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	345142	A. BUILDING _____ B. WING _____	C 07/12/2019

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 07/09/19 to 07/12/19. There was one allegation investigated and it was substanitated and cited. Immediate Jeopardy was identified at: CFR 483.25 at tag F-689 at a scope and severity of (J). The tag F 689 constituted Substandard Quallity of Care. Immediate Jeopardy began on 06/29/19 and was removed on 07/11/19. An extended survey was completed.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Medical Doctor (MD) interviews, the facility failed to monitor a severely cognitively impaired resident who wandered into an outdoor courtyard and sat in 90- degree sun without shade or fluids for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 was found slumped over to the side of his chair	F 689	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the	7/13/19

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

Electronically Signed | 08/05/2019

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F 689	Continued From page 1 and not responsive to caregivers. Resident #1 was sent out to the Emergency Department (ED) where he was treated for symptoms of heat stroke. Resident #1 was hospitalized, stabilized and returned to the facility four days later. Immediate jeopardy began on 06/29/19 when the facility failed to maintain a safe environment as evidenced by a severely cognitively impaired resident exiting the dining room door into the courtyard and was discovered approximately 75 feet from the door one and a half hours later in the direct sunlight without supervision. The Immediate Jeopardy was removed on 07/11/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: Resident #1 was admitted to the facility on 05/03/15 with diagnoses which included acute urinary obstruction with suprapubic catheter, history of urinary tract infections, complete heart block with cardiac pacemaker, mitral regurgitation, osteoarthritis, seizure disorder, mental retardation and other cognitive impairments, hypothyroidism, chronic anoxic encephalopathy and dementia. His date of birth was 12/20/1952 Resident #1's most recent quarterly Minimum Data Set (MDS) dated 06/21/19 revealed he was	F 689	facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor□s findings or conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied. F689 The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Corrective action has been accomplished for the alleged deficient practice in regards to resident #1. On 06/29/19 Resident #1 was assisted by 2 nursing assistants from the courtyard to his room. Clothing was partially removed by staff and cool compress applied. Medics already in facility and evaluated resident. Nurse contacted physician who gave order to transfer resident#1 to the hospital. Systemic Change: On 7/1/19 the director of nursing started a proactive in-service for staff of all departments on hydration (fluids will be present in courtyard) and frequent monitoring of residents outside. C.N.A.s and nurses will check residents on their assignment during each round, including residents who are in the courtyard. An administrative staff member will check the courtyard three time daily. This in-service was started as a proactive reminder to	

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F 689	Continued From page 2 severely cognitively impaired for daily decision making, required extensive assistance of 2 with transfers but was able to self-propel once he was in his wheelchair. The resident had no impairment of his upper or lower extremities and received antipsychotics on a routine basis. Review of Resident #1's Medication Administration Record revealed he was prescribed Ditropan XL 15 milligrams (mg) extended release (ER) - 1 tablet by mouth once daily for urinary urgency, Topomax 50 mg - take 3 tablets to equal 150 mg by mouth twice daily for seizure disorder and Zyprexa 5 mg tablet - take 1 tablet by mouth twice daily for schizophrenia, among others. Additionally, Resident #1 was diagnosed with a Urinary Tract Infection (UTI) on 06/27/19 and was started on Cipro 500 mg tablet - one tablet by mouth daily for 10 days beginning 06/28/19. Resident #1's medical record revealed a note written on 06/29/19 by Nurse #1 which read in part: Resident alert and wheeling self around during the morning. Noted to be outside around 11:00 AM in his wheelchair. At about 12:28 PM the resident was still outside and assisted back in the building by Nurse Aide (NA) #1 and NA #2 due to being less responsive. The resident was dressed in a tee shirt, sweat shirt and sweat pants and his temperature was noted to be increased with a decreased pulse. The resident was assisted to bed and had some clothing removed and cool towels were placed on the resident. The resident was assisted in drinking some sips of water and when assessed remained less responsive, so a telephone order was obtained to send the resident to the hospital for evaluation and treatment.	F 689	staff to provide hydration to residents outside to encourage hydration status. This in-service was completed on 7/10/19 by in- person in-servicing or by mail. If in-service was mailed the staff member must compete a quiz and return prior to working to validate competency. This in-service was added to the orientation for new staff on7/10/19 by the administrator. On 7/10/19 the facility implemented hydration station in the courtyard. The dietary manager or dietary aide will provide fresh ice and fluids to the hydration station. The hydration station allows for access to fluid for residents utilizing the courtyard. Fluids will be contained in a cooler. Residents who cannot physically access fluids at the hydration station will be assisted by staff. On 7/11/19 the facility placed four large patio umbrellas in the courtyard and two canopies in the courtyard to provide additional shade for resident safety to decrease the risk of heat related stress by addressing a risk factor in heat related stress. On 7/11/19 the staff facilitator initiated an in-service for staff of all departments on signs and symptoms of heat related stress, preventive actions to prevent heat related stress and actions to take if they note a resident with possible heat related stress change. This in-service was completed on 7/11/19 by in-person in-servicing or by mail on 7/11/19 (2nd mailing). If the in-service was mailed, the staff member must complete the included quiz to prove competence and return the quiz prior to their next	

