STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 02/25/2016

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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 medical record review and staff interviews the facility failed to notify the physician of a change of condition for 1 of 3 sampled	F 157	F157 SS=D 1) Resident #1 no longer resides at the facility. Nurse #1 was in serviced on the notification of change in condition on 03/08/16 by the Director of Clinical Services. 2) All residents have the potential to be affected by this citation. The Director of Clinical Services and Nursing Supervisor did an audit of the current patients on 02/26/16 to identify any other issues. 3) The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on notifying the physician in a residents' change in condition was completed on 03/03/16. In servicing of all nurses re: correct protocol with any change in condition of any patient. In servicing was completed 03/03/16. The Director of Clinical Services and/of Nursing Supervisor will perform Quality Improvement Monitoring audit of 10 medical records for notification of change in condition five times a week for eight weeks, three times a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/16/16

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F 157	Continued From page 1 residents. (Resident #1) The findings included: Resident #1 was admitted to the facility 07/29/15 with diagnoses which included anemia, senile dementia, macular degeneration with blindness, kidney disease, diabetes, hyperparathyroidism, hyperlipidemia, anxiety, hypertension, cervical spondylosis and cerebral artery occlusion. The latest Minimum Data Set (MDS) assessment for Resident #1 was dated 01/22/16 and assessed Resident #1 with severe cognitive impairment. The care plan last updated 02/06/16 for Resident #1 included the following problem areas: -Exhibits signs/symptoms of behaviors due to dementia as evidenced by disruptive behaviors, verbally inappropriate with screaming, yelling, repetitive verbalizations and disruptive sounds. -Has the potential for an ineffective breathing pattern related to drop in oxygen saturation at times. Approaches to this problem area included: Oxygen as ordered, Elevate head of bed as ordered by physician or requested by resident. The Medical Orders for Scope of Treatment (MOST) form in the medical record of Resident #1 with a 07/28/15 date noted the following: Do Not Attempt Cardiopulmonary Resuscitation and Limited Additional Interventions. Review of the medical record of Resident #1 noted the Department of Social Services had guardianship for his care. Review of February 2016 physician orders for	F 157	F 157 SS=D week for eight weeks, then two times week for eight weeks and/or until substantial compliance is obtained. 4) The results of the audit will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services. The Quality Assurance Performance Committee. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services , Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, MDS Nurse.	03/24/16

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F 157	Continued From page 2 Resident #1 noted there were no orders for oxygen on a routine or as needed (PRN) basis. Review of the medical record for Resident #1 noted a progress note in the medical record dated 02/11/16 which included the following: The patient does not have decision making capacity secondary to dementia. This is an acute visit to assess patient for ongoing behavioral disturbances in context of advanced and progressive dementia. Was readmitted to facility 11/11/15 following hospitalization for about one week secondary to behavioral disturbance. He was originally admitted to this facility on 07/29/15 following hospitalization that began 07/22/15 for right upper extremity pain, debility. Sent to emergency department 01/22/16 for acceleration of behaviors and returned with diagnosis of urinary tract infection with prescription for antibiotics. Recurrence of urinary tract infection detected 02/09/16 and treated with Gentamicin for 10 days. Significant debility. Staff reports patient continues to yell and scream throughout day and night. Several medication changes made to attempt to alleviate patient's agitation. On 02/02/16 Seroquel 150 milligrams started at bedtime, rather than A.M. In addition, gradual dose reduction of Cymbalta started to alleviate psychotropic side effects. The following day, Depakote increased 750 milligrams at bedtime, and medications added for probable constipation. On 02/05/16 Seroquel 25 milligrams every 6 hours when necessary added, as Depakote changes. Today, patient is observed sleeping, but staff reports that he will yell for hours at a time, sometimes during the night. Thorough review of medications made to search for opportunities for medication simplification and gradual dose reduction to alleviate psychotropic	F 157		

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F 157	Continued From page 3	F 157		

side effects. No complaints of chest pain, shortness of breath. Today's blood pressure 119/60. No upper or lower respiratory infection symptoms such as dyspnea, cough or wheezing. No chest pain, tightness or palpitations, No abdominal pain, nausea, vomiting or change in bowel habits. Questionable constipation. Temperature: 97.3, Pulse: 71, Respiratory rate 16, Oxygen Saturation 97%. Patient found lying supine in bed in no apparent acute distress or discomfort. He is somnolent and arousable, but not very interactive. Normal respiratory effort. Normal to auscultation with no wheezes, rales or rhonchi. Regular cardiovascular rhythm with no murmurs, rubs or gallops. No edema or varicosities. Abdomen is soft, flat, nontender and without masses. Bowel sounds are present. No reproducible tenderness. Assessment: Urinary tract infection-I have assessed the course of this patient's recent urinary tract infection, and the patient demonstrates instability that requires increased support and frequent monitoring. On Gentamicin. Prognosis guarded. Dementia with behavioral disturbance-I have assessed the course of this patient's dementia, and the patient demonstrates significant functional debility, is bed-bound and requires assistance with all activities of daily living. The patient also demonstrates significant cognitive dysfunction and is unable to communicate meaningfully or make their needs known. Continued decline is anticipated and the patient's risk for complications is high. We will continue to provide a safe environment, preventative measures for complications, and frequent monitoring for changes in status. The patient is likely eligible for hospice services related to end stage dementia. Delirium due to medical condition with behavioral disturbance. Debility: I have assessed the

