

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/31/2017
NAME OF PROVIDER OR SUPPLIER FISHER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401		
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F 000	INITIAL COMMENTS A revisit and complaint investigation survey was conducted from 7/26/17 through 7/31/17. Immediate Jeopardy was identified at: CFR 483.20 at tag F282 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) The tag F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 7/22/17 and was removed on 7/31/17. A Partial extended survey was conducted.	F 000			
F 282 SS=J	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 physician, nurse practitioner, staff, and emergency medical technician interviews, record review, and observations, the facility failed to follow nursing care plan interventions to avoid extreme heat and to anticipate the needs for one of 3 sampled residents, Resident #1, which resulted in extreme outdoor heat exposure for a duration of 2 hours. Resident #1 fell from his wheelchair onto the outdoor patio, had an altered	F 282	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	8/30/17	

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

TITLE

(X6) DATE

Electronically Signed

08/24/2017

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 282	<p>Continued From page 1</p> <p>mental status when he was discovered, and had a body temperature of 104.1 degrees Fahrenheit upon assessment by emergency medical technicians. Resident #1 was admitted to the hospital with a primary diagnosis of sepsis versus heat stroke and was hospitalized for 2 days.</p> <p>The Immediate Jeopardy began on 07/22/2017 when Resident Care Specialist (RCS) #1 discovered Resident #1 lying on the courtyard patio near his wheelchair with a pulse rate of 113, a blood pressure of 59/39, and verbally unresponsive. Resident #1 was transported by ambulance to the local hospital where he was admitted for suspected heat stroke. The Immediate Jeopardy was removed on 07/31/2017 at 6:35 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time.</p> <p>Findings included:</p> <p>Resident #1 was initially admitted to the facility on 1/20/2004 with diagnoses which included, in part, cerebrovascular accident, hypertension, diabetes mellitus, and dementia.</p> <p>Review of the quarterly minimum data set (MDS) assessment dated 05/18/2017 revealed Resident #1 had long term and short term memory problems and had moderate impairment with cognitive skills for daily decision making. Resident #1 also had behaviors of rejection of care present 1 to 3 days during the assessment</p>	F 282	<p>1. The alleged Resident was admitted to Fisher Park HR on 1/20/2004 with primary diagnosis of Alzheimer's, Type 2 Diabetes, seizures, hemiplegia and major depression disorder. On 7/22/17 at 1:14pm, resident fell out of wheelchair in the enclosed courtyard (per courtyard video camera). A certified Nursing Assistant went to the facility enclosed courtyard at 1:17pm (per courtyard video camera) after being alerted by a visitor that a resident was on the ground in the courtyard. The Nursing Assistant immediately responded and went to the courtyard. The certified Nursing Assistant determined that the resident had a pulse and was breathing but that the resident seemed to have a decrease level of consciousness. The Nursing Assistant stayed with the resident and summoned for assistance. The licensed nurse immediately responded. The nurse's initial assessment revealed and recorded Vital signs of Temperature of 100.9, pulse 113, BP 59/39. 911 was called by the licensed nursing staff and based on the camera video footage, EMS arrived at 1:30 pm. The resident's temperature was recorded by EMS of 104.2. The resident was transported to the hospital and subsequently admitted with a diagnosis of Sepsis versus heat stroke due to presenting with fever and being outside for a 2 hour period. Additional diagnoses during the resident's hospitalization included hypotension, history of stroke, generalized rash, acute</p>		

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F 282	<p>Continued From page 2</p> <p>look back period, and that he was independent with locomotion both on and off the unit. The same MDS assessment indicated he did not use a prosthesis. Extensive assistance was required for transfers and personal hygiene, and Resident #1 used a wheelchair for his mobility. His partial list of diagnoses included late effects of cerebrovascular disease, diabetes mellitus, a right leg amputation at the right knee, hypertension, peripheral vascular disease, aphasia, hemiparesis, and seizure disorder.</p> <p>The nursing care plan for Resident #1, initiated on 01/18/2017 and last revised on 07/05/2017, revealed a problem of diabetes mellitus with a goal to be free of signs and symptoms of hyperglycemia. An intervention to reach this goal was, "Avoid exposure to extreme heat or cold." Further review of the nursing care plan revealed on 02/27/2017, a problem of high risk for falls was added with a goal for Resident #1 to be free of falls through the review date. One of the interventions to achieve this goal was, "Anticipate and meet the resident's needs." On 06/21/2017, a behavior problem of refusing to come inside out of the sun/refusing to wear sunscreen was added. The goal related to this problem was that there would be fewer episodes of refusing to come in out of the sun. One intervention included, "Anticipate and meet the resident's needs." Another was, "Allow the resident to make choices within the individual's decision making abilities."</p> <p>A nurse's note of 07/22/17 at 2:18 PM indicated Resident #1 was found lying on the ground in the courtyard on his back, and that his blood pressure assessed at the time was 59/39, his pulse was 113, and his temperature was 100.9.</p>	F 282	<p>kidney injury, diabetes mellitus, and acute encephalopathy related to fevering notified and of the event around 1:40 pm. The responsible party was notified at approximately 2:00pm.</p> <p>The resident returned to the facility on 7/24/17 with active problems of sepsis, (HCC) Type 2 diabetes mellitus with neurological manifestations, Dementia without behavioral disturbance, Dermatitis of multiple sites, and leukocytosis. The resident was admitted for suspected heat stroke as he presented with fever and had been outside for a 2-hour period prior. Due to the leukocytosis, fever, elevated lactic acid, he was started on IV antibiotics for suspected aspiration and then changed to Augmentin. A repeat chest x ray for suspected aspiration showed no active disease. Resident was treated with IV fluids for hydration, BP improved and discharge exam from hospital show BP was 134/47.</p> <p>The resident has not been as interested in sitting in the courtyard since return to the facility, but he is tolerating being in wheelchair short period of times.</p> <p>The resident was re- assessed using the BIMS (Brief Interview for Mental Status) assessment tool on 7/28/17; his scoring was 0- severe impairment. Based on the BIMS score, the resident care plans were revised by the MDS coordinator on 7/31/17 to include providing supervision when in the courtyard. Resident also has been provided a hat for courtyard use. The diabetic Mellitus and Impaired Cognitive function / dementia careplan was revised on 7/31/17 by the MDS</p>		