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F 689	Continued From page 3 A telephone interview on 07/09/19 at 2:33 PM with Nurse #1 who had taken care of Resident #1 on 06/29/19 revealed she was not sure what time the resident had gone out into the courtyard. She stated she remembered him self-propelling his wheelchair in the hallway that morning but stated she was not aware of what happened after that until she was summoned by NA #1 and NA #2 to assess the resident after being out in the sun. Nurse #1 stated his temperature had been elevated (could not remember what it was) and his pulse had been low (could not remember what it was). Nurse #1 stated she was not aware how long the resident had been out in the courtyard but stated when he came in he was hot to the touch and he was unresponsive except to painful stimuli. She stated they tried to cool him off and get him comfortable and stated he was having some jerking movements but stated she was not sure that it was seizures. Nurse #1 stated Resident #1 remained unresponsive as he was taken out of the facility by EMS. Nurse #1 stated she had not typically taken care of Resident #1 and was not familiar with him. An interview on 07/09/19 at 2:18 PM with NA #1 who was assigned to Resident #1 on 06/29/19 on first shift (7:00 AM to 3:00 PM) revealed she recalled the day of the incident. NA #1 stated the resident had eaten breakfast in his room and was self-propelling himself in the hallway. She stated she rolled the resident into the Rose Dining Room at 11:00 AM while Bingo was going on. NA #1 stated at approximately 12:28 PM NA #2 discovered Resident #1 out in the courtyard leaning over to the side and came and got her and the two brought him in the facility. NA #1 stated he would not respond to them, so they put	F 689	scheduled shift. On 7/11/19 the administrator added the in-service to the new staff orientation for staff of all departments. The facility's expectation of staff for a cognitively impaired resident who is taken outside or propels outside to the courtyard is: 1. Follow the residents' plan of care/careguide; 2. Honor resident rights and choices; 3. Offer hydration and shade; 4. Provide supervision to prevent accidents. No staff will be allowed to work after 7/11/19 without in-service completion by phone, in-person, or satisfactory completion of mailed quiz. The quizzes are monitored and graded by the director of nursing, assistant director of nursing and the staff facilitator. Residents will be monitored during routine rounds by facility staff and more frequently based on the resident's current needs and preferences. On 7/11/19 facility staff members educated residents one on one and in small groups on heat stress, heat related stress prevention, and heat related stress risk factors. This education was also provided on 7/11/19 to family members via telephone or in person. On 7/11/19 facility staff members posted educational posters in visible places throughout the facility and courtyard to provide families and residents visual reminders of education they received on heat stress, heat related stress prevention, and heat related stress risk factors. The education will also be presented to the resident council on 7/25/19 and a family meeting on 7/30/19 as reinforcement. A complete	

