STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155797		06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00200175. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00200175 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F224, F241, F281, F282, F309, F323, F441, F490, F514. Survey dates: June 8, 9, 10, 11, 12, 13, 14, and 15, 2016 Facility number: 012854 Provider number: 155797 AIM number: 201104690 Census bed type: SNF: 20 SNF/NF: 36 Residential: 27 Total: 83 Census payor type: Medicare: 16 Medicaid: 23 Other: 17 Total: 56	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on June 21, 2016.			
F 0157 SS=K Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or			

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	roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to notify the physician of significant changes in resident conditions in a timely manner for 4 of 5 residents reviewed for notification of change. This deficient practice resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 3 residents (Residents D, E, and F). This Immediate Jeopardy began on 11/21/2015 when the facility failed to assess vital signs for a period between 11/20/2015 at 9:37 a.m. and 11/22/2015 at 6:51 a.m. and a 5.2 pound weight gain between 11/22/2015 and 11/23/2015 was not reported to the physician and was identified on 6/10/2016. The Executive Director, Assistant Director of Health Services, the Interim Director of Health Services, Clinical Support RN # 1, Clinical Support RN # 2, and the Medical Records Coordinator were notified of the Immediate Jeopardy at 1:42 p.m. on	F 0157	It is the practice of Aspen Place Health Campus to use resources effectively and efficiently to attain or maintain the highest practicable physical, mental & psychosocial well-being of each resident. F157: Failure to notify the physician of significant changes in the resident conditions in a timely manner for 4 of 5 residents reviewed for notification of change. The deficient practice resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 3 residents (Residents D, E, and F) · Resident B was discharged from the facility · Resident F expired on 6/12/16 · Resident D discharged from facility 6/14/2016 · Resident E assessed & md & family notified. · All residents have the potential to be effected · All residents with CHF were assessed to ensure current pulmonary status was captured and MD notified immediately of anyone with adventitious breath sounds, edema, or weight change per policy, and care plans where reviewedby 6/11/2016. · Director	06/29/2016

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	6/10/2016. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate Jeopardy . 1. Resident B's closed clinical record was reviewed on 6/8/2016 at 11:10 a.m. Diagnoses included, but were not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, hypertension, urinary retention, and localized edema. Resident B's Skilled Charting - Admission Assessment, dated 11/10/2015 at 11:22 p.m., indicated the resident was alert and oriented to person, place, time and situation, did not have difficulty sleeping at night, did not use oxygen, denied shortness of breath, and did not have anxiety present. The assessment indicated Resident B's respirations were regular and unlabored, he did not have a cough, and lung sounds were clear in all fields. The resident had 1 + pitting edema in his left and right lower extremities. The resident had a Foley catheter and no urinary symptoms. The resident denied pain. Initial Nutrition Plan of Care indicated, "observe weight...daily...Vitals: Pulse:		of Health Services, Assistant Director of Health Services, Unit Manager, Med Records Nurse, staffing nurse, and floor nurse did assess all current residents on campus to ensure no changes in condition by 6/11/2016 · All changes discovered upon assessment were reported to the MD and family, changes were documented, appropriate orders obtained and resident was added to pertinent charting for follow-up. · All Nurses (RN, LPN) were educated prior to working the floor, on head to toe assessment, identifying and documenting change in condition, notifying MD and family of changes as well as follow up documentation on any change in condition by 6/11/2016, and a pre and post test on critical thinking questions on several clinical pathways was completed. All licensed nurses were also required to take a pre and post test on critical thinking questions, related to several clinical pathways prior to working the floor starting 6/11/2016 educated on prior to working the floor. All licensed nurses were educated prior to working the floor on skilled documentation & notifying on call nurse, MD & family notification of any change of condition by 6/12/2016. In addition a list of all licensed nurses has been developed and no nurse will be allowed to work the floor without completing this	

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	67/per minute. Respirations 20/per minute. Blood Pressure: 146/77. O2 Saturation: 95%. Activity: Resting...Oxygen Use: No...." Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on 11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015. Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked or the physician was notified. Resident B's Physician Order Report for 11/10/2015 to 12/6/2015 indicated, "Start Date: 11/16/2015: check weight daily. Once a day; p.m...Fluid restriction of 1500 ml per day...Foley cath output every shift...."		education prior to assuming the floor. 100 % of all licensed nurses have been in serviced as of 6/29/16. · Director Health Services, Assistant Director Health Services, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by Director Health Services, Assistant Director Health Services or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy. · The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee. QA will occur weekly X 4 weeks and then monthly thereafter.	

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	A Progress Note for Resident B, dated 11/21/2015 at 1:45 p.m., indicated, "Resident has 3+ swelling to bilateral feet, Resident in recliner with feet elevated." A Progress Note for Resident B, dated 11/22/2015 at 11:41 p.m., indicated, "Resident continues to have bilateral lower leg edema..." There were no additional assessments, events, or physician notification related to these progress notes dated 11/21-22/2015. Resident B's Urine Output Record indicated the following: 12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the decreased urine output. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He			

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	c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L], tried repeatedly to have him do pursed lip breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhilation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the pursed lip breathing several times. Increased the O2 to 3.5L via nasal canula [sic]. Resident is very anxious...has not slept all night." There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's physician being notified of his shortness of breath and rapid mouth breathing on 12/4/2015. On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow: 2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated, "Resident frequently c/o shortness of			

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	breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure 191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated, "Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood pressure] and			

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	increase in respirations as well." There were no Progress Notes, Events, or other evidence in the record to indicate the physician or family were notified of the resident's change in condition on 12/6/2015. Resident B's Clinical Documents Progress Note (Hospital 2), dated 12/11/2015, indicated, "...History of present illness: ...recently here...between the dates of 11/5/2015 through 11/10/2015 for acute kidney injury superimposed on chronic kidney disease. He also had issues with systolic heart failure during that time. On discharge...as [renal function] improved patient gradually developed worsening weight gain and fluid retention. He presented to [Hospital 1] 12/7 [sic]/2015 and was diuresed...Unfortunately with aggressive diuresis at that time his creatinine continued to steadily increase...Assessment/Plan: 1. Acute kidney injury on chronic kidney disease stage 3-4. This is most likely in relation to requirements for aggressive diuresis in light of his issues with CHF exacerbation...2. Acute exacerbation on chronic systolic congestive heart failure...." Nephrology Clinical Consultation			

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	(Hospital 2), dated 12/12/2015, indicated, "...Assessment/Plan: ...had diuresis [forced urine output with diuretic] just over 2L [at Hospital 1] given his fairly massive volume expansion....Acutely decompensated systolic congestive heart failure. Resident B was discharged to Hospice on 12/18/2015 and expired 12/24/2015. Discharge Diagnoses indicated, "1. Acute kidney failure, unspecified. 2. Acute on chronic systolic (congestive heart failure. 3. Chronic obstructive pulmonary disease with (acute) exacerbation...." A Care Plan for Resident B indicated, "Problem Start Date: 11/23/2015. I am at risk for alteration in fluid balance related to my having a fluid restriction and my diagnosis of CKD [chronic kidney disease] with recent ARF [acute renal failure]. Approach Start Date: 11/23/2015...Observe me for s/s [signs/symptoms] fluid overload such as edema, distended neck veins, edema. Notify my MD as needed...Weigh resident as ordered." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have a diagnosis of congestive heart failure, HTN [hypertension]...Approach: ...Monitor me for fluid excess (wt. gain,			

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	increased BP, full/bounding pulse, jugular vein distention, SOB [shortness of breath], rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...Please monitor me and report signs of respiratory distress (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse..." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have COPD/Emphysema...Approach: My care givers will monitor my lung sounds daily. My care givers will observe me for changes in my breathing or level of consciousness and report to my doctor...." Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated that monitoring for fluid overload would include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be			

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	notified of a 5 pound weight gain in one day. On 6/9/2015 at 4:25 p.m., the Interim Director of Health Services (DHS) indicated the facility relied on "best practices" to direct nursing staff when to notify the physician of changes. The Assistant Director of Health Services (ADHS) was interviewed on 6/9/2016 at 4:31 p.m. regarding the policy and procedure related to documenting and reporting changes in condition, events, and monitoring for fluid overload. She indicated there were no policies and procedures. The ADHS indicated, "That's nursing judgement...." On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) provided a current copy of [facility] Guide to Event Notification Critical Thinking. She indicated that when changes in condition are observed, an "event" is initiated. She indicated that "artificial intelligence" indicated to the nursing staff when to notify the physician. The CNO indicated a section of the document which was circled and indicated the residents reviewed did not meet any of the criteria related to edema. The circled documentation indicated, "New Onset Edema Event. Notification Guidelines.			

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	Notify MD/NP immediately...for any of the following...Abrupt pt onset of edema in one leg with loss of sensation. Abrupt onset edema with tenderness and redness. Edema with sudden onset of shortness of breath, and/or chest pain." The notification guideline not circled by the CNO indicated, "Weight gain of 3 or more pounds in last 7 days." On 6/10/2015 at 10:06 a.m., CNC #2 indicated the facility did not have a specific policy or procedure related to change in condition. The CNC provided a current copy of [Facility] Guide to Events, which was reviewed at that time. The document indicated, "...Category of Observation: Cardiovascular. Event Name: ...New Onset Edema. Possible Reasons: Increased Or New Edema...Category of Observation: ...Other Events: ...Event Name: Other Physical Changes in Condition: Possible Reasons: Non-specified physical changes...Category of Observation: Respiratory/EENT: Event Name: Respiratory: Possible Reasons: Breathing/Respiration Changes..." On 6/8/2016 at 4:15 p.m., the ADHS was queried regarding the new onset/new documentation of Resident B's 3 + pitting edema on 11/21/2015 at 1:45 p.m. (above) and why event/change in			

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	condition documentation was not initiated or the physician notified of the change. The ADHS indicated, "It [edema] depends on other factors. It could just be the time of day." On 6/8/2016 at 4:36 p.m., the ADHS provided a copy of the current Physician Notification of Diagnostic Testing and Change in Condition Policy and Procedure and it was reviewed at that time. The document indicated, "Purpose: To ensure the...physician is aware of all...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure: 1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known....10. Attempts to notify the physician and their response should be documented in the resident record...." 2. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, Alzheimer's disease, hypertension, and localized edema. Resident F was admitted to the facility on			

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	6/5/2016 following hospitalization for a fecal transplant. The resident was admitted to Hospice on 6/9/2016 and expired on 6/12/16. Resident F's Admission Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place..." On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events, changes in condition, or physician notification associated with this abnormal value. A Progress Note for Resident F, dated 6/7/2016 at 1:20 p.m., indicated, New order received...to send Resident to ER to be evaluated for decreased appetite and difficulty swallowing. Family member...very concerned about Resident's current state of health and would like her sent to ER for eval [evaluation]." A Progress Note for Resident F, dated 6/7/2016 at 6:20 p.m., indicated, "resident returned from emergency room with peripheral IV [PIV] in left wrist. no s/s			

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	[signs/symptoms] infiltration noted. has normal saline running at 100 cc per hour for dehydration...is oriented to person and place. alert. asking for television to be turned on the news...nonpitting edema noted in both hands. 2-3+ pitting edema noted in bilateral legs...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat." Resident F's Progress Note, dated 6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%." A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request."			