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F 282	<p>Continued From page 3</p> <p>A situation/background/assessment/recommendati on (SBAR) note dated 07/22/17 revealed Resident #1 was found lying on his back beside his wheelchair in the courtyard, and that the resident was unable to say what was happening. The note indicated that since the incident happened, the situation had gotten worse, and that he was unresponsive for his mental status. The resident was transferred to the hospital and the resident's primary care clinician was notified at 1:40 PM. The resident's guardian was notified at 2:00 PM.</p> <p>Review of the facility's courtyard/patio camera footage dated 7/22/17 revealed the following:</p> <p>On 07/22/2017 at 11:13 AM, Resident #1 was seen independently entering the enclosed courtyard area via the facility's door on the north side of the building. He navigated in his wheelchair about the courtyard on the sidewalk and on the patio by propelling himself with his left leg. There was partial shade in the courtyard from a tree located on the side of the courtyard closer to the south side of the building. Outdoor tables were located on the part of the patio closest to the door on the north side of building. Resident #1 navigated to one of the tables in the sun and sat in his wheelchair.</p> <p>By 12:00 noon on 07/22/2017, the resident had navigated himself to another table on the patio which was in partial sun. A staff member was seen entering the patio from the north entrance door at this time and approaching the resident, talking with him, and then exiting the patio area via the north door. There were no other staff members seen in the courtyard until</p>	F 282	<p>coordinator. The MDS coordinator implemented a resident care plan for at risk for heat exhaustion on 7/31/17.</p> <p>The licensed nurse assigned to the resident on 7/22/17 no longer works at the facility. The certified nursing assistant assigned to the resident on 7/22/17 at the time of the incident was provided one on one re- education regarding sign and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakness and contact nursing staff if symptoms occur. The nursing assistant education also included offering hydration to residents that are outside more than thirty minutes by district director of clinical services on 7/31/17.</p> <p>2. It was determined on 7/26/17 during an IDT ADHOC QAPI meeting that the resident had been assessed and identified with severely impaired cognition based on BIMS assessment on 11/22/16. During staff interviews on 7/24/17 it was identified that the resident routinely went to the court yard unsupervised and refused to come inside for extensive periods of time. After review of the resident care plans, the investigation of alleged event and staff interviews it was identified that the facility had failed to follow resident care plans as relates to</p> <ol style="list-style-type: none"> Diabetic Mellitus care plans stated to avoid extreme heat or cold Impaired cognitive function/dementia 		

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F 282	<p>Continued From page 4</p> <p>12:20 PM when a staff member was seen at a vending machine which was located at the entrance to the courtyard area. This staff member did not approach the resident or speak with him.</p> <p>At 12:48 PM, Resident #1 navigated to another table in the courtyard that was in partial shade. There were no staff members seen in the courtyard other than the staff member who came outside at 12:00 noon and the staff member who accessed the vending machine at 12:20 PM. No one was seen providing fluids to Resident #1 to drink between 11:13 AM and 1:14 PM.</p> <p>At 1:14 PM, Resident #1 was seen falling out of his wheelchair onto the patio. No further movement was noted</p> <p>At 1:17 PM, a staff member was seen entering the courtyard with a male (identified as a visitor) and finding Resident #1 lying on the patio. The staff member stooped down to the resident, then stood and pointed to the south side of the building. The "visitor" was seen pulling the patio table away from the resident and walking back into the building. The staff member remained with the resident. Another staff member entered the patio at 1:18 PM. At 1:22 PM, a third staff member entered the courtyard with a vital signs monitor.</p> <p>At 1:30 PM, paramedics were seen entering the courtyard. (The camera angle did not allow a view of the resident's response to any treatment or stimulation by staff or paramedics.)</p> <p>The weather conditions per Weather Underground on 07/22/2017 at 12:54 PM for the</p>	F 282	<p>or impaired thought processes related to determine residents needs and supervision as needed</p> <p>c. The care plan goal related to resident's behavior problem of refusing to come inside out of the sun and will not wear sunscreen □ intervention of anticipate and meet the resident's needs (initiated 6/21/17)</p> <p>The facility MDS coordinator initiated an audit of the facility residents care plans to ensure that each residents identified with desire to sit in the enclosed court yard was care planned for at risk for heat exhaustion on 7/31/17</p> <p>3. The facility staff (nursing, housekeeping and administrative staff) will be provided education regarding the risk of heat exhaustion for facility residents that are outside in the enclosed courtyard . This education included recognizing signs and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, elevated temperatures, and weakens and contact nursing staff if symptoms are observed. The education also included basic supervision and knowing where assigned residents are. The education will include assessing the residents in the court yard every thirty minutes for signs and symptoms of heat exhaustion and document on the courtyard monitoring tool</p>		

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F 282	<p>Continued From page 5</p> <p>facility's location was 93.9 degrees Fahrenheit with a heat index of 102.1 degrees.</p> <p>A review of the Emergency Medical Services (EMS) Report dated 07/22/2017 revealed the Emergency Medical Technicians (EMTs) arrived at the facility at 1:42 PM on 07/22/2017, and at 1:46 PM, the EMTs determined Resident #1 was in sinus tachycardia. At 1:52 PM, the EMTs assessed Resident #1's temperature to be 104.2, and intravenous fluids were administered at 1:57 PM. The text on the report indicated the EMTs removed Resident #1's clothing to assist in cooling him, and at 1:59, a cold wet towel was placed on the resident's chest and abdomen, and ice packs were placed under the axilla (under arms.) The resident was transported at 1:58 PM to the hospital.</p> <p>The hospital discharge summary dated 7/24/17 revealed the primary diagnosis during Resident #1's hospitalization was sepsis versus heat stroke. Under this diagnosis, the summary indicated resident was admitted for suspected heat stroke, and that due to leukocytosis, fever, and elevated lactic acid, the resident was started on IV antibiotics. The suspected reason for sepsis was aspiration. His blood cultures were negative for bacteria, and his urinalysis dated 7/23/2017 showed no bacteria. The second diagnosis during the hospital course was hypotension (low blood pressure), suspected due to hypovolemia (low fluid volume.) The seventh diagnosis during the hospital course was acute encephalopathy, suspected to be related to fever. The resident was hospitalized from 7/22/17 until his discharge on 7/24/17 and he was prescribed Augmentin (an antibiotic), one tablet by mouth twice per day per the discharge medication list.</p>	F 282	<p>and offering fluids appropriate hydration. The education was initiated on 7/30/17 and will be completed on 7/31/17 by the assistant director of nursing. Staff members who have not received the education will not work until they complete the education to include agency staff.</p> <p>The facility staff (nursing, housekeeping and administrative staff, agency staff) were provided education to refer to the resident care card to ensure that resident identified with desire to sit outside care plan are being followed on 7/31/17 by Assisted Director of Nursing .</p> <p>The facility newly admitted or re-admitted residents that are identified with desire to sit outside in the enclosed courtyard will be care planned for at risk for heat exhaustion by MDS coordinator. The resident care card will be updated to reflect care plans for resident at risk for heat exhaustion</p> <p>4.New admissions will have BIMs reviewed and will be educated on heat exhaustion on admission. Careplans will be completed to indicate if supervision is required when the resident is outside. Auditing will be done to monitor new admits, cognitively impaired residents, and residents with significant change. Audit to include the completion of BIMs, careplan (r/t) heat exhaustion, and if resident is supervised or not while outside. Auditing will be done Monday - Friday for 12 weeks. BIMs will be</p>		