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F 689	Continued From page 4 him in the bed and summoned the nurse and 2 emergency medical technicians (EMTs) who happened to be in the facility picking up another resident. She stated they put him in the bed with the help of the nurse and the EMTs took his temperature and it was 105.1 degrees F. NA #1 stated Resident #1's skin was hot to touch, and they started taking off some of his clothing and applying cold towels to his body. She said Nurse #1 called the Medical Doctor (MD) and received orders to transport the resident to the ED for evaluation and treatment. NA #1 stated EMS came and transported the resident to the hospital. NA #1 stated Resident #1 had never gone out of the facility into the courtyard on his own when she had taken care of him and stated she was not sure why he had done it on this day. NA #1 stated she was not sure how he had gotten out the door unless he followed a staff member out or opened the door himself. A second interview on 07/10/19 at 11:30 AM with NA #1 revealed the location where the resident was found out in the courtyard. The resident was found in his wheelchair in the direct sun with no shade on the concrete walkway approximately 75 feet from the door of the dining room. An interview on 07/09/19 at 2:45 PM with NA #2 revealed during lunch on 06/29/19 she had noticed Resident #1 in the courtyard slumped to the side and went and got NA #1. She stated the two of them brought him into the facility and put him to bed, so they could take some of his clothing off and cool him down. NA #2 stated he was not verbally responding to them and stated it was hot outside that day and where he was sitting in the courtyard there was no shade. She stated the EMTs and Nurse #1 came into the room and	F 689	mailing of the education material to all resident representatives was completed on 7/11/19. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: On 07/10/2019 Courtyard Audits were initiated by the Director of Nursing, Assistant Director of Nursing and Staff Facilitator and will be completed 3 times daily by administrative staff during the hours of 9am-12pm. 12pm-3pm, 3pm-7pm for 3 months. The Director of Nursing, Assistant Director of Nursing or Staff Facilitator will present the findings and recommendations at monthly QI committee meeting. QAPI/QI committee will evaluate for continued compliance for 3 months.	

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started assessing him and the nurse obtained orders from the MD to send him out to the ED for evaluation and treatment. She stated he had not had any fluids with him when they brought him in from outside and to her knowledge he had not had any fluids since going out in the sun. She stated she had not typically seen him out in the courtyard and was not sure how he had gotten out there that day. NA #2 stated the door was not closing properly that day and that if he could push it open it was possible that he went out on his own or he had followed a staff member out the door.

An interview on 07/09/19 at 3:20 PM with NA #3 revealed she had cut through the courtyard and seen Resident #1 sitting in his wheelchair in the sun. She stated she remembered she was going to get him something to drink on her way back across the courtyard but stated by the time she got back NA #1 and NA #2 were getting him in the facility. She stated he had not typically gone out into the courtyard but stated he could go out if he wanted because he was not monitored for wandering. She stated she was not sure how he got out there or how long he had been out there.

A review of the Emergency Medical Services (EMS) report revealed they were dispatched to the facility on 06/29/19 at 12:57 PM and arrived on scene at 1:07 PM. EMS was informed by Nurse #1 the resident was found outside by staff members of the facility in his wheelchair. Resident #1 was found noncommunicative and moved into his room inside the facility. The EMS report documented temperature noted outside at approximately 90 degrees F and sunny. Their assessment revealed Resident #1 was noncommunicative, patent airway but breathing at

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an elevated rate and shallow depth with mild distress and clear lung sounds with oxygen saturation at 94 percent on room air, skin color normal, skin hot to touch, slow and irregular radial pulses noted, tremors noted, not following commands but is making some purposeful movement to pain stimuli, no noted trauma, pupils equal and remainder of physical exam unremarkable. Temporal temperature (forehead scanner) obtained and shown to be 105.1 degrees F. Nurse #1 arrived in room with resident and stated she believed the resident went outside at approximately 9:00 AM and had been outside since EMS was notified. Resident #1 was placed on cot and secured, ice packs were placed bilaterally to resident's axillary, fluid bolus was infusing, and resident was transferred to the Emergency Department (ED) at the local hospital.

A review of the ED notes at the hospital revealed Resident #1 arrived at the ED on 06/29/19 at 1:31 PM via EMS for evaluation of a potential heat stroke. Resident #1 arrived showing signs of altered mental status with a temperature of 105 degrees F. Resident #1's temperature was assessed in the ED as 98.9 degrees F, heart rate 111, respirations 25 and blood pressure 93/74 with oxygen saturation at 100 percent. Resident #1 was responsive to painful stimuli and withdrew to pain and had active seizure activity. The resident appeared to purposefully withdraw to painful stimulus in his right lower extremity and had a positive Babinski (a reflex action in which the big toe remains extended or extends itself when the sole of the foot is stimulated, abnormal except in young infants) bilaterally. Resident #1's initial seizure activity appeared to have subsided after multiple rounds of intravenous (IV)