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	There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was discontinued. On 6/9/2016 at 3:25 p.m., Certified Nursing Assistant (CNA) # 14 indicated that, prior to this date, Resident F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. CNA # 10 was interviewed on 6/9/2016 at 9:50 a.m. She indicated, "[Resident F has] been in the hospital. They sent her out yesterday because she was unresponsive. She had an IV for dehydration, but it wasn't working. It caused her to swell up like a balloon...." Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't			

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	waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON, DON, Executive Director (ED) indicated they were not aware Resident F had been unresponsive or her IV had infiltrated. Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably			

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	should have called the on-call...Her swelling was terrible...a lot of third spacing...her legs, her feet, all over. Her skin was cool...." 3. Resident E was interviewed on 6/8/2016 at 3:12 p.m. The resident was observed wearing cotton athletic socks and open sandals with 3+ edema in his bilateral lower ankles and feet. He was sitting up with his legs (hanging down) in his wheelchair. The resident indicated he had occasional lower extremity edema/swelling at baseline, but worsening edema since he had been in the facility. The resident indicated he had notified staff he was concerned regarding his increased edema in recent weeks. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery. Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers			

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	and bed mobility. Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated, "Edema present: Yes. Vitals: Pulse: 96/per minute. Respirations: 18 per minute. Blood Pressure: 138/83 mmHg...." Resident E's recorded weights were as follows: 4/2/2016: 172.6 pounds 4/3/2016: 172.3 pounds 4/10/2016: 176.4 pounds 5/11/2016: 184.2 pounds There was no evidence anywhere in Resident E's clinical record that the physician was notified related to Resident E's weight gain or lower extremity edema.. On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]." There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was done, or the physician was notified. A Progress Note for Resident E, dated 5/30/2016, indicated the resident was			

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	"extremely edematous" with no additional values/assessments/comparisons related to the edema, vital signs, or respiratory assessments. There was no evidence the physician was notified. A Care Plan, initiated 4/20/2016, indicated, "Problem: High Risk Medications. I have potential for decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure...." On 6/10/2016 at 3:46 p.m., the DHS indicated resident alerts abnormal vital signs (highlighted in red) go the the DHS in the form of "messages." On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure (above). 4. Resident D's clinical record was reviewed on 6/9/2016 at 2:15 p.m. Diagnoses included, but not limited to, COPD, CHF, acute kidney failure, and recent foot fracture. The resident was admitted to the facility			

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	3/7/2016 for rehabilitation following a foot fracture. Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." Resident D's Admission Nursing Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift... Cardiovascular: Heart Rate: irregular...Edema present: Yes. Location of edema: Right upper extremity. Other: lyphedema /t radical mastectomy. Left leg edema: [blank]. Right leg edema: [blank]...Initial Cardiovascular Plan of Care: ...Pacemaker checks...." Resident D's documented weights indicated the following significant weight gains: 3/07/2016 - 3/09/2016: 26 pound gain.			

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	(no weight check 3/8/2016) 3/23/2016 - 3/24/2016: 5.6 pound gain. 4/10/2016 - 4/11/2016: 100.8 pound gain 4/29/2016 - 4/30/2016: 5.5 pound gain 5/02/2016 - 5/03/2016: 5.2 pound gain 5/10/2016 - 5/12/2016: 7.8 pound gain (no weight check 5/11/2016) 5/31/2016 - 6/01/2016: 7.8 pound gain There was no documentation of verification of weights, re-weights, or physician notification of change related to weight gain. A current Care Plan for Resident D indicated, "Problem: I have a diagnosis/history of congestive heart failure...Approach: Administer oxygen at 2L Q HS, PRN....Monitor me for fluid excess (wt. gain, increased BP; full/bounding pulse...SOB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...." A current Care Plan for Resident D indicated, "Problem: I have COPD...Approach: My care givers will monitor my lung sounds as indicated. My care givers will monitor my 02 sat..." A current Care Plan for Resident D indicated, "Problem: I have a			

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	pacemaker...Approach: Please monitor my apical pulse as needed and report abnormalities to my physician...." Resident D was observed to have 3+ edema to bilateral lower extremities during random observations on 06/08, 06/09 and 06/10/2016. The ADHS was interviewed on 6/9/2016 at 4:12 p.m. regarding Resident D's 100.8 pound gain between 4/10/2016 and 4/11/2016. She indicated, "It was probably an error. She probably should have had a re-weight." The ADHS indicated that "best practices" for reporting weight gain in residents being monitored for fluid overload or CHF would be 3 pounds in a day or 5 pounds in a week. Resident D was interviewed 6/10/2016 at 4:10 p.m. She indicated her lower extremity edema had been worse since she had been in the facility and more so over the past two weeks. On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Resident D's weight changes were related to transcription errors and that the resident's admission weight was incorrect.			

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	On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Residents B, D, E and F were cognitively intact and could alert staff of any changes in condition. On 6/15/2016 at 6:12 p.m., CNC # 2 indicated if a resident experienced a change in condition, the physician should be notified. A copy of the current Vital Signs Guidelines Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. and it was reviewed at that time. The document indicated, "Purpose: To document and track vital signs to monitor changes in condition...Procedure: 1. Vital signs will be taken at the following times: ...c. Change in condition...e. Per physician order...4. The physician will be notified of a significant change in vitals...5. The nurse shall utilize critical think [sic] skills and nursing assessments/evaluation of vital signs to monitor resident condition." A copy of the current Guidelines for Change in Resident Condition Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. The document indicated, "Purpose: To identify resident changes in condition...reassess the resident's risk factors, evaluate the current			

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	care plan interventions for effectiveness and select additional interventions if required. Policy: 1. Upon assessment of resident change in condition, the ...nurse will initiate the appropriate 'Event' ...in order to fully reflect and document the nursing process...3. Notification of the resident physician and responsible party will be documented...." A copy of the current Guidelines for Lung Auscultation Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 6:12 p.m. The document indicated, "Purpose: To evaluate the air flow through the lungs, presence of fluid or mucus and determine the condition of the lungs...Procedure: 7. A complete assessment should be performed...8. Diminished or absent sounds indicate inability to ventilate the lungs sufficiently...9. Wheezing indicates bronchospasms. 10: Rhonchi and crackles indicate ineffective secretion clearance...15. Document the results...16. Notify the physician and family of and [sic] change in condition." A current copy of the Guidelines for Acute Care Transfer Policy and Procedure was provided by the ED on 6/9/2016 at 1:35 p.m. and reviewed at that time. The document indicated, "Purpose: To ensure residents are			

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	provided with the appropriate care setting for adequate treatment. Procedure: 1. A thorough assessment shall be completed when a change in resident condition is noted. 2. Assessment information shall be communicated to the attending/on-call physician...." A copy of the current Guidelines for Administration of Oxygen Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 5:55 p.m. The document indicated, "Procedure: 1. Verify physician's order for the procedure...9. Before administering emergency oxygen...asses for the following: b. Signs or symptoms of hypoxia (i.e. rapid breathing, rapid pulse rate, restlessness, confusion); c. Signs or symptoms of oxygen toxicity (i.e. ...difficulty breathing, or...shallow rate of breathing); d. Vital signs; e. Lung sounds...." The Immediate Jeopardy that began on 11/21/2015 was removed on 6/13/2016 when the facility completed resident assessments and staff education on identifying and documenting change in condition, following physician orders, notifying MD and family of changes, follow up documentation on any resident change in condition, and resident positioning. The Immediate Jeopardy was removed on 6/11/2016, but			

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	noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on identifying and documenting change in condition, following physician orders, notifying MD and family of changes, follow up documentation on any resident change in condition, and resident positioning. This Federal tag relates to Complaint IN00200175. 3.1-5(a)(2)			

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F 0224 SS=K Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview, the facility failed to ensure effective monitoring and interventions to prevent a delay in medical care and /or hospitalization for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4 residents (Residents C, D, E, and F). This Immediate Jeopardy began on 11/21/2015 when the facility failed to monitor/assess vital signs for a period between 11/20/2015 at 9:37 a.m. and 11/22/2015 at 6:51 a.m. and a 5.2 pound weight gain between 11/22/2015 and 11/23/2015 was not reported to the physician and was identified on 6/10/2016. The Executive Director, Assistant Director of Health Services, the Interim Director of Health Services,	F 0224	F224: Failure to ensure effective monitoring and interventions to prevent a delay in medical care and/or hospitalization for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4 residents (Residents C, D, E and F) · Resident B was discharged from the facility · Resident D discharged from the facility on 6/14/2016 · Resident C & E was assessed and md & family notified · Resident F was discharged from the facility on 6/12/2016 · All residents have the	06/29/2016