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F 282	Continued From page 6 In an interview with resident care specialist (RCS) #1 on 07/27/2017 at 9:38 AM, she stated she was the RCS assigned to care for Resident #1 during the 7:00 AM to 3:00 PM shift on 07/22/2017, when the courtyard incident occurred, but she was not present when the incident occurred. RCS #1 stated she reviewed the care card (Kardex) for residents if they were new or she was not familiar with them in order to know what to do for them. She added that she knew Resident #1 and there was no need to refer to his care card and she knew he wore sunscreen daily. RCS #1 stated she provided morning care to Resident #1 after breakfast on 7/22/2017, then transferred him to his wheelchair and rolled him into the hall near the nurse's station on the south side of the building. She explained she then provided care for her other assigned residents, then checked on Resident #1 again. At that time (not sure of the exact time of day) she did not see Resident #1 in the hallway but later noted he was outside. RCS #1 stated that Resident #1 typically did not talk much, but he seemed to understand what people said to him and that he was able to feed himself. He was also able to get around the facility very well in his wheelchair by scooting himself with his feet and he enjoyed sitting outside. RCS #1 added that he was able to navigate to the courtyard whenever he wanted, and she had a concern for him the day of the incident because it was so hot. She said she saw him outside; however he generally rejected care, and she did not know how to deal with him when he refused offers to come inside. She stated she reported to the nurse that he was outside during the morning hours on 07/22/2017, but she was not sure what time she reported it.	F 282	completed by Social Worker. Careplans will be updated during Clinical Start-up by the IDT. The audits will be reviewed by the Director of Nursing and the Administrator. The findings will be presented to the QAPI committee for monitoring of ongoing compliance.		

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

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F 282	<p>Continued From page 7</p> <p>In a telephone interview on 07/27/2017 at 10:12 AM with Nurse #1 who was assigned to care for Resident #1 during the 7:00 AM to 3:00 PM shift on 07/27/2017, she stated she worked for a staffing agency and had cared for Resident #1 in the past and was familiar with his behavior. Nurse #1 explained she provided the resident his medications about 8:00 AM on 7/22/17, and that the next time she saw him was around 12:00 noon. She explained she did not recall RCS #1 reporting to her the resident was outside. She added she had to look for him and was unable to find him in his room, the dining room or lobby, but she found him outside in the courtyard at 12:00 noon. Nurse #1 indicated she needed to check his capillary blood glucose level (by finger stick) at that time to determine his sliding scale insulin dose. She stated Resident #1 refused to have his blood glucose level checked, saying, "No, no, no," and that he also refused to come inside when she offered him his lunch, so she left Resident #1 outside and decided to check on him again later, although she said she never did. Nurse #1 stated about an hour later, someone summoned her to the courtyard (could not remember who it was) and she found 2 other staff members on the patio assessing Resident #1 who was lying on the patio and appeared unresponsive. She stated she immediately got her supervisor while the 2 staff members remained with the resident.</p> <p>On 7/27/2017 at 11:40 AM, an interview was conducted with the nurse practitioner (NP) who was on call on Saturday, 7/22/17 when Resident #1 was found on the ground on the courtyard patio. The NP stated she would expect the staff to bring the resident inside on a hot day and that she thought he was care planned for his refusals</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>to come inside out of the sun. She explained that Resident #1 at times rejected care, but it was not very often. She stated the challenge was knowing how to deal with his refusals to come inside. The NP explained that it was sometimes necessary to be creative and "act as a parent" when a resident refused care or were unable to make appropriate decisions for their own well-being. The NP suggested that offering a cool drink or a snack might be used to coax the resident inside.</p> <p>In an interview with Resident #1's physician on 07/27/2017 at 12:00 PM, she stated she would not want the resident to stay outside for any length of time without hydration and she would expect staff to check on him every 30 minutes to an hour in order to meet his needs.</p> <p>In an interview with RCS #2 on 7/27/2017, she stated she was the staff member who discovered Resident #1 was in the courtyard lying on the patio on 07/22/2017 when a visitor alerted her about it. She stated Resident #1 was not assigned to her care on 07/22/2017, but she was familiar with him because she had cared for him the previous week, RCS #2 added she knew he had often enjoyed being outside. She also indicated that she knew how to care for her assigned residents by referring to the care plan. She stated when she found Resident #1 outside, she checked his radial pulse, then his carotid pulse, and it was very faint and weak. She told the visitor to go inside to get a nurse, and a short time later, a nurse and another nurse aide came with a vital signs monitor. RCS #2 stated she was unable to get a blood pressure reading on his left arm, so she removed the blood pressure cuff and applied it to his right arm below the</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>elbow to palpate his blood pressure and it was 59/39. She explained that Resident #1 was not responding to her verbal stimulation.</p> <p>On 7/27/17 at 3:25 PM, an interview was conducted with the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the District Director of Clinical Services (DDCS.) The DDCS stated Resident #1 was on the ground in the courtyard for about 3 minutes before he was discovered by staff. The DON, the ADON, and the DDCS reviewed Resident #1's nursing care plan and acknowledged the staff did not follow the intervention put in place to avoid extreme heat or cold, and did not anticipate and meet the needs of the resident related to his problem of refusing to come inside out of the sun by allowing him to remain in the facility's outdoor courtyard area for a two hour period. She acknowledged he was not provided any hydration according per camera footage.</p> <p>On 07/31/2017 at 11:30 AM, an interview was conducted with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated that there were clinical meetings held each weekday to discuss any acute episodes that have taken place with the residents, and that on Mondays, they would discuss any acute episodes that had taken place over the weekend. She stated the interdisciplinary team updated care plans on a daily basis depending on acute events that had taken place, and that the unit managers were responsible for updating the information on the Kardex and for communicating the new information to the nurses and resident care specialists. MDS Nurse #1 explained that if the unit managers were not present, then the MDS nurse was responsible for the communication, so</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>all nursing staff should be aware of interventions in place for the resident. MDS #1 acknowledged that there was an intervention on Resident #1's care plan for him to avoid extreme heat and cold, as well as interventions to anticipate and meet the resident's needs, and to allow the resident to make choices within his decision making abilities. She also acknowledged that the resident was at risk for falls with a goal to be free of falls through the next review date, and that it also included an intervention to anticipate and meet the resident's needs. MDS Nurse #1 did not offer a reason why staff did not follow the care plan.</p> <p>The DDCS (present during the absence of the Administrator), the DON, and the ADON were notified of Immediate Jeopardy on 07/28/2017 at 12:25 PM.</p> <p>On 07/31/17 at 6:35 PM, the facility provided a credible allegation as follows:</p> <p>1. The alleged Resident was admitted to Fisher Park HR on 1/20/2004 with primary diagnosis of Alzheimer's, Type 2 Diabetes, seizures, hemiplegia and major depression disorder. On 7/22/17 at 1:14pm, resident fell out of wheelchair in the enclosed courtyard (per courtyard video camera). A certified Nursing Assistant went to the facility enclosed courtyard at 1:17pm (per courtyard video camera) after being alerted by a visitor that a resident was on the ground in the courtyard. The Nursing Assistant immediately responded and went to the courtyard. The certified Nursing Assistant determined that the resident had a pulse and was breathing but that the resident seemed to have a decrease level of consciousness. The Nursing Assistant stayed with the resident and summoned for assistance.</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>The licensed nurse immediately responded. The nurse's initial assessment revealed and recorded Vital signs of Temperature of 100.9, pulse 113, BP 59/39. 911 was called by the licensed nursing staff and based on the camera video footage, EMS arrived at 1:30 pm. The resident's temperature was recorded by EMS of 104.2. The resident was transported to the hospital and subsequently admitted with a diagnosis of Sepsis versus heat stroke due to presenting with fever and being outside for a 2 hour period. Additional diagnoses during the resident's hospitalization included hypotension, history of stroke, generalized rash, acute kidney injury, diabetes mellitus, and acute encephalopathy related to fevering notified and of the event around 1:40 pm. The responsible party was notified at approximately 2:00pm.</p> <p>The resident returned to the facility on 7/24/17 with active problems of sepsis, (HCC) Type 2 diabetes mellitus with neurological manifestations, Dementia without behavioral disturbance, Dermatitis of multiple sites, and leukocytosis. The resident was admitted for suspected heat stroke as he presented with fever and had been outside for a 2-hour period prior. Due to the leukocytosis, fever, elevated lactic acid, he was started on IV antibiotics for suspected aspiration and then changed to Augmentin. A repeat chest x ray for suspected aspiration showed no active disease. Resident was treated with IV fluids for hydration, BP improved and discharge exam from hospital show BP was 134/47.</p> <p>The resident has not been as interested in sitting in the courtyard since return to the facility, but he is tolerating being in wheelchair short period of</p>	F 282			