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Lorazepam. Resident #1 continued with myoclonic jerking of bilateral upper and lower extremities and was unclear if this represented ongoing intermittent seizure activity which prompted a stat neurological consult. At the urging of the Neurologist intravenous Dilantin was given and transfer to a facility that had EEG (a test that detects electrical activity in your brain using small, metal discs (electrodes) attached to your scalp) capabilities was arranged. Resident #1 received a nasal trumpet to support his breathing and high flow nasal canula was initiated. Resident #1 continued with ongoing bouts of hypotension (low blood pressure- less than 90/60), attempted to minimize amount of IV fluids given, resident was able to make urine and his temperature was greatly improved so ice packs and fans with topical water spray were discontinued. At 2:15 PM reexamination revealed Resident #1's blood pressure dropped and Resident #1 was started on an additional cool normal saline IV. Resident #1's suprapubic catheter was draining urine and the resident's temperature was assessed at 100 degrees F. The resident was discharged to a secondary hospital that supported continuous EEG monitoring at 6:26 PM via EMS.

A review of the secondary hospital record dated 06/29/19 for Resident #1 revealed on admission he remained unresponsive and unable to provide any history. He was only grimacing to painful stimuli, remained hypotensive and Resident #1 was admitted to the Intensive Care Unit for monitoring. His temperature went down to 99 degrees after some cooling blankets were applied and his computerized tomography (CT) scan of his head did not show any acute intracranial process. The physician's assessment noted a

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fever of unclear etiology, likely secondary to heat stroke and the assessment so far did not favor infection. The physician documented the unresponsiveness was likely secondary to heat stroke and the seizure-like activity could have caused the unresponsiveness, but unresponsiveness seemed to be very prolonged. The last problem noted by the physician was acute kidney injury. The Plan was for Resident #1 to be admitted to ICU, IV normal saline at 125 milliliters (ml) per hour, continuous EEG monitoring, Dilantin 300 mg daily IV since resident cannot take medications by mouth, Neurology consult and hold antibiotics for now due to no leukocytosis and no clear source of infection.

The hospital discharge summary dated 07/03/19 revealed Resident #1 was stabilized over the next 3 days and was discharged back to the facility on 07/03/19. His primary diagnoses were unresponsiveness with associated diagnoses of seizure-like activity and acute hypoxemic respiratory failure. The resident was discharged on Dilantin and was to continue on Lamictal and Topomax as previously ordered. Resident #1 was discharged back to the facility at 6:27 PM on 07/03/19 via EMS.

Observation on 07/09/19 at 9:15 AM of Resident #1 revealed him lying in bed resting with his eyes closed.

Observation on 07/09/19 at 1:00 PM of Resident #1 revealed him walking with a walker with Physical Therapy Assistant (PTA) with wheelchair being rolled behind him.

Observation on 07/09/19 at 3:00 PM of Resident

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#1 revealed him in the gym with Physical Therapy working on a machine to strengthen his arms.

An interview on 07/09/19 at 4:30 PM was attempted with the resident; however, he did not recall anything about the incident.

An interview on 07/09/19 at 5:00 PM with the Administrator revealed she was aware of the incident with Resident #1 on 06/29/19 and stated her investigation was unable to determine how Resident #1 got out into the courtyard, but stated she suspected he followed a staff member out the door without the staff member realizing the door had not closed. The Administrator provided copies of her complete investigation. The root cause analysis was determined to be the resident's underlying medical conditions, including a urinary tract infection (UTI) and seizure disorder. The Management Team and Quality Assurance/Process Improvement (QAPI) recommended: a proactive in-service be presented to staff, to residents playing Bingo, to resident council, and to families during the next family meeting on hydration to residents and frequent monitoring of residents outside during periods of inclement weather including increased temperatures. A Process Improvement Plan was put into place with updates to be made at upcoming meetings as necessary. An in-service was conducted on 07/01/19 with staff present in the building on hydration to residents and frequent monitoring of residents outside during periods of inclement weather including increased temperatures - 38 of 137 staff members were educated. On 07/02/19 an in-service was conducted on the Rose Dining Room door being kept locked. Staff was instructed not to let any resident out without first checking with their nurse

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- 38 of 137 staff members were educated. The Administrator stated it was her expectation that staff be aware of any resident out in the courtyard and monitor them and assure they are properly hydrated.