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	Clinical Support RN # 1, Clinical Support RN # 2, and the Medical Records Coordinator were notified of the Immediate Jeopardy at 1:42 p.m. on 6/10/2016. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident B's admission Minimum Data Set (MDS) assessment, dated 11/17/2015, indicated a Brief Interview for Mental Status (BIMS) score of 14; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ person physical assist for transfers and was non-ambulatory. The resident had an indwelling Foley catheter and received oxygen therapy. Diagnoses included, but were not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, hypertension, urinary retention, and localized edema. Resident B's Skilled Charting - Admission Assessment, dated 11/10/2015 at 11:22 p.m., indicated the		potential to be effected. · All residents with CHF were assessed to ensure current pulmonary status was captured and MD notified immediately of anyone with adventitious breath sounds, edema, or weight change per policy, and care plans reviewed. · DHS, ADHS, UM, Med Records nurse, staffing nurse, and floor nurse did assess all current residents on campus to ensure no changes in condition. All changes discovered upon assessment were reported to the MD and family, changes were documented, appropriate orders obtained and resident was added to pertinent charting for follow-up. · All Nurses (RN, LPN) were educated on head to toe assessment, identifying and documenting change in condition, notifying MD and family of changes as well as follow up documentation on any change in condition. All nurses were educated and pre	

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	resident was alert and oriented to person, place, time and situation, did not have difficulty sleeping at night, did not use oxygen, denied shortness of breath, and did not have anxiety present. The assessment indicated Resident B's respirations were regular and unlabored, he did not have a cough, and lung sounds were clear in all fields. The resident had 1 + pitting edema in his left and right lower extremities. The resident had a Foley catheter and no urinary symptoms. The resident denied pain. Initial Nutrition Plan of Care indicated, "observe weight...daily...Vitals: Pulse: 67/per minute. Respirations: 20/per minute. Blood Pressure: 146/77. O2 Saturation: 95%. Activity: Resting...Oxygen Use: No...." Hospital Extended Care Admitting Orders for Resident B, dated 11/10/2015 at 2:15 p.m., indicated, "...Diet: 1500 ml [milliliter] fluid restriction]...No Longer Take the Following Medications: ...furosemide [Lasix] 40 mg [milligram] oral tablet, 1 tablet by mouth every day...Discharge Instructions/Patient Education Materials: ...weigh yourself every day, at the same time of day, and in the same kind of clothes. When to call your doctor: Call your doctor right away if you have any of these signs of worsening heart failure: sudden weight		and post test on critical thinking questions on several clinical pathways was completed. All licensed nurses were educated on completing skilled documentation and notifying on call nurse of any change of condition. All licensed nurses were educated prior to working the floor. · DHS, ADHS, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by DHS, ADHS or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment	

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	gain (more than 2 pounds in 1 day or 5 pounds in 1 week, or whatever weight gain you were told by your doctor). Trouble breathing related to not being active. New or increased swelling in your legs or ankles...Breathing trouble at night...." Resident B's Hospital Nephrology Discharge Note, dated 11/10/2015, indicated, "...Chronic SOA [shortness of air] - [at] baseline. Chronic LE [lower extremity] swelling - states at baseline...ext [extremities] trace BLE [edema bilateral lower extremities]...hesitant to start...diuretic for now, but should he develop sig [significant] edema or worsening breathing, a loop diuretic could be restarted...." Resident B's Physician Order Report for 11/10/2015 to 12/6/2015 indicated, "Start Date: 11/16/2015: check weight daily. Once a day; p.m...Fluid restriction of 1500 ml per day...Foley cath output every shift...." Physician's Progress Notes for Resident B, signed by the resident's primary care physician (PCP), dated 11/11/2015 at 4:15 p.m., indicated, "...breathing at baseline...Lungs - CTA [clear to auscultation] B [bilaterally]...Ext		documented x12 weeks then continue to review daily per facility policy. · The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee weekly X 4 weeks and then monthly thereafter. · ADHS or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy. Nursing staff were in serviced on resident positioning including bed height to ensure resident's safety. Rounds will be conducted every shift for 12 weeks and documented	

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	[extremities] - 2+ edema on R [right], 1+ [edema] on L [left]...CHF - stable - monitor for fluid overload. Daily weights." A Progress Note for Resident B, dated 11/21/2015 at 1:45 p.m., indicated, "Resident has 3+ swelling to bilateral feet, Resident in recliner with feet elevated." A Progress Note for Resident B, dated 11/22/2015 at 11:41 p.m., indicated, "Resident continues to have bilateral lower leg edema..." There were no additional assessments, events, or physician notification related to these progress notes dated 11/21-22/2015. Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on 11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015.		with any concerns addressed and corrected immediately with staff re-education	

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	Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked, associated assessments were competed, the physician was notified, or a change of condition/event was initiated. Resident B's Vitals Report indicated his intake of fluids was 1840 ml fluids on 12/3/2015. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L], tried repeatedly to have him do pursed lip breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhilation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the purse d lip breathing several times. Increased the O2 to 3.5 L via nasal canula [sic]. Resident is very anxious...has not slept all night."			

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	On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow: 2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated, "Resident frequently c/o shortness of breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure 191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated,			

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	"Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood pressure] and increase in respirations as well." The following vital signs, dated 12/6/2015 at 8:04 p.m., indicated, "Blood Pressure 152/74 mmHg. Pulse: 66. 02 Saturation: 95%. Resting. Oxygen Use: Yes - Liter Flow: 3.5 Liter. Activity: Low. Respirations: 26/minute. Resting." A Progress Note for Resident B, dated 12/6/2015 at 7:48 p.m., indicated, "Res. [resident] c/o SOB [shortness of breath], SpO2 recorded at 88%/3L/NC [liter/nasal cannula]. Assessment revealed oxygen tubing had beside [sic] table sitting on it, Resident's w/c was also parked on top of and crushing the oxygen tubing. Additionally the oxygen line had become completely separated the water trap by the w/c rolling over it...new tubing installed...saturations hold steady at 95%...."			

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	A Progress Note for Resident B, dated 12/6/2015 at 7:58 p.m., indicated, "Res. stated he feels "like I need to go to the hospital." Res. spoke with [family member] on the phone and states his [family member] is on the way here. Assessment completed (See vitals)." There was no evidence of an assessment related to this Progress Note anywhere in Resident B's record. A Progress Note for Resident B, dated 12/6/2015 at 8:21 p.m., indicated, "Res POA [family member] arrived at the facility...POA states he wants the resident to go to the ER [emergency room]...N.O. [new order]...to send to...ER for eval and Tx." There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's respiratory status being assessed (lung sounds), shortness of air, or edema being assessed, or the physician or family being notified on 12/4/2015, 12/5/2015 or 12/6, 2015 prior to the POA's (family member) request for the resident to be sent to the hospital. There was no evidence of, and facility staff were unable to provide any evidence of skilled charting or nursing assessments for Resident B on November 14, 21 or			

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	25, 2015 or December 2 or 5, 2015. Resident B's skilled nursing assessment documentation from 11/10/2015 through 12/6/2015 routinely indicated the resident was on a diuretic and had no side effects as a result of that diuretic. Daily skilled nursing assessment documentation routinely did not address/left blank edema and/or lung sounds. There were no additional events or progress notes related to resident assessment of lung sounds, edema, or physician notification. The last documented breath sounds for Resident B were 12/1/2015 at 11:09 a.m., which indicated, "CTA [clear to auscultation]." Resident B's Urine Output Record indicated the following: 12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the			

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	decreased urine output. The resident had no evidence anywhere in the Medication Administration Record (MAR) or Treatment Administration Record (TAR) that lung sounds were assessed related to small volume nebulizer treatments. Resident B's Emergency Medical Services (EMS) Ambulance Report, dated 12/6/2015, indicated they were dispatched at 8:38 p.m., arrived at the facility at 8:42 p.m., and arrived at the Emergency Department at 9:04 p.m. The report indicated, "Pt [patient] is shorter of breath than normal...pt with obvious edema globally...Respiratory: Effort: Distressed. Sounds: L: Diminished bases. R: Diminished bases. Oxygen: 3.5 lpm via NC Healthcare Provider [facility]...." EMS records indicated the resident did not receive any intravenous fluids or diuretic medication en route to the Emergency Department. Resident B's Emergency Room Record, dated 12/6/2015 at 9:10 p.m., indicated, "CC [chief complaint]: [up arrow] SOB, edema x 3 days. Location: chest/respiratory...Severity: severe. Duration: last 2-3 days. Timing: Constant...Associated signs: leg swelling...CXR [chest x-ray]:			

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	CHF...Diagnosis; exacerbation CHF, CRF...." A Hospital Emergency Department Primary Nursing Assessment for Resident B, dated 12/6/2015, indicated, "...Respiratory: Labored, Dyspnea,Increased rate, Cough - moist/nonproductive. Breath sounds: Left: Rhonchi, wheezing. Right: Rhonchi, wheezing...Peripheral edema: Feet, Ankles 4+...Neurological: Alert. Oriented x 3. Anxious...Nursing Problem List: 1. SOB [shortness of breath]. 2. Edema...2106 [9:06 p.m.] pt sent from [facility]...increased SOB, along with edema for 3 days, report states it is increasingly getting worse. Pt. has 4+ pitting edema...." A Care Plan for Resident B indicated, "Problem Start Date: 11/23/2015. I am at risk for alteration in fluid balance related to my having a fluid restriction and my diagnosis of CKD [chronic kidney disease] with recent ARF [acute renal failure]. Approach Start Date: 11/23/2015. Assist with fluids as needed...Observe me for s/s [signs/symptoms] fluid overload such as edema, distended neck veins, edema. Notify my MD as needed...Weigh resident as ordered."			