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F 282	<p>Continued From page 12 times.</p> <p>The resident was re- assessed using the BIMS (Brief Interview for Mental Status) assessment tool on 7/28/17; his scoring was 0- severe impairment. Based on the BIMS score, the resident care plans were revised by the MDS coordinator on 7/31/17 to include providing supervision when in the courtyard. Resident also has been provided a hat for courtyard use. The diabetic Mellitus and Impaired Cognitive function / dementia care plan was revised on 7/31/17 by the MDS coordinator. The MDS coordinator implemented a resident care plan for at risk for heat exhaustion on 7/31/17.</p> <p>The licensed nurse assigned to the resident on 7/22/17 no longer works at the facility. The certified nursing assistant assigned to the resident on 7/22/17 at the time of the incident was provided one on one re- education regarding sign and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakness and contact nursing staff if symptoms occur. The nursing assistant education also included offering hydration to residents that are outside more than thirty minutes by district director of clinical services on 7/31/17.</p> <p>2. It was determined on 7/26/17 during an IDT ADHOC QAPI meeting that the resident had been assessed and identified with severely impaired cognition based on BIMS assessment on 11/22/16. During staff interviews on 7/24/17 it was identified that the resident routinely went to the court yard unsupervised and refused to come</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>inside for extensive periods of time. After review of the resident care plans, the investigation of alleged event and staff interviews it was identified that the facility had failed to follow resident care plans as relates to</p> <p>a. Diabetic Mellitus care plans stated to avoid extreme heat or cold</p> <p>b. Impaired cognitive function/dementia or impaired thought processes related to determine residents needs and supervision as needed</p> <p>c. The care plan goal related to resident's behavior problem of refusing to come inside out of the sun and will not wear sunscreen - intervention of anticipate and meet the resident's needs (initiated 6/21/17)</p> <p>The facility MDS coordinator initiated an audit of the facility residents care plans to ensure that each residents identified with desire to sit in the enclosed court yard was care planned for at risk for heat exhaustion on 7/31/17</p> <p>3. The facility staff (nursing, housekeeping and administrative staff) will be provided education regarding the risk of heat exhaustion for facility residents that are outside in the enclosed courtyard. This education included recognizing signs and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, elevated temperatures, and weakens and contact nursing staff if symptoms are observed. The education also included basic supervision and knowing where assigned residents are. The education will include assessing the residents in the court yard every thirty minutes for signs and</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>symptoms of heat exhaustion and document on the courtyard monitoring tool and offering fluids appropriate hydration. The education was initiated on 7/30/17 and will be completed on 7/31/17 by the assistant director of nursing. Staff members who have not received the education will not work until they complete the education to include agency staff.</p> <p>The facility staff (nursing, housekeeping and administrative staff, agency staff) were provided education to refer to the resident care card to ensure that resident identified with desire to sit outsider care plan are being followed on 7/31/17 by Assisted Director of Nursing .</p> <p>The facility newly admitted or re-admitted residents that are identified with desire to sit outside in the enclosed courtyard will be care planned for at risk for heat exhaustion by MDS coordinator. The resident care card will be updated to reflect care plans for resident at risk for heat exhaustion.</p> <p>On 7/31/17 at 7:45 PM, validation of the credible allegation was evidenced via interviews with nurses, resident care specialists, residents, and unit supervisors who stated they received in-service education regarding the importance of providing supervision and fluids to residents who are outside on a hot day, and the signs of heat exhaustion. Each staff member interviewed was able to names signs of heat exhaustion and demonstrated they knew to follow the resident's care plans. An observation of the facility's door to the courtyard area revealed a keypad was in place, and an alarm sounded when the door was opened. There were no residents observed in the</p>	F 282			

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F 323 SS=J	<p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on physician, nurse practitioner, staff, and emergency medical technician interviews, record review, and observations, the facility failed to provide supervision and hydration for 1 of 3 residents, Resident #1, which resulted in extreme outdoor heat exposure for a duration of 2 hours.</p>	F 323		8/30/17	
			<p>1. The alleged Resident was admitted to Fisher Park HR on 1/20/2004 with primary diagnosis of Alzheimer's, Type 2 Diabetes, seizures, hemiplegia and major depression disorder. On 7/22/17 at 1:14pm, resident fell out of wheelchair in</p>		

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F 323	<p>Continued From page 16</p> <p>Resident #1 fell from his wheelchair onto the outdoor patio, had an altered mental status when he was discovered, and had a body temperature of 104.1 degrees Fahrenheit upon assessment by emergency medical technicians. Resident #1 was admitted to the hospital with a primary diagnosis of sepsis versus heat stroke and was hospitalized for 2 days.</p> <p>The Immediate Jeopardy began on 07/22/2017 when Resident Care Specialist (RCS) #1 discovered Resident #1 lying on the courtyard patio near his wheelchair with a pulse rate of 113, a blood pressure of 59/39, and was verbally unresponsive. Resident #1 was transported by ambulance to the local hospital where he was admitted for suspected heat stroke. The Immediate Jeopardy was removed on 07/31/2017 at 6:35 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation of corrective action at that time.</p> <p>Findings included:</p> <p>Resident #1 was initially admitted to the facility on 1/20/2004 with diagnoses which included, in part, late effects of cerebral vascular disease, hemiplegia, diabetes mellitus, Alzheimer's disease, and an amputation above the knee.</p> <p>Review of the quarterly minimum data set (MDS) assessment dated 05/18/2017 revealed Resident #1 had long term and short term memory problems and had had moderate impairment with</p>	F 323	<p>the enclosed courtyard (per courtyard video camera). A certified Nursing Assistant went to the facility enclosed courtyard at 1:17 pm (per courtyard video camera) after being alerted by a visitor that a resident was on the ground in the courtyard. The Nursing Assistant immediately responded and went to the courtyard. The certified Nursing Assistant determined that the resident had a pulse and was breathing but that the resident seemed to have a decrease level of consciousness. The Nursing Assistant stayed with the resident and summoned for assistance. The licensed nurse immediately responded. The nurse's initial assessment revealed and recorded Vital signs of Temperature of 100.9, pulse 113, BP 59/39. 911 was called by the licensed nursing staff and based on the camera video footage, EMS arrived at 1:30 pm. The resident was transported to the hospital and subsequently admitted with a diagnosis of Sepsis versus heat stroke due to presenting with fever and being outside for a 2 hour period. The nurse practitioner on call was notified of 911 being notified and of the event around 1:40 pm. The responsible party was notified at approximately 2:00pm.</p> <p>The resident returned to the facility on 7/24/17 with active problems of sepsis, (HCC) Type 2 diabetes mellitus with neurological manifestations, Dementia without behavioral disturbance, Dermatitis of multiple sites, and leukocytosis. The resident was admitted for suspected heat stroke as he presented with fever and had been outside for a 2 hour period prior.</p>		