A telephone interview on 07/09/19 at 5:26 PM with the MD revealed he was aware of the incident with Resident #1. The MD stated apparently the resident went outside for a period of time and normally this would not have been a problem except no one was aware that he had gone outside. The MD stated any time any of the residents were outside, he would expect the staff to be aware and monitor the time they are outside and make sure they had something to drink. The MD stated Resident #1 had a history of seizures and had been on an antibiotic for at least 48 hours for a urinary tract infection (UTI). The MD stated this particular antibiotic (Cipro) could have lowered Resident #1's threshold for seizure activity. The MD stated this along with his overall poor health and the heat exposure more than likely contributed to him having seizure activity. The MD stated it was his understanding the staff at the facility had not witnessed any seizure activity and this had not occurred until he was in the ED at the first hospital. He stated in his experience, all factors could have contributed to the seizure activity noted at the first hospital. The MD also stated in his experience a heat stroke takes a longer time to normalize body temperature than had occurred with Resident #1. He stated his body temperature returned to normal much quicker than residents he had seen with heat stroke but stated it was probably the logical answer for his unexplained fever as he had no symptoms of an infection. The MD stated he had examined the resident on 07/08/19 and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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stated that he was up in the wheelchair, and had the same cognitive deficits, communication skills and looked exactly the same as prior to the incident. He stated Resident #1 had not suffered any new deficits as a result of the incident.

A review of the weather conditions per Weather Underground web site revealed the following data for Charlotte, North Carolina (NC) on 06/29/19 at 11:00 AM to 12:30 PM: sunny and 90 degrees Fahrenheit (F) with wind at 6 miles per hour in south southwest direction and no precipitation.

The Administrator was informed of Immediate Jeopardy on 07/10/19 at 1:41 PM.

On 07/12/19 the facility provided the following Credible Allegation of Compliance:

Removal Plan
7/11/19
Supervision to prevent accidents

1. Identify the residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of non-compliance:
6/29/19 at 11am Resident #1 was assisted to Rose dining room by facility staff.
6/29/19 prior to meal trays being delivered in Rose dining room a CNA observed Resident #1 outside in the enclosed courtyard sitting at a table outside of the Rose dining room.

6/29/19 at approximately 12:28pm Resident #1 was observed by additional staff outside in enclosed courtyard outside Rose dining room sitting in wheelchair at a table. Resident #1 was noted by staff member to be leaning more to side.

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	345142	A. BUILDING _____ B. WING _____	C 07/12/2019

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Per staff interviews resident was not verbal but eyes open when observed. Vital signs not obtained by CNA staff while resident was outside.

6/29/19 at approximately 12:30pm two staff nursing assistants assisted Resident #1 in his wheelchair to the resident's room.

6/29/19 at approximately 12:32pm the staff nurse assessed Resident #1, clothing was partially removed by staff and cool compress (towel) applied. Nurse assessment revealed resident was responding and drinking sips of water. Emergency services (medics) were already in the facility for an unrelated issue; and were asked by facility staff to evaluate Resident # 1. Nurse was unable to obtain vital signs before medics arrived in room to evaluate Resident #1. CNA staff were present with medics when nurse exited resident room to notify physician.

6/29/19 at approximately 12:33pm, while medics were present, the nurse contacted Resident #1's physician. The physician gave an order to transfer Resident #1 to the hospital for evaluation.

6/29/19 emergency medical services (EMS) that were dispatched at 12:55pm were in addition to initial emergency services who were already onsite. The additional emergency services team arrived at facility at 1:07pm and departed with Resident #1 at 1:21pm.

6/29/19 per ED documentation Resident #1's initial assessment shows: a tympanic temperature of 98.9 F, heart rate of 111, blood pressure of 93/74 (within normal range for the resident), 100% SpO2, with active seizure activity at 1:31pm, and pacemaker at end of battery life.

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The emergency room treatment was initiated based on the EMS report of temporal temperature (skin) of 105 F and the resident presenting symptoms of active seizure activity (lasting less than 9 minutes). Resident #1 was provided with intravenous fluid, and oxygen for respiration drive after provided with Ativan for seizures.

6/29/19 6:26pm Resident #1 was subsequently transferred to another acute care hospital for neurology monitoring (EEG) and in-depth evaluation as this was not available at the facility housing the emergency room.