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	A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have a diagnosis of congestive heart failure, HTN [hypertension]...Approach: Administer oxygen as ordered. Monitor me for fluid excess (wt. gain, increased BP, full/bounding pulse, jugular vein distention, SOB [shortness of breath], rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...Please monitor me and report signs of respiratory distress (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse. Please monitor my intake of food and fluids...." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have COPD/Emphysema...Approach: My care givers will monitor my lung sounds daily. My care givers will observe me for changes in my breathing or level of consciousness and report to my doctor...." Resident B's Hospital History and Physical Examination (Hospital 1), dated 12/6/2015, indicated, "...He presented to the emergency department with significant shortness of breath and tight lungs. He was admitted with an			

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	exacerbation of his chronic obstructive pulmonary disease and congestive heart failure, diuresed, and states he is starting to feel better already...." Resident B's Cardiology Consultation (Hospital 1), dated 12/7/2015, indicated, "...The patient had been doing relatively well and participating in rehab at [facility]. In the last 3 to 4 days, he started having some increasing shortness of breath and noted some ankle swelling. Yesterday, he became orthopneic with PND [paroxysmal nocturnal dyspnea] and had shortness of breath at rest...came to the emergency department where he was found to have evidence of heart failure. He has received IV [intravenous] Lasix and is already feeling improved...." Hospital 1 documentation indicated the resident required on-going Nephrology consultation/care and was transferred/admitted to Hospital 2 on 12/11/2015. Resident B's Clinical Documents Progress Note (Hospital 2), dated 12/11/2015, indicated, "...History of present illness: ...recently here...between the dates of 11/5/2015 through 11/10/2015 for acute kidney injury superimposed on chronic kidney disease. He also had issues with systolic heart			

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	failure during that time. On discharge...as [renal function] improved patient gradually developed worsening weight gain and fluid retention. He presented to [Hospital 1] 12/7 [sic]/2015 and was diuresed...Unfortunately with aggressive diuresis at that time his creatinine continued to steadily increase...Assessment/Plan: 1. Acute kidney injury on chronic kidney disease stage 3-4. This is most likely in relation to requirements for aggressive diuresis in light of his issues with CHF exacerbation...2. Acute exacerbation on chronic systolic congestive heart failure...." Nephrology Clinical Consultation (Hospital 2), dated 12/12/2015, indicated, "...Assessment/Plan: ...had diuresis just over 2L [at Hospital 1] given his fairly massive volume expansion....Acutely decompensated systolic congestive heart failure. Resident B was discharged to Hospice on 12/18/2015 and expired 12/24/2015. Discharge Diagnoses indicated, "1. Acute kidney failure, unspecified. 2. Acute on chronic systolic (congestive heart failure. 3. Chronic obstructive pulmonary disease with (acute) exacerbation...." Resident B's [family member], primary			

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	care giver and Power of Attorney (POA), was interviewed on 6/8/2016 at 1:16 p.m. Resident B's [family member] indicated he was not notified that [Resident B] was not on Lasix while he was at the facility and Resident B's [family member] indicated he raised repeated concerns over [Resident B's] increased lower extremity edema and increasing shortness of breath to staff and was told [Resident B] was "fine." Resident B's [family member] indicated the resident and family alerted staff multiple times throughout his stay that his ankles and feet were more swollen than usual and the family took the resident's recliner into him. The [family member] indicated he had never seen [Resident B] with that much swelling. Resident B's [family member] indicated [Resident B] called him 12/6/2015 and indicated to him that he had spent the previous 2 nights and 3 days sitting up in his wheelchair and not in his recliner due to shortness of breath. The [family member] indicated, "He [Resident B] said, 'I felt like I was going to drown if I laid back [in my recliner].'" Resident B's [family member] indicated he was not notified by the facility of [Resident B's] additional increased swelling and increasing shortness of breath 12/3/2015 through 12/6/2015. He indicated [Resident B] called him related to his decline and he requested his			

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	physician be called and he be sent to the emergency room for evaluation on 12/6/2015. Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated that monitoring for fluid overload would include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be notified of a 5 pound weight gain in one day. Licensed Practical Nurse (LPN) # 2 was interviewed on 6/8/2016 at 3:06 p.m. He indicated he cared for Resident B periodically and was on duty on 12/6/2016 when Resident B was sent to the Emergency Department. LPN # 2 indicated, "[Resident B] was just not doing good...he wasn't in good condition. He had swelling issues." LPN # 2 indicated, "If [a resident's] sats are not doing well, we [nursing] would put on our report sheet and in [resident] progress notes." LPN # 2 indicated daily assessments and documentation were			

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	based on the resident's primary admitting diagnosis. Regarding monitoring for fluid overload, weight fluctuations, and edema, LPN # 2 indicated the physician would order parameters regarding notification. The LPN indicated, "If the weight exceeds the parameters, I would send a fax...unless it says call." LPN # 2 indicated, "The staff would catch a 5 pound weight gain in a day...if there's a change [in resident condition] from the norm, I don't know if that would be an event, but I would let somebody know. I would just do a progress note." The Interim Director of Health Services (DHS) and the Assistant Director of Health Services (ADHS) were interviewed on 6/8/2016 at 4:12 p.m. The Interim DHS indicated that Resident B was being assessed related to his renal failure because that was his admitting diagnoses. The ADHS indicated nursing staff would be charting on the renal diagnoses because that was their "number one concern." The DHS indicated all residents were assessed daily related to their primary admitting diagnosis. She indicated a resident who was admitted for a foot fracture, but had co-morbidities such as COPD, CHF, or kidney failure, would be prompted to do a daily orthopedic assessment. She indicated orthopedic assessments did not			

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	include assessments of edema, breath sounds, or respiratory status. Both the DHS and ADHS indicated there were no policies or procedures related to monitoring for fluid overload, monitoring for changes in condition, documentation or assessment and that they relied on "best [nursing] practices." The Director of Health Services (DHS) was interviewed on 6/9/2015 at 1:50 p.m. regarding expectations for monitoring for fluid overload. The DHS indicated there was no policy and procedure related to edema, monitoring for fluid overload, CHF, or COPD. The DHS indicated, "Just monitor their intake and edema. That's what I would do." On 6/9/2015 at 4:25 p.m., the DHS indicated she "probably would not" document an event or change in condition for a weight change." The DHS indicated the facility relied on "best practices" to direct nursing staff when to do assessments, under what category to document them, and when to notify the physician of changes. The Assistant Director of Health Services (ADHS) was interviewed on 6/9/2016 at 4:31 p.m. regarding the policy and procedure related to documenting and reporting changes in condition, events,			

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	and monitoring for fluid overload. She indicated there were no policies and procedures. The ADHS indicated, "That's nursing judgement whether to do an event, a change in condition, or a progress note." On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) provided a current copy of [facility] Guide to Event Notification Critical Thinking. She indicated that when changes in condition are observed, an "event" is initiated. She indicated that "artificial intelligence" indicated to the nursing staff when to notify the physician. The CNO indicated a section of the document which was circled and indicated the residents reviewed did not meet any of the criteria related to edema. The circled documentation indicated, "New Onset Edema Event. Notification Guidelines. Notify MD/NP immediately...for any of the following...Abrupt pt onset of edema in one leg with loss of sensation. Abrupt onset edema with tenderness and redness. Edema with sudden onset of shortness of breath, and/or chest pain." The notification guideline not circled by the CNO indicated, "Weight gain of 3 or more pounds in last 7 days." On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy			

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	of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident B over the last three months and/or with small volume nebulizer treatments (SVN's). On 6/10/2015 at 10:06 a.m., the CNC indicated the facility did not have a specific policy or procedure related to change in condition. The CNC provided a current copy of [Facility] Guide to Events, which was reviewed at that time. The document indicated, "...Category of Observation: Cardiovascular. Event Name: ...New Onset Edema. Possible Reasons: Increased Or New Edema...Category of Observation: ...Other Events: ...Event Name: Other Physical Changes in Condition: Possible Reasons: Non-specified physical changes...Category of Observation: Respiratory/EENT: Event Name: Respiratory: Possible Reasons:			

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	Breathing/Respiration Changes..." On 6/8/2016 at 4:15 p.m., the ADHS was queried regarding the new onset/new documentation of Resident B's 3 + pitting edema on 11/21/2015 at 1:45 p.m. (above) and why event/change in condition documentation was not initiated or the physician notified of the change. The ADHS indicated, "It [edema] depends on other factors. It could just be the time of day." On 6/8/2016 at 4:25 p.m. the ADHS and DHS provided a copy of the current Guidelines for Weight Tracking Policy and Procedure and it was reviewed at that time. They indicated there were no additional policies or procedures related to weight tracking and/or specific to edema and/or respiratory diagnoses. The Procedure indicated, "...6. The weight should be recorded in the individual resident medical record. 7. Residents who have a weight that seem [sic] out of normal range shall be re-weighed to determine the accuracy of the original weight..." On 6/8/2016 at 4:36 p.m., the ADHS provided a copy of the current Physician Notification of Diagnostic Testing and Change in Condition Policy and Procedure and it was reviewed at that			

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	time. The document indicated, "Purpose: To ensure the...physician is aware of all...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure: 1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known....10. Attempts to notify the physician and their response should be documented in the resident record...." On 6/10/2016 at 4:42 p.m., LPN # 8 indicated she would document any significant change in resident condition in the progress notes. On 6/15/2016 at 5:37 p.m., the CNC # 2 indicated oxygen did not require a physician's order and was a "standing order." 2. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, Alzheimer's disease, hypertension, and localized edema. Resident F was admitted to the facility on 6/5/2016 following hospitalization for a			

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	fecal transplant. The resident was admitted to Hospice on 6/9/2016 and expired on 6/12/16. Resident F's Admission Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place...Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]. Sacral edema: [blank]. Left upper extremity edema: [blank]. Right upper extremity edema: [blank]...Comments: [blank]...." Resident F, who was admitted 6/5/2016 at 3:45 p.m., had no vital signs documented until 6/6/2016 at 3:55 a.m. A Care Plan for Resident F indicated, "I have edema...monitor and record my edema...." A Progress Note for Resident F, dated 6/5/2016 at 3:45 p.m., indicated, "Admitted...alert [and] oriented x 3, mood pleasant...." A Progress Note for Resident F, dated 6/7/2016 at 6:20 p.m., indicated, "resident returned from emergency room with peripheral IV [PIV] in left wrist. no s/s [signs/symptoms] infiltration noted. has			

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	normal saline running at 100 cc per hour for dehydration...is oriented to person and place. alert. asking for television to be turned on the news...nonpitting edema noted in both hands. 2-3+ pitting edema noted in bilateral legs...." The following Progress Note, dated 6/8/2016 at 3:30 a.m., indicated, "...Edema continues...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat." Resident F's Progress Note, dated 6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%."			