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F 323	<p>Continued From page 17</p> <p>cognitive skills for daily decision making. Resident #1 also had behaviors of rejection of care present 1 to 3 days during the assessment look back period, and that he was independent with locomotion both on and off the unit. The same MDS assessment indicated he did not use a prosthesis. Extensive assistance was required for transfers, personal hygiene, toilet use, and dressing, and Resident #1 used a wheelchair for his mobility. His partial list of diagnoses included diabetes mellitus, hypertension, peripheral vascular disease, aphasia, hemiparesis, and seizure disorder.</p> <p>The nursing care plan for Resident #1, initiated on 01/18/2017 and last revised on 07/05/2017, indicated Resident #1 had diabetes mellitus with a goal to be free of signs and symptoms of hyperglycemia. An intervention to reach this goal was for the resident to avoid extreme heat or cold. Further review of the nursing care plan revealed on 02/27/2017 another problem was added on 02/27/2017 for high risk for falls related to confusion, hemiplegia, poor communication/comprehension, and unawareness of safety needs. One of the interventions to address this problem was "Anticipate and meet the resident's needs." On 06/21/2017 a behavior problem of refusing to come inside out of the sun/refusing to wear sunscreen was added. The goal was that there would be fewer episodes of refusing to come in out of the sun, and one intervention included, "Anticipate and meet the resident's needs." Another was to allow the resident to make choices within the resident's decision making abilities.</p> <p>Review of the facility's courtyard/patio camera</p>	F 323	<p>Due to the leukocytosis, fever, elevated lactic acid, he was started on IV antibiotics for suspected aspiration and then changed to Augmentin. Additional diagnoses during the resident's hospitalization included hypotension, history of stroke, generalized rash, acute kidney injury, diabetes mellitus, and acute encephalopathy related to fever. A repeat chest x ray for suspected aspiration showed no active disease. Resident was treated with IV fluids hydration, BP improved and discharge exam from hospital show BP was 134/47. The resident has not been as interested in sitting in the courtyard since return to the facility, but he is tolerating being in wheelchair short period of times. The resident was re- assessed using the BIMS (Brief Interview for Mental Status) assessment tool on 7/28/17, his scoring was 0- severe impairment. Based on the BIMS score, the resident care plans were revised by the MDS coordinator on 7/31/17 to include providing supervision when in the courtyard. Resident also has been provided a hat for courtyard use. The licensed nurse assigned to the resident on 7/22/17 no longer works at the facility. The certified nursing assistant assigned to the resident on 7/22/17 at the time of the incident was provided one on one re- education regarding sign and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakness and contact nursing staff if</p>		

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F 323	<p>Continued From page 18 footage dated 7/22/17 revealed the following:</p> <p>On 07/22/2017 at 11:13 AM, Resident #1 was seen entering the enclosed courtyard area via the facility's door on the north side of the building. He navigated in his wheelchair about the courtyard on the sidewalk and on the patio by propelling himself with his left leg. There was partial shade in the courtyard from a tree located on the side of the courtyard closer to the south side of the building. Outdoor tables were located on the part of the patio closest to the door on the north side of building. Resident #1 navigated to one of the tables in the sun and sat in his wheelchair.</p> <p>By 12:00 noon on 07/22/2017, the resident had navigated himself to another table on the patio which was in partial sun. A staff member was seen entering the patio from the north entrance door at this time and approaching the resident, talking with him, and then exiting the patio area via the north door. There were no other staff members seen in the courtyard until 12:20 PM when a staff member was seen at the vending machine which was located at the entrance to the courtyard area. This staff member did not approach the resident or speak with him.</p> <p>At 12:48 PM, Resident #1 navigated to another table in the courtyard that was in partial shade. There were no staff members seen in the courtyard other than the staff member at 12:00 noon and the staff member who did not check on the resident at 12:20 PM. No one was seen providing fluids to Resident #1 to drink between 11:13 AM and 1:14 PM.</p>	F 323	<p>symptoms occur. The nursing assistant education also included offering hydration to residents that are outside more than thirty minutes by district director of clinical services on 7/31/17.</p> <p>2. It was determined on 7/26/17 during an IDT ADHOC QAPI meeting that the resident had been assessed and identified as severely impaired based on BIMS assessment on 11/22/16. During staff interviews on 7/24/17 it was identified that the resident routinely went to the court yard unsupervised and refused to come inside for extensive periods of time. After review of the medical record, the investigation of alleged event and staff interviews it was identified that the facility had failed to provide.</p> <ol style="list-style-type: none"> Supervision when residents are in the court yard to ensure that residents are not showing signs and symptoms of heat exhaustion/ dehydration. Hydration cart, that included water and electrolyte fluids when outside in enclosed count yard Education to staff, residents and responsibly/facility visitors regarding signs of heat stroke and/or dehydration. The enclosed court yard entrance was rekeyed so that the alarm will sound at any time, 24 hours a day, unless the code is entered into the keypad. The code is provided to all staff members. Any resident may exit through the door to the courtyard, but an alarm will sound, and a staff member will need to silence the alarm by entering the code. 		

