # 3 did have a PICC line inserted on 5/14/15 and received IV fluids via this route. Resident was assessed on the full dietary assessment 2/24/15 for hydration needs by the registered dietician. All residents have the potential to be affected by this cited deficiency. Under the direction of the Director of Nursing licensed nurses were in-serviced for Accurate and complete documentation according to professional standard of practice. With hiring of current Director of Nurses this has been a major focus since May 2015. Documentation training continues to be going an ongoing process as identified through the current daily audits of documentation. To enhance the current compliant operations and under the direction of the Director of Nurses on 08/07/15 all Licensed nursing staff were in-serviced of importance and professional standard of practice for initiating orders and follow through for calling and documenting the physician when the order cannot be completed. Documenting changes in resident conditions and assessments of residents to paint a picture of the resident. Reviewed the board of nursing expectation for documentation with licensed nurses 08/7/15. Under the supervision of the Director of Nurses the following is achieved: Audit 10 nurse progress notes for content, Monday through Friday x1 month then 3 days per	

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F 514	Continued From page 32 #3's condition. A review of a care plan with a focus statement of nutritional needs indicated in part to offer adequate fluid intake. A section labeled intervention which was updated 05/14/15 indicated IV fluid 100 ml per hour for 2 liters of fluid. A review of nurse's progress notes dated 05/14/15 revealed there was no documentation regarding staff attempts to start Resident #3 ' s IV, or assessments of Resident #3's condition or offers of fluid intake by staff to Resident #3. A review of a Monitoring Assessments Report dated 05/14/15 revealed Resident #3's blood pressure was 125/72 which was in the average range of blood pressures documented for Resident #3. A review of nurse's notes dated 05/16/15 at 6:42 PM by Nurse #5 revealed Resident #3's blood pressure was low 97/68 this shift but other vital signs were within normal limits for this resident. There was no documentation for a recheck of Resident #3's blood pressure in the nurse's notes and there was no documentation of an assessment of Resident #3's condition. During an interveiw on 08/06/15 at 2:07 PM with Nurse #3 she confirmed she was the day shift nurse from 7:00 AM until 3:00 PM on 05/13/15 and provided care to Resident #3. She stated she remembered Resident #3 did not eat or drink a lot and explained she recalled a conversation with a Nurse Practitioner (NP) who no longer worked at the facility about IV fluids for Resident #3. She stated the NP said she wanted to give	F 514	week for 4 weeks, then 10 progress notes weekly x 4 weeks, then random weekly audits to ensure compliance and follow through. Any concerns/deficiencies are immediately addressed and corrected on the spot with the staff member involved. The findings of these quality assurance audits are documented and submitted at the quarterly quality assurance committee meeting for further review and corrective action. The Director of Nursing is responsible for monitoring, follow up, and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 08/14/2015

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F 514	Continued From page 33	F 514		

Resident #3 IV fluids of normal saline but she did not write an order for them and did not say how much IV fluid to give or how fast to give them. Nurse #3 stated she should have asked the NP about flow rate and amount of fluids to give and should have written it as a verbal order but she didn't because she thought the NP would write an order for it. She stated she reported to Nurse #2 who worked on second shift from 3:00 PM to 11:00 PM what the NP had said and she thought Nurse #2 got orders for the IV.

The NP was no longer employed by the facility and was unable to be reached for an interview.

Nurse #2 was no longer employed at the facility and was unable to be reached for an interview.

During a telephone interview on 08/06/15 at 3:59 PM with Nurse #6 she confirmed she worked night shift from 11:00 PM to 7:00 AM. She stated she remembered she was assigned to care for Resident #3 and could not recall details about IV fluids but after review of her nurse's progress notes she remembered she attempted to try to start Resident #3's IV. She stated if she had assessed Resident #3 she should have documented it but she could not recall anything because it had been too long ago.

During an interview on 08/06/15 at 4:21 PM with Nurse #4 she explained she was not assigned to care for Resident #3 on 05/14/15 but was asked by a nurse to start an IV on Resident #3. She stated she tried but Resident #3's veins were collapsing and could not get it in. She further stated she should have documented her attempts at starting Resident #3's IV on 05/14/15 but she was busy trying to get mobile x-ray to put the

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F 514	Continued From page 34 PICC line in. During a telephone interview on 08/06/15 at 5:05 PM with Nurse #5 she verified she worked second shift from 3:00 PM to 11:00 PM on 05/16/15 and remembered Resident #3's blood pressure was low and she documented it in her nurse's progress notes. She stated she checked Resident #3's blood pressure again in 30 minutes and it had come up but she did not document it because she got busy and forgot. She further stated she also forgot to document her assessment of Resident #3's condition and she was aware she needed to put more information in her nurse's progress notes. During an interview on 08/06/15 at 4:30 PM the Director of Nursing (DON) explained she was new in the facility but had identified that documentation was a problem. She stated she had been working with nurses to get them to document but they had a lot of staff turnover and it was a work in progress. She stated she expected for staff to document changes in condition, assessments, the attempts to start Resident #3's IV and notification of the physician and responsible party.	F 514		