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	A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request." On 6/9/2016 at 2:51 p.m., the CNC indicated nursing staff did not have time to complete or document an assessment related to Resident F's change in condition prior to being sent to the Emergency Department on 6/8/2016 at 11:32 a.m. On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events, changes in condition, or physician notification associated with this abnormal value. The next blood pressure assessment was not until 6/7/2016 at 7:07 p.m. There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was discontinued. There was no documentation anywhere in Resident F's clinical record to indicate Resident F's left upper extremity was			

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	assessed following the 6/8/2016 at 6:46 a.m. progress note. On 6/9/2016 at 3:25 p.m., CNA # 14 indicated that, prior to this date, Resident F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. CNA # 10 was interviewed on 6/9/2016 at 9:50 a.m. She indicated, "[Resident F has] been in the hospital. They sent her out yesterday because she was unresponsive. She had an IV for dehydration, but it wasn't working. It caused her to swell up like a balloon...." Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She			

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	indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON, DON, Executive Director (ED) indicated they were not aware Resident F had been unresponsive or her IV had infiltrated. On 6/9/2016 at 5:37 p.m., the ADHS indicated she had just gotten off the phone with RN # 7, who cared for Resident F the morning the resident went to the Emergency Department on 6/8/2016. The ADHS indicated the resident was sleeping "normally" when the nurse checked on the resident and the resident was at baseline. Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid			

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	filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably should have called the on-call...Her swelling was terrible...a lot of third spacing...her legs, her feet, all over. Her skin was cool....I would just chart it [change of condition] under Progress Notes." Resident F was interviewed on 6/10/2016 at 11:50 a.m. She was observed to be awake and alert, but hard of hearing. When queried as to how she felt, she indicated, "Better." RN # 11 was interviewed on 6/10/2016 at 2:00 p.m. regarding assessing residents with CHF and edema who were at risk for fluid overload. RN # 11 indicated, "I wouldn't listen to lungs everyday, but I would check swelling and temperature." 3. Resident E was interviewed on 6/8/2016 at 3:12 p.m. The resident was observed wearing cotton athletic socks and open sandals with 3+ edema in his bilateral lower ankles and feet. He was sitting up with his legs (hanging down) in his wheelchair. The resident indicated he had occasional lower extremity edema/swelling at baseline, but worsening edema since he had been in the facility. The resident indicated he had			

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	notified staff he was concerned regarding his increased edema in recent weeks. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery. Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated, "Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]...Vitals: Pulse: 96/per minute. Respirations: 18 per minute. Blood Pressure: 138/83 mmHg...." There was no evidence in Resident E's clinical record that he had a care plan related to edema. A Care Plan, initiated 4/20/2016,			

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	indicated, "Problem: High Risk Medications. I have potential for decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure...." LPN # 16 was interviewed on 6/9/2016 at 3:15 p.m. at Resident E's bedside. She touched resident E's foot lightly over his socked foot and indicated his edema was, "3+ pitting." LPN # 16 indicated the resident had edema since admission and it had started to get worse approximately two weeks ago. LPN # 16 indicated a form had been sent in to Resident E's physician to notify him/her of the resident's change in condition that day. LPN # 16 indicated that nursing staff assisted Resident E to elevate his legs during the day, pointing to a bench against the wall. During an interview on 6/9/2016 at 3:06 p.m., Resident E indicated he was not encouraged or assisted to elevate his legs during the day and that the edema in his bilateral lower extremities had become progressively worse in recent weeks. The resident indicated he had pain and "tingling" related to the edema.			

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	During multiple random observations throughout the survey, including 6/8/2016 at 9:59 a.m. 6/8/2016 at 3:12 p.m., 6/9/2016 at 3:06 p.m., and 6/10/2016 at 11:15 a.m., Resident E was observed to have 3+ edema in his bilateral lower ankles and feet, with his legs dependent (hanging down) in his wheelchair. There was no evidence in the clinical record that Resident E's lower extremity edema was fully assessed or monitored, or that the physician was notified of changes. There were no events or changes in condition related to Resident E's edema. Resident E did not have evidence of daily skilled assessments on 5/24, 5/29, or 6/3/2016. Resident E's recorded weights were as follows: 4/2/2016: 172.6 pounds 4/3/2016: 172.3 pounds 4/10/2016: 176.4 pounds 5/11/2016: 184.2 pounds There was no evidence anywhere in Resident E's clinical record that the physician was notified related to Resident E's weight gain.			

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	On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]." There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was done, or the physician was notified. The next recorded vital signs were on 5/7/2016, when Resident E's blood pressure was indicated to be 111/82 mmHg. A Progress Note for Resident E, dated 5/30/2016, indicated the resident was "extremely edematous" with no additional values/assessments/comparisons related to the edema, vital signs, or respiratory assessments. On 6/10/2016 at 3:46 p.m., the DHS indicated resident alerts abnormal vital signs (highlighted in red) go the the DHS in the form of "messages." On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure (above). 4. Resident D's clinical record was reviewed on 6/9/2016 at 2:15 p.m.			

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	Diagnoses included, but not limited to, COPD, CHF, acute kidney failure, and recent foot fracture. The resident was admitted to the facility 3/7/2016 for rehabilitation following a foot fracture. Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." Resident D's Admission Nursing Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift... Cardiovascular: Heart Rate: irregular...Edema present: Yes. Location of edema: Right upper extremity. Other: lyphedema /t radical mastectomy. Left leg edema: [blank]. Right leg edema: [blank]...Initial Cardiovascular Plan of Care: ...Pacemaker checks...."			

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	A current Care Plan for Resident D indicated, "Problem: I have a diagnosis/history of congestive heart failure...Approach: Administer oxygen at 2L Q HS, PRN....Monitor me for fluid excess (wt. gain, increased BP; full/bounding pulse...SOB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...." A current Care Plan for Resident D indicated, "Problem: I have COPD...Approach: My care givers will monitor my lung sounds as indicated. My care givers will monitor my 02 sat..." A current Care Plan for Resident D indicated, "Problem: I have a pacemaker...Approach: Please monitor my apical pulse as needed and report abnormalities to my physician...." Resident D was observed to have 3+ edema to bilateral lower extremities during random observations on 06/08, 06/09 and 06/10/2016. Resident D was interviewed 6/10/2016 at 4:10 p.m. She indicated nursing staff did not listen to her lungs/chest every day and indicated the CNAs checked the swelling in her bilateral extr			

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F 0241 SS=G Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure the privacy and dignity within a reasonable person expectation for 2 of 5 residents reviewed this deficient practice caused harm in one resident (Resident F). (Resident F's) door was open with the resident's bare feet and soiled linens on the floor visible from the hallway. Upon entering the doorway, (Resident F) was observed completely exposed, except for an adult brief. The resident's arms were crossing her chest to cover her breasts. (Residents E and F). Findings include: 1. During an observation on 6/9/2016 at 3:24 p.m., Resident F's door was observed to be open with a large pile of sheets, gowns, towels, and disposable incontinence pads, soiled with a brown, wet, foul-smelling substance on the carpeted floor at the foot of the bed. Resident F's bare feet were visible from the doorway. A bare,blue pillow was on the floor partially on top of the pile of	F 0241	F241: Failure to ensure the privacy and dignity within a reasonable person expectation for 2 of 5 residents reviewed this deficient practice caused harm in one resident (Resident F) (Resident F's) door was open with the residents bare feet and soiled linens on the floor visible from the hallway. Upon entering the doorway, (Resident F) was observed completely exposed, except for an adult brief. The resident's arms were crossed over her chest to cover her breasts. (Residents E and F) · CRCA immediately went into Resident F's room and provided privacy and dressed the resident, ensured that the bed was at proper height and the call light was within reach & cleaned linen from the floor. Environmental Services deep cleaned the	07/06/2016

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	soiled linens. Upon entering the doorway, Resident F was observed to be alone in the room, with the air mattress in the high position, legs apart, completely exposed except for an adult brief. The resident's arms were crossing her chest to cover her breasts. At 3:25 p.m., CNA #14 entered the room and indicated, "My nurse was just in here." CNA # 14 indicated she left the room to answer a call light across the hall. Resident F's Admission Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "...Staff assist with transfer: 2 person facility staff assist...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place..." Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, and Alzheimer's disease. Resident F was admitted to the facility on 6/5/2016 following hospitalization for a fecal transplant. The resident was admitted to Hospice on 6/9/2016. Resident F was interviewed on 6/10/2016 at 11:50 a.m. She was observed to be		carpet in resident F's room. Resident E was immediately taken to his room and catheter covering was applied to maintain resident's dignity. · All residents have the potential to be effected. · All staff will be in-serviced on Residents Rights with the focus on dignity and respect by July 6, 2016. Social Service or designee will interview 10 residents per week x 4 weeks, 10 residents per month x 2 months then 10 residents per a quarter thereafter to ensure the facility has maintained the residents dignity and privacy. · Director Health Services and Assistant Director Health Services, Unit Manager, Executive Director, Medical Records Director or designee will audit all residents with a Foley catheters for dignity covers and a random sample of 10 residents per week x 4 weeks, 10 residents per month x 2 months then 10 residents per quarter thereafter to ensure the facility has maintained the	

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	awake and alert, but hard of hearing. When queried as to how she felt, she indicated, "Better." 2. During an observation on 6/8/2016 at 3:12 p.m., Resident E was observed self-propelling in his wheelchair down the main hallway of the facility with his urinary catheter bag partially full of urine, exposed, and dragging on the floor under his wheelchair. The resident was assisted to his room by the Executive Director moments later and was interviewed at that time. The resident indicated he did not recall having a privacy bag for his catheter. On 6/9/2016 at 3:06 p.m., the resident was observed with his catheter tubing and bag exposed hanging on the back of his wheelchair. On 6/9/2016 at 10:20 a.m., Physical Therapist # 6 indicated Resident E required two person assist for transfers to and from his wheelchair. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for		residents dignity and privacy. · . They will monitor them for proper dignity and privacy. · The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee weekly X 4 weeks and then monthly thereafter. -	