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F 323	<p>Continued From page 19</p> <p>At 1:14 PM, Resident #1 was seen falling out of his wheelchair onto the patio. No further movement was noted.</p> <p>At 1:17 PM, a staff member was seen entering the courtyard with a male (identified as a visitor) and finding Resident #1 lying on the patio. The staff member stooped down to the resident, then stood and pointed to the south side of the building. The "visitor" was seen pulling the patio table away from the resident and walking back into the building. The staff member remained with the resident. Another staff member entered the patio at 1:18 PM. At 1:22 PM, a third staff member entered the courtyard with a vital signs monitor.</p> <p>At 1:30 PM, paramedics were seen entering the courtyard. (The camera angle did not allow a view of the resident's response to any treatment or stimulation by staff or paramedics.)</p> <p>A nurse's note of 07/22/2017 at 2:18 PM indicated Resident #1 was found lying on the ground in the courtyard on his back, and that his blood pressure assessed at the time was 59/39, his pulse was 113, and his temperature was 100.9.</p> <p>A situation/background/assessment/recommendation (SBAR) note dated 07/22/2017 revealed Resident #1 was found lying on his back beside his wheelchair in the courtyard, and that the resident was unable to say what was happening. The note indicated that since the incident happened, the situation had gotten worse, and that he was unresponsive for his mental status. The resident was transferred to the hospital and the resident's primary care clinician was notified at 1:40 PM. The resident's guardian was notified</p>	F 323	<p>There have been no other residents that presented with signs and symptoms of heat exhaustion based on the review of the monitoring tools that have been in place since 7/24/17.</p> <p>The facility implemented a plan to address each item that was identified during the ADHOC QAPI meeting on 7/26/17 Hydration cart with water was placed outside in enclosed courtyard on 7/24/by dietary staff. Beverages with electrolytes have been added as of 7/31/17. The facility Dietary staff was provided education regarding keeping water and electrolyte fluid in the cooler 7/31/17 by the dietary manager. The dietary staff received education regarding replenishing process of the fluids to include check before breakfast, after lunch and dinner daily.</p> <p>The facility posted an information sheet regarding signs and symptoms of heat exhaustion at the door in the enclosed courtyard on 7/31/17 by director of Nursing</p> <p>The facility interview able residents will be provided education regarding sign and symptoms of heat exhaustion to include: sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakness. If symptoms occur staff is to contact license nursing staff. The facility interviewable residents will be educated on using the hydration cart while sitting in courtyard with recommendations to drink electrolyte fluids from the hydration cart if they are outside greater</p>		

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F 323	<p>Continued From page 20 at 2:00 PM.</p> <p>The weather conditions per Weather Underground on 07/22/2017 at 12:54 PM for the facility's location was 93.9 degrees Fahrenheit with a heat index of 102.1 degrees.</p> <p>A review of the Emergency Medical Services (EMS) Report dated 07/22/2017 revealed the emergency medical Technicians (EMTs) arrived at the facility at 1:42 PM on 07/22/2017, and at 1:46 PM, the EMTs determined Resident #1 was in sinus tachycardia. At 1:52 PM, the EMTs assessed Resident #1's temperature to be 104.2, and intravenous fluids were administered at 1:57 PM. The text on the report indicated the EMTs removed Resident #1's clothing to assist in cooling him, and at 1:59, a cold wet towel was placed on the resident's chest and abdomen, and ice packs were placed under the axilla (under arms.)</p> <p>In an interview with the resident care specialist (RCS) #1 on 07/27/2017 at 9:38 AM, she stated she was the RCS assigned to care for Resident #1 on 07/22/2017 when the courtyard incident occurred. RCS #1 explained she did not discover the resident on the ground on 7/22/17. RCS #1 stated she provided morning care to Resident #1 after breakfast on 7/22/2017, then transferred him to his wheelchair and rolled him into the hall near the nurse's station on the south side of the building. She explained she then provided care for her other assigned residents, then checked on Resident #1 again. At that time (not sure of the exact time of day) she did not see Resident #1 in the hallway but later noted he was outside. She stated that the resident typically did not talk much, but he seemed to understand what people said to</p>	F 323	<p>than 2 hours. The education provided to the residents was completed on 7/31/17 by MDS coordinator on 7/31/17.</p> <p>The facility staff (including, nursing, housekeeping and administrative) will be provided education regarding signs and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakens and contact nursing staff if symptoms are observed. The education also included basic supervision and knowing where assigned residents are. The education will include assessing the residents in the court yard every thirty minutes for signs and symptoms of heat exhaustion and document on the courtyard monitoring tool and offering fluids appropriate hydration. The education was initiated on 7/30/17 and will be completed on 7/31/17 by the assistant director of nursing. Staff members who have not received the education will not work until they complete the education to include agency staff. A facility staff member will provide 30 minute checks in the courtyard and document on the courtyard monitoring tool. A facility staff member will be assigned daily by the Director of Nursing.</p> <p>The enclosed court yard entrance was rekeyed so that the alarm will sound at any time, 24 hours a day, unless the code is entered into the keypad. The code is provided to all staff members. Any resident may exit through the door to the courtyard, but an alarm will sound, and a</p>		

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F 323	<p>Continued From page 21</p> <p>him and that he was able to feed himself. He was also able to get around the facility very well in his wheelchair by scooting himself with his feet. RCS #1 indicated she could not remember what time it was, but she observed staff members go into the courtyard. She stated it was another RCS (RCS #2) who first found Resident #1 on the ground. RCS #1 added that when she went into the courtyard after he had been discovered, she observed the resident's left arm was blue below the blood pressure cuff when RCS #2 was trying to take his blood pressure.</p> <p>In a telephone interview with Nurse #1 who was assigned to care for Resident #1 on 07/27/2017 at 10:12 AM, she stated she worked for a staffing agency and had cared for Resident #1 in the past and was familiar with his behavior. Nurse #1 explained she provided the resident his medications about 8:00 AM on 7/22/17, and that the next time she saw him was around 12:00 noon. She stated she had to look for him and was unable to find him in his room, the dining room or lobby, but she found him outside in the courtyard at 12:00 noon. Nurse #1 indicated she needed to check his capillary blood glucose level (by finger stick) at that time to determine his sliding scale insulin dose. She stated Resident #1 refused to have his blood glucose level checked, and that he also refused to come inside when she offered him his lunch, so she left Resident #1 outside. Nurse #1 stated about an hour later, someone summoned her to the courtyard. (Could not remember who it was.) She stated he was found on the ground in the courtyard by another staff member, but she could not recall who that staff member was. In addition, Nurse #1 said other nurse aides and nurses were with the resident assessing him, so she got her</p>	F 323	<p>staff member will need to silence the alarm by entering the code.</p> <p>3. The door alarm for the door that entrances the court yard will be checked daily by director of maintenace and /or manager of duty to ensure that the door alarms when opened. Daily for thirty days .</p> <p>An Information sheet was posted on the door that enters the enclosed court yard regarding the signs and symptoms of heat exhaustion and steps to take to avoid heat exhaustion to include hydration and notify the nursing staff if signs and symptoms occur</p> <p>4. A magnetic lock with a coded keypad has been installed on the door from the lobby to the courtyard. All residents must be assisted by a staff member to exit the lobby to the court yard. The new keypad system will be audited during the hours the courtyard is open for use (9am-7pm) every 30 minutes for 2 weeks and then every 60 minutes for 2 weeks to insure the new keypad system is effective and that residents are not able to exit to the courtyard without staff assistance and knowlege. To insure that residents who require direct supervision can not enter courtyard unsupervised. The audits will be reviewed by the Director of Nursing and the Administrator. The findings will be presented to the QAPI committee for monitoring of ongoing compliance.</p>		