All residents that utilize the courtyard (which has the potential to be any resident not in the memory care unit) have the potential to be affected by a heat related stress event during times of elevated environmental temperatures in the outside courtyard area. But on 6/29/19, the day of incident with Resident # 1, no other residents were observed outside in the courtyard at 12:38pm by facility staff.

2. Specify the action taken to alter the process or system failure to prevent a serious adverse event from occurring or reoccurring, and when the action will be complete.

On 7/1/19 the director of nursing started a proactive in-service for staff of all departments on hydration (fluids will be present in courtyard) and frequent monitoring of residents outside. C.N.A.s and nurses will check residents on their assignment during each round, including residents who are in the courtyard. An administrative staff member will check the courtyard three time daily. This in-service was

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started as a proactive reminder to staff to provide hydration to residents outside to encourage hydration status. This in-service was completed on 7/10/19 by in- person in-servicing or by mail. If in-service was mailed the staff member must compete a quiz and return prior to working to validate competency. This in-service was added to the orientation for new staff on 7/10/19 by the administrator.

On 7/10/19 the facility implemented hydration station in the courtyard. The dietary manager or dietary aide will provide fresh ice and fluids to the hydration station. The hydration station allows for access to fluid for residents utilizing the courtyard. Fluids will be contained in a cooler. Residents who cannot physically access fluids at the hydration station will be assisted by staff.

On 7/11/19 the facility placed four large patio umbrellas in the courtyard and two canopies in the courtyard to provide additional shade for resident safety to decrease the risk of heat related stress by addressing a risk factor in heat related stress.

On 7/11/19 the staff facilitator initiated an in-service for staff of all departments on signs and symptoms of heat related stress, preventive actions to prevent heat related stress and actions to take if they note a resident with possible heat related stress change. This in-service was completed on 7/11/19 by in-person in-servicing or by mail on 7/11/19 (2nd mailing). If the in-service was mailed, the staff member must complete the included quiz to prove competence and return the quiz prior to their next scheduled shift. On 7/11/19 the administrator added the in-service to the new staff orientation for staff of all departments. The

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facility's expectation of staff for a cognitively impaired resident who is taken outside or propels outside to the courtyard is:

1. Follow the residents' plan of care/care guide;
2. Honor resident rights and choices;
3. Offer hydration and shade;
4. Provide supervision to prevent accidents.

No staff will be allowed to work after 7/11/19 without in-service completion by phone, in-person, or satisfactory completion of mailed quiz. The quizzes are monitored and graded by the director of nursing, assistant director of nursing and the staff facilitator. Residents will be monitored during routine rounds by facility staff and more frequently based on the resident's current needs and preferences.

On 7/11/19 facility staff members educated residents one on one and in small groups on heat stress, heat related stress prevention, and heat related stress risk factors. This education was also provided on 7/11/19 to family members via telephone or in person.
On 7/11/19 facility staff members posted educational posters in visible places throughout the facility and courtyard to provide families and residents visual reminders of education they received on heat stress, heat related stress prevention, and heat related stress risk factors.
The education will also be presented to the resident council on 7/22/19 and the family council on 7/16/19. A complete mailing of the education material to all resident representatives was completed on 7/11/19.
University Place Nursing & Rehab alleges removal of immediate jeopardy as of 7/11/19.

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F 689	Continued From page 16 The credible allegation was verified on 07/12/19 at 1:45 PM as evidenced by observations and interviews. Observations revealed canopies and patio umbrellas placed in the courtyards. (There were 2 canopies and 4 patio umbrellas in the main courtyard and 1 patio umbrella in the smoker's courtyard). Each courtyard had a cooler with bottled water available. Staff checked on residents and offered them fluids. Signage which listed warnings and interventions to avoid extreme heat were posted on the front doors and courtyard doors. Resident and family member interviews revealed receipt of information regarding heat stress and hydration. Staff interviews revealed receipt of training regarding hydration needs, symptoms of heat stress and implementation of interventions to prevent heat stress. Staff reported residents received regular checks and hydration passes. Review of the training records and copies of mailed information revealed staff members and responsible persons received heat stress information and those mailed were informed they would have to complete education prior to their next scheduled work day.	F 689		