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	rehabilitation following spinal surgery. Admission Minimum Data Set (MDS) assessment, dated 2/27/2016, indicated a Brief Interview for Mental Status (BIMS) score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. The resident had a Foley catheter. A copy of the current Guidelines for the Use of Indwelling Catheter Policy and Procedure was provided by the Executive Director on 6/9/2016 at 10:41 a.m. The document indicated, "A resident that does have a...catheter...all efforts should be made to maintain dignity by covering catheter bags, which may include utilizing the fig leaf [privacy] bag. A current copy of the current Resident Rights Policy and Procedure was provided by the Medical Records Coordinator on 6/8/2016 at 11:15 a.m. The policy indicated, "...You have the right to personal privacy. THIS MEANS THAT: ...2. When you are undergoing an examination or treatment, the staff should...maintains the privacy of your body (i.e., room door should be closed, privacy curtain should be pulled around the bed, etc.)...4. You should be granted			

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	privacy when going to the bathroom and in other activities of personal hygiene. (Note: If you need assistance, the staff should still respect your privacy.)...." This Federal tag relates to Complaint IN00200175. 3.1-3(t)			
F 0281 SS=E Bldg. 00	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 0281	F281: Failure to ensure standards were followed	06/29/2016

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	Based on observation, record review and interview, the facility failed to ensure standards were followed during nursing assessments and physician notification for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4 residents (Residents C, D, E, and F). Findings include: 1. Resident B's closed clinical record was reviewed on 6/8/2016 at 11:10 a.m. Diagnoses included, but were not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, hypertension, urinary retention, benign prostatic hypertrophy (BPH) with lower urinary symptoms/retention, history of venous thrombosis, peripheral vascular disease, and localized edema. Resident B's Physician Order Report for 11/10/2015 to 12/6/2015 indicated, "Start Date: 11/16/2015: check weight daily. Once a day; p.m...Fluid restriction of 1500 ml per day...Foley cath output every shift...." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have a		during nursing assessments and physician notifications for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B) and the delay in medical care for 4 residents (Residents C, D, E and F). · Resident B was discharged from the facility · Resident D was discharged from facility 6/14/2016 · Resident F expired 6/12/16 · Resident C & E were assessed and md & family notified · All residents have the potential to be effected · All residents with CHF were assessed to ensure current pulmonary status was captured and MD notified immediately of anyone with adventitious breath sounds, edema, or weight change per policy, and care plans where reviewed by 6/11/2016. · Director of Health Services, Assistant Director of Health Services, Unit	

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	diagnosis of congestive heart failure, HTN [hypertension]...Approach: Administer oxygen as ordered. Monitor me for fluid excess (wt. gain, increased BP, full/bounding pulse, jugular vein distention, SOB [shortness of breath], rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...Please monitor me and report signs of respiratory distress (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse. Please monitor my intake of food and fluids...." A Care Plan for Resident B indicated, "Problem Start Date: 11/23/2015. I am at risk for alteration in fluid balance related to my having a fluid restriction and my diagnosis of CKD [chronic kidney disease] with recent ARF [acute renal failure]. Approach Start Date: 11/23/2015. Assist with fluids as needed...Observe me for s/s [signs/symptoms] fluid overload such as edema, distended neck veins, edema. Notify my MD as needed...Weigh resident as ordered." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have		Manager, Med Records Nurse, staffing nurse, floor nurse did assess all current residents on campus to ensure no changes in condition by 6/11/2016 · All changes discovered upon assessment were reported to the MD and family, changes were documented, appropriate orders obtained and resident was added to pertinent charting for follow-up. All Nurses (RN, LPN) were educated prior to working the floor, on head to toe assessment, identifying and documenting change in condition, notifying MD and family of changes as well as follow up documentation on any change in condition by 6/11/2016, and a pre and post test on critical thinking questions on several clinical pathways was completed. All licensed nurses were also required to take a pre and post test on critical thinking questions, related to several clinical pathways prior to working the floor starting 6/11/2016 educated	

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	COPD/Emphysema...Approach: My care givers will monitor my lung sounds daily. My care givers will observe me for changes in my breathing or level of consciousness and report to my doctor...." Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on 11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015. Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked, associated assessments were competed, the physician was notified, or a change of condition/event was initiated. Physician's Progress Notes for Resident B, signed by the resident's primary care physician (PCP), dated 11/11/2015 at 4:15 p.m., indicated, "...breathing at		on prior to working the floor. All licensed nurses were educated prior to working the floor on skilled documentation & notifying on call nurse, MD & family notification of any change of condition by 6/12/2016. In addition a list of all licensed nurses has been developed and no nurse will be allowed to work the floor without completing this education prior to assuming the floor. 100 % of all licensed nurses have been in serviced as of 6/29/16. · Director Health Services, Assistant Director Health Services, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by Director Health Services, Assistant Director Health Services or designee to ensure proper follow up and	

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	baseline...Lungs - CTA [clear to auscultation] B [bilaterally]...Ext [extremities] - 2+ edema on R [right], 1+ [edema] on L [left]...CHF - stable - monitor for fluid overload. Daily weights." A Progress Note for Resident B, dated 11/21/2015 at 1:45 p.m., indicated, "Resident has 3+ swelling to bilateral feet, Resident in recliner with feet elevated." A Progress Note for Resident B, dated 11/22/2015 at 11:41 p.m., indicated, "Resident continues to have bilateral lower leg edema..." There were no additional assessments, events, or physician notification related to these progress notes dated 11/21-22/2015. Resident B's Vitals Report indicated his intake of fluids was 1840 ml fluids on 12/3/2015. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L], tried repeatedly to have him do pursed lip		notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy. · The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee. QA will occur weekly X 4 weeks and then monthly thereafter.	

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	breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhilation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the pursed lip breathing several times. Increased the O2 to 3.5 L via nasal canula [sic]. Resident is very anxious...has not slept all night." On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow: 2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated, "Resident frequently c/o shortness of breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure			

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	191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated, "Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood pressure] and increase in respirations as well." A Progress Note for Resident B, dated 12/6/2015 at 7:48 p.m., indicated, "Res. [resident] c/o SOB [shortness of breath], SpO2 recorded at 88%/3L/NC [liter/nasal cannula]. Assessment revealed oxygen tubing had beside [sic] table sitting on it, Resident's w/c was also parked on top of and crushing the oxygen tubing. Additionally the oxygen line had become			

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	completely separated the water trap by the w/c rolling over it...new tubing installed...saturations hold steady at 95%...." A Progress Note for Resident B, dated 12/6/2015 at 7:58 p.m., indicated, "Res. stated he feels "like I need to go to the hospital." Res. spoke with [family member] on the phone and states his [family member] is on the way here. Assessment completed (See vitals)." There was no evidence of an assessment related to this Progress Note anywhere in Resident B's record. A Progress Note for Resident B, dated 12/6/2015 at 8:21 p.m., indicated, "Res POA [family member] arrived at the facility...POA states he wants the resident to go to the ER [emergency room]...N.O. [new order]...to send to...ER for eval and Tx." There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's respiratory status being assessed (lung sounds), or edema being assessed, or the physician or family being notified on 12/4/2015, 12/5/2015 or 12/6, 2015 prior to the family member's request for the resident to be sent to the ER. The last documented breath sounds for			

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	Resident B were 12/1/2015 at 11:09 a.m., which indicated, "CTA [clear to auscultation]." Resident B's Urine Output Record indicated the following: 12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the decreased urine output. The resident had no evidence anywhere in the Medication Administration Record (MAR) or Treatment Administration Record (TAR) that lung sounds were assessed related to small volume nebulizer treatments. Daily skilled nursing assessment documentation routinely did not address/left blank edema and/or lung sounds. There were no additional events or progress notes related to resident assessment of lung sounds, edema, or physician notification.			

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	Resident B's Emergency Medical Services (EMS) Ambulance Report, dated 12/6/2015, indicated they were dispatched at 8:38 p.m., arrived at the facility at 8:42 p.m., and arrived at the Emergency Department at 9:04 p.m. The report indicated, "Pt [patient] is shorter of breath than normal...pt with obvious edema globally...Respiratory: Effort: Distressed. Sounds: L: Diminished bases. R: Diminished bases. Oxygen: 3.5 lpm via NC Healthcare Provider [facility]...." EMS records indicated the resident did not receive any intravenous fluids or diuretic medication en route to the Emergency Department. Resident B's Emergency Room Record, dated 12/6/2015 at 9:10 p.m., indicated, "CC [chief complaint]: [up arrow] SOB, edema x 3 days. Location: chest/respiratory...Severity: severe. Duration: last 2-3 days. Timing: Constant...Associated signs: leg swelling...CXR [chest x-ray]: CHF...Diagnosis; exacerbation CHF, CRF...." A Hospital Emergency Department Primary Nursing Assessment for Resident B, dated 12/6/2015, indicated, "...Respiratory: Labored, Dyspnea,Increased rate, Cough - moist/nonproductive. Breath sounds:			

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	Left: Rhonchi, wheezing. Right: Rhonchi, wheezing...Peripheral edema: Feet, Ankles 4+...Neurological: Alert. Oriented x 3. Anxious...Nursing Problem List: 1. SOB [shortness of breath]. 2. Edema...2106 [9:06 p.m.] pt sent from [facility]...increased SOB, along with edema for 3 days, report states it is increasingly getting worse. Pt. has 4+ pitting edema...." Resident B's Hospital History and Physical Examination (Hospital 1), dated 12/6/2015, indicated, "...He presented to the emergency department with significant shortness of breath and tight lungs. He was admitted with an exacerbation of his chronic obstructive pulmonary disease and congestive heart failure, diuresed, and states he is starting to feel better already...." Resident B's Cardiology Consultation (Hospital 1), dated 12/7/2015, indicated, "...The patient had been doing relatively well and participating in rehab at [facility]. In the last 3 to 4 days, he started having some increasing shortness of breath and noted some ankle swelling. Yesterday, he became orthopneic with PND [paroxysmal nocturnal dyspnea] and had shortness of breath at rest...came to the emergency department where he was found to have evidence of heart failure.			