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F 323	<p>Continued From page 22</p> <p>unit supervisor who helped prepare the resident for a transfer to the hospital. She stated she thought she was the one who called 911 and the nurse practitioner, but was not sure.</p> <p>An interview was conducted with RCS #2 on 7/27/2017 at 12:54 PM. RCS #2 stated she was the first staff member to find Resident #1 on the ground on the courtyard patio on 7/22/17. She explained that a man who was a visitor came to her and reported he saw a resident on the ground beside his wheelchair in the courtyard, so she ran outside. RCS #2 stated she stooped down and checked Resident #1's radial pulse which was weak and fast, and she then checked for his carotid pulse which was also faint. She did not know the exact pulse rate at that time because she did not have the vital sign monitor. The resident's head was under the table and he was mentally "out" per her description. She explained she could see his chest rising and falling and the resident's skin was red. RCS #2 said she asked the visitor to run inside to get the resident's nurse and that the nurse came outside shortly thereafter. Another nurse aide brought the vital signs monitor out to the courtyard, and she (RCS #2) measured his vital signs. She stated at first she was unable to get a blood pressure reading in the resident's left arm, so she removed the blood pressure cuff and placed it on his right arm below the elbow to take his blood pressure. (The resident's right arm was partially drawn at the elbow due to hemiparesis.) RCS #2 stated his arm turned purple below the cuff, but she was able to get a blood pressure reading by palpation and it was very low. RCS #2 added she could not remember the exact blood pressure reading and had no recollection of times when she entered the courtyard or when other staff</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>members arrived, but that she stayed with the resident until paramedics arrived to take care of Resident #1. RCS #2 also stated she had observed Resident #1 fall asleep in his wheelchair outside the day before, but no one knew for certain how the resident had fallen out of his wheelchair on 07/22/2017.</p> <p>In an interview with the unit supervisor (US) on 07/27/2017 at 1:11 PM, she explained she was passing medications to residents when she was called to the courtyard STAT (immediately) on 7/22/17. She found Resident #1 on the ground and there were 2 nurses already present with him from the facility's south wing, as well as a nurse aide. She explained she bent down over the resident and called his name, and the resident opened his eyes, then closed them, but did not respond verbally. The US also stated the nurse aide and one of the nurses were reattempting to get the resident's vital signs. She added that one of the nurses from the staffing agency called 911 and that she herself called the nurse practitioner who was on call for the physician. An order was obtained to transport the resident to the hospital. The US was not certain of the time when she entered the courtyard area, but once she was out there, the EMS came within 5 or 6 minutes.</p> <p>The nurse practitioner (NP) who was notified about the resident's courtyard incident was interviewed on 07/27/2017 at 11:40 AM. The NP stated the facility called 911 before contacting her and that she provided the order to send the Resident #1 to the hospital. The NP also indicated she felt there was no long term negative impact on the resident's health after he had been exposed to the hot weather for a few hours. She stated that ideally she would expect the staff to</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>bring the resident inside on a hot day and that staff needed to provide fluids for the resident to keep him hydrated. The NP did not provide a length of time Resident #1 should have been able to stay outside on a hot day.</p> <p>In an interview with Resident #1's physician on 07/27/2017 at 12:00 noon, she explained she was on vacation when Resident #1 was found on the ground outside, so the facility notified the nurse practitioner who was on call. The physician stated she learned of the incident after returning from her vacation on 7/26/17 and that she had read the emergency department report. In addition, she stated she would not want the resident to stay outside any length of time on a hot day without hydration, and that the resident may not have had the ability to make an appropriate decision to come inside. The physician stated she would expect for the resident to be checked every 30 minutes to one hour. She added that heat would affect individuals in different ways depending on physical condition and that Resident #1 commonly sat outside.</p> <p>On 07/27/2017 at 3:25 PM, and interview was conducted with the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the District Director of Clinical Services (DDCS.) The DDCS stated Resident #1 was on the ground in the courtyard for about 3 minutes before he was discovered by staff. The DON stated she did an investigation of the incident and that she felt the resident's temperature of 104 was incorrect, that the facility recorded his temperature to be 100.9, and that the EMS had a temperature of 101. The DON stated there were no recorded temperatures higher than 101 for Resident #1. The DON</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>added that she felt the resident had sepsis and that was the reason for his elevated temperature on 7/22/17. The DDCS added that staff had been educated about checking on residents who are outside more often and that the facility had placed a magnetic feature on the door to the courtyard so that an alarm would sound 24 hours a day whenever a resident entered the courtyard. She explained that the alarm would encourage staff to check the courtyard for a resident and the alarm would have to be reset by a staff member. In addition, the DDCS stated that the dietary department was now keeping a cooler of water with cups in the courtyard for residents to receive fluids when the temperatures were warm. She stated she was not sure that Resident #1 would be able to help himself to the water in the cooler.</p> <p>A follow up interview was conducted with RCS #2 on 07/28/2017 at 4:49 PM. RCS #2 stated she thought she had her cell phone with her on 7/22/17 when she found Resident #1 lying in the courtyard outside, but she stated she did not call 911 because she wasn't certain of the protocol was for calling emergency services.</p> <p>On 7/31/2017 at 2:02 PM a telephone interview was completed with EMT #1 who was the lead paramedic who responded to the courtyard incident for Resident #1 on 7/22/17. EMT #1 stated he did check the resident's temperature and it was 104.1 degrees and he recorded it on the EMS report. He added that a facility staff member was with the resident, and that fire department personnel had arrived just before he did. Upon his assessment, Resident #1 was not verbally responsive but his eyes were open. He stated the resident was unaware of his presence. EMT #1 reported he administered intravenous</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>(IV) fluids and placed ice packs under the arms and around the groin area to help reduce Resident #1's elevated body temperature.</p> <p>The hospital discharge summary dated 7/24/17 revealed the primary diagnosis during Resident #1's hospitalization was sepsis versus heat stroke. Under this diagnosis, the summary indicated resident was admitted for suspected heat stroke, and that due to leukocytosis, fever, and elevated lactic acid, the resident was started on IV antibiotics. The suspected reason for sepsis was aspiration. His blood cultures were negative for bacteria, and his urinalysis dated 7/23/2017 showed no bacteria. The second diagnosis during the hospital course was hypotension (low blood pressure), suspected due to hypovolemia (low fluid volume.) The seventh diagnosis during the hospital course was acute encephalopathy, suspected to be related to fever. The resident was hospitalized from 7/22/17 until his discharge on 7/24/17 and he was prescribed Augmentin (an antibiotic), one tablet by mouth twice per day per the discharge medication list.</p> <p>The DDCS (present during the absence of the Administrator), the DON, and the ADON were notified of Immediate Jeopardy on 07/28/2017 at 12:25 PM.</p> <p>On 07/31/17 at 6:35 PM, the facility provided a credible allegation as follows:</p> <p>1. The alleged Resident was admitted to Fisher Park HR on 1/20/2004 with primary diagnosis of Alzheimer's, Type 2 Diabetes, seizures, hemiplegia and major depression disorder. On 7/22/17 at 1:14pm, resident fell out of wheelchair in the enclosed courtyard (per courtyard video</p>	F 323			