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F 157	Continued From page 4	F 157		

course of this patient's debility, and the patient demonstrates significant progression that increases the patient's risk for complications such as skin breakdown, infections, contractures, malnutrition, falls and aspiration, any of which could be life-threatening. The patient's functional status requires total assistance with all activities of daily living, and the patient demonstrates instability requiring significant support and frequent monitoring. This patient's prognosis is poor and the patient is eligible for hospice services related to end stage debility. This patient is at high risk for complications related to multiple co-morbidities. We will monitor the patient's condition frequently for any signs or symptoms of complications or changes in condition.

Review of nurses notes in the medical record of Resident #1 included the following:
02/13/16 6:00 AM-Yelling out. Vomited approximately 60 cc (cubic centimeters) old dark brown liquid. Abdomen soft, non-distended, positive bowel sounds.
02/13/16 11:59 AM-Resident with no pulse, blood pressure, respirations.

Nurse #1 (that worked with Resident #1 on 02/12/16 from 10:45 PM-02/13/16 at 7:15 AM) was interviewed on 02/24/16 at 1:44 PM and reported there were no concerns with Resident #1 on 02/13/16 other than at the end of her shift Resident #1 was noted with a small amount of dark brown liquid oozing from his mouth. Nurse #1 stated she reported this to the oncoming nurse.

Nurse Assistant (NA) #1 (that worked with Resident #1 on 02/12/16 from 10:45 PM-02/13/16

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F 157	Continued From page 5	F 157		

at 7:15 AM) was interviewed on 02/25/16 at 6:00 AM and reported Resident #1 appeared weaker than usual during the night on 02/12/16 and that she checked his vital signs throughout her shift and they were all okay. NA #1 stated Resident #1 reported he thought he was going to vomit and reported she never saw him vomit. NA #1 stated Resident #1 appeared to be having trouble breathing but, when checked, his oxygen saturation levels were normal. NA #1 stated the nurse had her elevate the head of the bed of Resident #1 to make him more comfortable.

Nurse #2 (that worked with Resident #1 on 02/13/16 from 06:45 AM until he expired) was interviewed on 02/24/16 at 2:02 PM and reported that she was told at the beginning of her shift on 02/13/16 that Resident #1 had a "little dark spit" earlier that morning. Nurse #2 stated she checked on Resident #1 several times during her shift which included giving him his morning medications. Nurse #2 recalled that Resident #1 ate a little of breakfast that morning and, at the beginning of the shift, had no complaints other than he wanted something to drink. Nurse #2 stated she provided Resident #1 with something to drink. Nurse #2 stated that about an hour and a half before Resident #1 expired she noticed he was going about 15-20 seconds without a breath. Nurse #2 stated Resident #1 appeared peaceful, was mottling and appeared to be "passing". Nurse #2 stated she checked on Resident #1 several times until he expired. Nurse #2 stated she did not notify the physician when there was a change in the respiratory status of Resident #1. Nurse #2 could not explain why she did not notify the physician other than noting the resident was mottling and appeared to be "passing". Nurse #2 stated she did notify the physician when Resident

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F 157	Continued From page 6 #1 expired but had no explanation why the physician was not notified when there was a change in the resident's respiratory status. On 02/24/16 at 4:50 PM the physician of Resident #1 reported he recalled seeing Resident #1 on 02/11/16 and did a thorough physical review and medication management review. The physician stated he would not have expected to be notified of the 60 cc of dark brown emesis on 02/13/16 but would have expected to be called when there was a change in the resident's respiratory status. The physician stated he would have expected staff to call for guidance and would have had staff reference the MOST form in the resident's medical record to determine the aggressiveness of treatment. The physician stated, due to his dementia, Resident #1 was never able to give input into end of life decisions. The physician stated if staff had called he most likely would have staff elevate the bed and initiate oxygen on Resident #1 though he noted it most likely would not have made a difference. The physician noted Resident #1 was medically compromised and chances of recuperating would have "been a stretch" but agreed that he should have been notified by the nurse when there was a change in the respiratory status of Resident #1.	F 157		