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	He has received IV [intravenous] Lasix and is already feeling improved...." Hospital 1 documentation indicated the resident required on-going Nephrology consultation/care and was transferred/admitted to Hospital 2 on 12/11/2015. Resident B's Clinical Documents Progress Note (Hospital 2), dated 12/11/2015, indicated, "...History of present illness: ...recently here...between the dates of 11/5/2015 through 11/10/2015 for acute kidney injury superimposed on chronic kidney disease. He also had issues with systolic heart failure during that time. On discharge...as [renal function] improved patient gradually developed worsening weight gain and fluid retention. He presented to [Hospital 1] 12/7 [sic]/2015 and was diuresed...Unfortunately with aggressive diuresis at that time his creatinine continued to steadily increase...Assessment/Plan: 1. Acute kidney injury on chronic kidney disease stage 3-4. This is most likely in relation to requirements for aggressive diuresis in light of his issues with CHF exacerbation...2. Acute exacerbation on chronic systolic congestive heart failure...."			

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	Nephrology Clinical Consultation (Hospital 2), dated 12/12/2015, indicated, "...Assessment/Plan: ...had diuresis just over 2L [at Hospital 1] given his fairly massive volume expansion....Acutely decompensated systolic congestive heart failure. Resident B was discharged to Hospice on 12/18/2015 and expired 12/24/2015. Discharge Diagnoses indicated, "1. Acute kidney failure, unspecified. 2. Acute on chronic systolic (congestive heart failure. 3. Chronic obstructive pulmonary disease with (acute) exacerbation...." Resident B's [family member], primary care giver and Power of Attorney (POA), was interviewed on 6/8/2016 at 1:16 p.m. Resident B's [family member] indicated he was not notified that [Resident B] was not on Lasix while he was at the facility and Resident B's [family member] indicated he raised repeated concerns over [Resident B's] increased lower extremity edema and increasing shortness of breath to staff and was told [Resident B] was "fine." Resident B's [family member] indicated the resident and family alerted staff multiple times throughout his stay that his ankles and feet were more swollen than usual and the family took the resident's recliner into him. The [family member] indicated he			

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	had never seen [Resident B] with that much swelling. Resident B's [family member] indicated [Resident B] called him 12/6/2015 and indicated to him that he had spent the previous 2 nights and 3 days sitting up in his wheelchair and not in his recliner due to shortness of breath. The [family member] indicated, "He [Resident B] said, 'I felt like I was going to drown if I laid back [in my recliner].'" Resident B's [family member] indicated he was not notified by the facility of [Resident B's] additional increased swelling and increasing shortness of breath 12/3/2015 through 12/6/2015. He indicated [Resident B] called him related to his decline and he requested his physician be called and he be sent to the emergency room for evaluation on 12/6/2015. Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated that monitoring for fluid overload would include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be			

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	notified of a 5 pound weight gain in one day. Licensed Practical Nurse (LPN) # 2 was interviewed on 6/8/2016 at 3:06 p.m. He indicated he cared for Resident B periodically and was on duty on 12/6/2016 when Resident B was sent to the Emergency Department. LPN # 2 indicated, "[Resident B] was just not doing good...he wasn't in good condition. He had swelling issues." LPN # 2 indicated, "If [a resident's] sats are not doing well, we [nursing] would put on our report sheet and in [resident] progress notes." LPN # 2 indicated daily assessments and documentation were based on the resident's primary admitting diagnosis. Regarding monitoring for fluid overload, weight fluctuations, and edema, LPN # 2 indicated the physician would order parameters regarding notification. The LPN indicated, "If the weight exceeds the parameters, I would send a fax...unless it says call." LPN # 2 indicated, "The staff would catch a 5 pound weight gain in a day...if there's a change [in resident condition] from the norm, I don't know if that would be an event, but I would let somebody know. I would just do a progress note." The Interim Director of Health Services (DHS) and the Assistant Director of			

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	Health Services (ADHS) were interviewed on 6/8/2016 at 4:12 p.m. The Interim DHS indicated that Resident B was being assessed related to his renal failure because that was his admitting diagnoses. The ADHS indicated nursing staff would be charting on the renal diagnoses because that was their "number one concern." The DHS indicated all residents were assessed daily related to their primary admitting diagnosis. She indicated a resident who was admitted for a foot fracture, but had co-morbidities such as COPD, CHF, or kidney failure, would be prompted to do a daily orthopedic assessment. She indicated orthopedic assessments did not include assessments of edema, breath sounds, or respiratory status. Both the DHS and ADHS indicated there were no policies or procedures related to monitoring for fluid overload, monitoring for changes in condition, documentation or assessment and that they relied on "best [nursing] practices." The Director of Health Services (DHS) was interviewed on 6/9/2015 at 1:50 p.m. regarding expectations for monitoring for fluid overload. The DHS indicated there was no policy and procedure related to edema, monitoring for fluid overload, CHF, or COPD. The DHS indicated, "Just monitor their intake and edema.			

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	That's what I would do." On 6/9/2015 at 4:25 p.m., the DHS indicated she "probably would not" document an event or change in condition for a weight change." The DHS indicated the facility relied on "best practices" to direct nursing staff when to do assessments, under what category to document them, and when to notify the physician of changes. The Assistant Director of Health Services (ADHS) was interviewed on 6/9/2016 at 4:31 p.m. regarding the policy and procedure related to documenting and reporting changes in condition, events, and monitoring for fluid overload. She indicated there were no policies and procedures. The ADHS indicated, "That's nursing judgement whether to do an event, a change in condition, or a progress note." On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) provided a current copy of [facility] Guide to Event Notification Critical Thinking. She indicated that when changes in condition are observed, an "event" is initiated. She indicated that "artificial intelligence" indicated to the nursing staff when to notify the physician. The CNO indicated a section of the document which was			

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	circled and indicated the residents reviewed did not meet any of the criteria related to edema. The circled documentation indicated, "New Onset Edema Event. Notification Guidelines. Notify MD/NP immediately...for any of the following...Abrupt pt onset of edema in one leg with loss of sensation. Abrupt onset edema with tenderness and redness. Edema with sudden onset of shortness of breath, and/or chest pain." The notification guideline not circled by the CNO indicated, "Weight gain of 3 or more pounds in last 7 days." On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident B over the last three months and/or with small volume nebulizer treatments (SVN's).			

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	On 6/10/2015 at 10:06 a.m., the CNC indicated the facility did not have a specific policy or procedure related to change in condition. The CNC provided a current copy of [Facility] Guide to Events, which was reviewed at that time. The document indicated, "...Category of Observation: Cardiovascular. Event Name: ...New Onset Edema. Possible Reasons: Increased Or New Edema...Category of Observation: ...Other Events: ...Event Name: Other Physical Changes in Condition: Possible Reasons: Non-specified physical changes...Category of Observation: Respiratory/EENT: Event Name: Respiratory: Possible Reasons: Breathing/Respiration Changes..." On 6/8/2016 at 4:15 p.m., the ADHS was queried regarding the new onset/new documentation of Resident B's 3 + pitting edema on 11/21/2015 at 1:45 p.m. (above) and why event/change in condition documentation was not initiated or the physician notified of the change. The ADHS indicated, "It [edema] depends on other factors. It could just be the time of day." On 6/8/2016 at 4:25 p.m. the ADHS and DHS provided a copy of the current Guidelines for Weight Tracking Policy and Procedure and it was reviewed at that			

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	time. They indicated there were no additional policies or procedures related to weight tracking and/or specific to edema and/or respiratory diagnoses. The Procedure indicated, "...6. The weight should be recorded in the individual resident medical record. 7. Residents who have a weight that seem [sic] out of normal range shall be re-weighed to determine the accuracy of the original weight..." On 6/8/2016 at 4:36 p.m., the ADHS provided a copy of the current Physician Notification of Diagnostic Testing and Change in Condition Policy and Procedure and it was reviewed at that time. The document indicated, "Purpose: To ensure the...physician is aware of all...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure: 1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known....10. Attempts to notify the physician and their response should be documented in the resident record...." On 6/10/2016 at 4:42 p.m., LPN # 8 indicated she would document any			

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	significant change in resident condition in the progress notes. On 6/15/2016 at 5:37 p.m., the CNC # 2 indicated oxygen did not require a physician's order and was a "standing order." 2. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, Alzheimer's disease, hypertension, and localized edema. Resident F was admitted to the facility on 6/5/2016 following hospitalization for a fecal transplant. The resident was admitted to Hospice on 6/9/2016 and expired on 6/12/16. Resident F's Admission Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place...Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]. Sacral edema: [blank]. Left upper extremity edema: [blank]. Right upper extremity edema: [blank]...Comments: [blank]...." Resident F, who was admitted 6/5/2016			

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	at 3:45 p.m., had no vital signs documented until 6/6/2016 at 3:55 a.m. A Care Plan for Resident F indicated, "I have edema...monitor and record my edema...." A Progress Note for Resident F, dated 6/5/2016 at 3:45 p.m., indicated, "Admitted...alert [and] oriented x 3, mood pleasant...." A Progress Note for Resident F, dated 6/7/2016 at 6:20 p.m., indicated, "resident returned from emergency room with peripheral IV [PIV] in left wrist. no s/s [signs/symptoms] infiltration noted. has normal saline running at 100 cc per hour for dehydration...is oriented to person and place. alert. asking for television to be turned on the news...nonpitting edema noted in both hands. 2-3+ pitting edema noted in bilateral legs...." The following Progress Note, dated 6/8/2016 at 3:30 a.m., indicated, "...Edema continues...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res			

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	c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat." Resident F's Progress Note, dated 6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%." A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request." On 6/9/2016 at 2:51 p.m., the CNC indicated nursing staff did not have time to complete or document an assessment related to Resident F's change in condition prior to being sent to the Emergency Department on 6/8/2016 at 11:32 a.m. On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events,			

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	changes in condition, or physician notification associated with this abnormal value. The next blood pressure assessment was not until 6/7/2016 at 7:07 p.m. There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was discontinued. There was no documentation anywhere in Resident F's clinical record to indicate Resident F's left upper extremity was assessed following the 6/8/2016 at 6:46 a.m. progress note. On 6/9/2016 at 3:25 p.m., CNA # 14 indicated that, prior to this date, Resident F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. CNA # 10 was interviewed on 6/9/2016 at 9:50 a.m. She indicated, "[Resident F has] been in the hospital. They sent her out yesterday because she was unresponsive. She had an IV for dehydration, but it wasn't working. It caused her to swell up like a balloon...."			