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F 323	Continued From page 27 camera). A certified Nursing Assistant went to the facility enclosed courtyard at 1:17 pm (per courtyard video camera) after being alerted by a visitor that a resident was on the ground in the courtyard. The Nursing Assistant immediately responded and went to the courtyard. The certified Nursing Assistant determined that the resident had a pulse and was breathing but that the resident seemed to have a decrease level of consciousness. The Nursing Assistant stayed with the resident and summoned for assistance. The licensed nurse immediately responded. The nurse's initial assessment revealed and recorded Vital signs of Temperature of 100.9, pulse 113, BP 59/39. 911 was called by the licensed nursing staff and based on the camera video footage, EMS arrived at 1:30 pm. The resident was transported to the hospital and subsequently admitted with a diagnosis of Sepsis versus heat stroke due to presenting with fever and being outside for a 2 hour period. The nurse practitioner on call was notified of 911 being notified and of the event around 1:40 pm. The responsible party was notified at approximately 2:00pm. The resident returned to the facility on 7/24/17 with active problems of sepsis, (HCC) Type 2 diabetes mellitus with neurological manifestations, Dementia without behavioral disturbance, Dermatitis of multiple sites, and leukocytosis. The resident was admitted for suspected heat stroke as he presented with fever and had been outside for a 2 hour period prior. Due to the leukocytosis, fever, elevated lactic acid, he was started on IV antibiotics for suspected aspiration and then changed to Augmentin. Additional diagnoses during the resident's hospitalization included hypotension, history of stroke, generalized rash, acute kidney	F 323			

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F 323	<p>Continued From page 28</p> <p>injury, diabetes mellitus, and acute encephalopathy related to fever. A repeat chest x ray for suspected aspiration showed no active disease. Resident was treated with IV fluids hydration, BP improved and discharge exam from hospital show BP was 134/47.</p> <p>The resident has not been as interested in sitting in the courtyard since return to the facility, but he is tolerating being in wheelchair short period of times.</p> <p>The resident was re- assessed using the BIMS (Brief Interview for Mental Status) assessment tool on 7/28/17, his scoring was 0- severe impairment. Based on the BIMS score, the resident care plans were revised by the MDS coordinator on 7/31/17 to include providing supervision when in the courtyard. Resident also has been provided a hat for courtyard use.</p> <p>The licensed nurse assigned to the resident on 7/22/17 no longer works at the facility. The certified nursing assistant assigned to the resident on 7/22/17 at the time of the incident was provided one on one re- education regarding sign and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakness and contact nursing staff if symptoms occur. The nursing assistant education also included offering hydration to residents that are outside more than thirty minutes by district director of clinical services on 7/31/17.</p> <p>2. It was determined on 7/26/17 during an IDT ADHOC QAPI meeting that the resident had been assessed and identified as severely impaired</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>based on BIMS assessment on 11/22/16. During staff interviews on 7/24/17 it was identified that the resident routinely went to the court yard unsupervised and refused to come inside for extensive periods of time. After review of the medical record, the investigation of alleged event and staff interviews it was identified that the facility had failed to provide.</p> <p>a. Supervision when residents are in the court yard to ensure that residents are not showing signs and symptoms of heat exhaustion/ dehydration.</p> <p>b. Hydration cart, that included water and electrolyte fluids when outside in enclosed count yard</p> <p>c. Education to staff, residents and responsibly/facility visitors regarding signs of heat stroke and/or dehydration.</p> <p>d. The enclosed court yard entrance was rekeyed so that the alarm will sound at any time, 24 hours a day, unless the code is entered into the keypad. The code is provided to all staff members. Any resident may exit through the door to the courtyard, but an alarm will sound, and a staff member will need to silence the alarm by entering the code.</p> <p>There have been no other residents that presented with signs and symptoms of heat exhaustion based on the review of the monitoring tools that have been in place since 7/24/17.</p> <p>The facility implemented a plan to address each item that was identified during the ADHOC QAPI meeting on 7/26/17 Hydration cart with water was placed outside in enclosed courtyard on 7/24/by dietary staff. Beverages with electrolytes have been added as</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>of 7/31/17. The facility Dietary staff was provided education regarding keeping water and electrolyte fluid in the cooler 7/31/17 by the dietary manager. The dietary staff received education regarding replenishing process of the fluids to include check before breakfast, after lunch and dinner daily.</p> <p>The facility posted an information sheet regarding signs and symptoms of heat exhaustion at the door in the enclosed court yard on 7/31/17 by director of Nursing</p> <p>The facility interviewable residents will be provided education regarding sign and symptoms of heat exhaustion to include:sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakness. If symptoms occur staff is to contact license nursing staff. The facility interviewable residents will be educated on using the hydration cart while sitting in courtyard with recommendations to drink electrolyte fluids from the hydration cart if they are outside greater than 2 hours. The education provided to the residents was completed on 7/31/17 by MDS coordinator on 7/31/17.</p> <p>The facility staff (including, nursing, housekeeping and administrative) will be provided education regarding signs and symptoms of heat exhaustion to include sweating, fatigue, headache, pale clammy skin, thirst, rapid heartbeat, dizziness, fainting, nausea, vomiting, muscle and abdominal cramps, temperature elevation, and weakens and contact nursing staff if symptoms are observed. The education also included basic supervision and knowing where assigned residents are. The education will include</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/31/2017
NAME OF PROVIDER OR SUPPLIER FISHER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401		
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F 323	<p>Continued From page 31</p> <p>assessing the residents in the court yard every thirty minutes for signs and symptoms of heat exhaustion and document on the courtyard monitoring tool and offering fluids appropriate hydration. The education was initiated on 7/30/17 and will be completed on 7/31/17 by the assistant director of nursing. Staff members who have not received the education will not work until they complete the education to include agency staff. A facility staff member will provide 30 minute checks in the courtyard and document on the courtyard monitoring tool. A facility staff member will be assigned daily by the Director of Nursing.</p> <p>The enclosed court yard entrance was rekeyed so that the alarm will sound at any time, 24 hours a day, unless the code is entered into the keypad. The code is provided to all staff members. Any resident may exit through the door to the courtyard, but an alarm will sound, and a staff member will need to silence the alarm by entering the code.</p> <p>3. The door alarm for the door that entrances the court yard will be checked daily by director of maintenance and /or manager of duty to ensure that the door alarms when opened. Daily for thirty days.</p> <p>An Information sheet was posted on the door that enters the enclosed court yard regarding the signs and symptoms of heat exhaustion and steps to take to avoid heat exhaustion to include hydration and notify the nursing staff if signs and symptoms occur.</p> <p>On 7/31/17 at 7:45 PM, validation of the credible allegation was evidenced via interviews with</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/31/2017
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F 323	Continued From page 32 nurses, resident care specialists, residents, and unit supervisors who stated they received in-service education regarding the importance of providing supervision and fluids to residents who are outside on a hot day, and the signs of heat exhaustion. An observation of the facility's door to the courtyard area revealed a keypad was in place, and an alarm sounded when the door was opened. There were no residents observed in the courtyard area at the time of validation of the credible allegation.	F 323			