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	Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON, DON, Executive Director (ED) indicated they were not aware Resident F had been unresponsive or her IV had infiltrated. On 6/9/2016 at 5:37 p.m., the ADHS indicated she had just gotten off the phone with RN # 7, who cared for Resident F the morning the resident went to the Emergency Department on 6/8/2016. The ADHS indicated the resident was sleeping "normally" when the nurse checked on the resident and the resident was at baseline.			

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	Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably should have called the on-call...Her swelling was terrible...a lot of third spacing...her legs, her feet, all over. Her skin was cool....I would just chart it [change of condition] under Progress Notes." Resident F was interviewed on 6/10/2016 at 11:50 a.m. She was observed to be awake and alert, but hard of hearing. When queried as to how she felt, she indicated, "Better." RN # 11 was interviewed on 6/10/2016 at			

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	2:00 p.m. regarding assessing residents with CHF and edema who were at risk for fluid overload. RN # 11 indicated, "I wouldn't listen to lungs everyday, but I would check swelling and temperature." 3. Resident E was interviewed on 6/8/2016 at 3:12 p.m. The resident was observed wearing cotton athletic socks and open sandals with 3+ edema in his bilateral lower ankles and feet. He was sitting up with his legs (hanging down) in his wheelchair. The resident indicated he had occasional lower extremity edema/swelling at baseline, but worsening edema since he had been in the facility. The resident indicated he had notified staff he was concerned regarding his increased edema in recent weeks. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery. Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required			

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	extensive, 2+ physical assist for transfers and bed mobility. Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated, "Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]...Vitals: Pulse: 96/per minute. Respirations: 18 per minute. Blood Pressure: 138/83 mmHg...." There was no evidence in Resident E's clinical record that he had a care plan related to edema. A Care Plan, initiated 4/20/2016, indicated, "Problem: High Risk Medications. I have potential for decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure...." LPN # 16 was interviewed on 6/9/2016 at 3:15 p.m. at Resident E's bedside. She touched resident E's foot lightly over his socked foot and indicated his edema was, "3+ pitting." LPN # 16 indicated the resident had edema since admission and it starting getting worse approximately two weeks ago. LPN # 16 indicated a form			

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	had been sent in to Resident E's physician to notify him/her of the resident's change in condition that day. LPN # 16 indicated that nursing staff assisted Resident E to elevate his legs during the day, pointing to a bench against the wall. During an interview on 6/9/2016 at 3:06 p.m., Resident E indicated he was not encouraged or assisted to elevate his legs during the day and that the edema in his bilateral lower extremities had become progressively worse in recent weeks. The resident indicated he had pain and "tingling" related to the edema. During multiple random observations throughout the survey, including 6/8/2016 at 9:59 a.m. 6/8/2016 at 3:12 p.m., 6/9/2016 at 3:06 p.m., and 6/10/2016 at 11:15 a.m., Resident E was observed to have 3+ edema in his bilateral lower ankles and feet, with his legs dependent (hanging down) in his wheelchair. There was no evidence in the clinical record that Resident E's lower extremity edema was fully assessed or monitored, or that the physician was notified of changes. There were no events or changes in condition related to Resident E's edema. Resident E did not have evidence of daily			

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	skilled assessments on 5/24, 5/29, or 6/3/2016. Resident E's recorded weights were as follows: 4/2/2016: 172.6 pounds 4/3/2016: 172.3 pounds 4/10/2016: 176.4 pounds 5/11/2016: 184.2 pounds There was no evidence anywhere in Resident E's clinical record that the physician was notified related to Resident E's weight gain. On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]." There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was done, or the physician was notified. The next recorded vital signs were on 5/7/2016, when Resident E's blood pressure was indicated to be 111/82 mmHg. A Progress Note for Resident E, dated 5/30/2016, indicated the resident was "extremely edematous" with no additional			

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	values/assessments/comparisons related to the edema, vital signs, or respiratory assessments. On 6/10/2016 at 3:46 p.m., the DHS indicated resident alerts abnormal vital signs (highlighted in red) go the the DHS in the form of "messages." On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure (above). 4. Resident D's clinical record was reviewed on 6/9/2016 at 2:15 p.m. Diagnoses included, but not limited to, COPD, CHF, acute kidney failure, and recent foot fracture. The resident was admitted to the facility 3/7/2016 for rehabilitation following a foot fracture. Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." Resident D's Admission Nursing			

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	Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift... Cardiovascular: Heart Rate: irregular...Edema present: Yes. Location of edema: Right upper extremity. Other: lyphedema /t radical mastectomy. Left leg edema: [blank]. Right leg edema: [blank]...Initial Cardiovascular Plan of Care: ...Pacemaker checks...." A current Care Plan for Resident D indicated, "Problem: I have a diagnosis/history of congestive heart failure...Approach: Administer oxygen at 2L Q HS, PRN....Monitor me for fluid excess (wt. gain, increased BP; full/bounding pulse...SOB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...." A current Care Plan for Resident D indicated, "Problem: I have COPD...Approach: My care givers will monitor my lung sounds as indicated. My care givers will monitor my 02 sat..."			

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	A current Care Plan for Resident D indicated, "Problem: I have a pacemaker...Approach: Please monitor my apical pulse as needed and report abnormalities to my physician...." Resident D was observed to have 3+ edema to bilateral lower extremities during random observations on 06/08, 06/09 and 06/10/2016. Resident D was interviewed 6/10/2016 at 4:10 p.m. She indicated nursing staff did not listen to her lungs/chest every day and indicated the CNAs checked the swelling in her bilateral extremities when they helped her with her nightly routine before bed. Resident D indicated that, prior to her admission, she had intermittent bilateral lower extremity edema that "came and went." Resident D indicated her lower extremity edema had been worse since she had been in the facility and more so over the past two weeks. A Progress Note dated 4/17/16 at 6:30 p.m. indicated, "...audible wheezes noted throughout lung fields...O2 sats 96 % on 2 lpm per nasal cannula...." There was no evidence of additional documentation or assessment related to lung sounds, respiratory status, or edema in resident progress notes, events, skilled			

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	nursing assessments/observations, MAR or TAR until 6/12/2016. MAR review indicated Resident D received as-needed SVN treatments related to wheezing and shortness of breath during her admission. On 6/10/2016 at 12:53 p.m., the ADHS indicated nursing staff are required to assess breath sounds with SVN treatments. The ADHS indicated she could not find evidence in Resident D's clinical record that assessment of breath sounds had been done. Resident D's documented weights indicated the following significant weight gains: 3/07/2016 - 3/09/2016: 26 pound gain. (no weight check 3/8/2016) 3/23/2016 - 3/24/2016: 5.6 pound gain. 4/10/2016 - 4/11/2016: 100.8 pound gain 4/29/2016 - 4/30/2016: 5.5 pound gain 5/02/2016 - 5/03/2016: 5.2 pound gain 5/10/2016 - 5/12/2016: 7.8 pound gain (no weight check 5/11/2016) 5/31/2016 - 6/01/2016: 7.8 pound gain There was no documentation of verification of weights, re-weights, notification of change, events, progress notes, or follow up related to weight gain.			

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	No skilled nursing assessments on 3/8, 3/11, 3/15, 3/21, 3/22, 3/25. 4/5, 4/13, 4/15, 4/21, 4/26, 4/30, 5/3, 5/6, 5/10, 5/17, 5/20, 5/24, 5/27, 6/3/2016. There were no nursing assessments located in the resident's progress notes related to these dates. On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident D over the last three months and/or with small volume nebulizer treatments (SVN's). The ADHS was interviewed on 6/9/2016 at 4:12 p.m. regarding Resident D's 100.8 pound gain between 4/10/2016 and 4/11/2016. She indicated, "It was probably an error. She probably should have had a re-weight." The ADHS			

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	indicated that "best practices" for reporting weight gain in residents being monitored for fluid overload or CHF would be 3 pounds in a day or 5 pounds in a week. On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Resident D's weight changes were related to transcription errors and that the resident's admission weight was incorrect. 5. Resident C's clinical record was reviewed on 6/9/2016 at 3:20 p.m. Diagnoses included but not limited to, chronic kidney disease, stage III, neuromuscular dysfunction of bladder, Parkinson's disease, and history of urinary tract infection (UTI). Quarterly MDS assessment, dated 3/8/2016, indicated BIMS score of 7; indicating moderate cognitive impairment. The resident required extensive 2+ person assist for transfers and all ADL's except eating. The resident had no behaviors and no rejection of care. Admission			
F 0282 SS=K Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified			

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	persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to follow individualized care plans related to nursing assessments and notification to the physician of significant change in condition for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4 residents (Residents C, D, E, and F). This Immediate Jeopardy began on 11/21/2015 when the facility failed to assess vital signs for a period between 11/20/2015 at 9:37 a.m. and 11/22/2015 at 6:51 a.m. and a 5.2 pound weight gain between 11/22/2015 and 11/23/2015 was not reported to the physician and was identified on 6/10/2016. The Executive Director, Assistant Director of Health Services, the Interim Director of Health Services, Clinical Support RN # 1, Clinical Support RN # 2, and the Medical Records Coordinator were notified of the Immediate Jeopardy at 1:42 p.m. on 6/10/2016. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity level of pattern, no	F 0282	F282: Failure to follow individualized care plans related to nursing assessments and notification of the physician of significant change in condition for 4 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B) and delay in medical care for 4 residents (Resident C, D, E and F). · Resident B was discharged from the facility · Resident D was discharged from facility 6/14/2016 · Resident F expired 6/12/16 · Resident C & E were assessed and md & family notified · All residents have the potential to be effected · All residents with CHF were assessed to ensure current pulmonary status was captured and MD notified immediately of anyone with adventitious breath sounds,	06/29/2016

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	actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident B's admission Minimum Data Set (MDS) assessment, dated 11/17/2015, indicated a Brief Interview for Mental Status (BIMS) score of 14; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ person physical assist for transfers and was non-ambulatory. The resident had an indwelling Foley catheter and received oxygen therapy. Diagnoses included, but were not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, hypertension, urinary retention, benign prostatic hypertrophy (BPH) with lower urinary symptoms/retention, history of venous thrombosis, peripheral vascular disease, and localized edema. A Care Plan for Resident B indicated, "Problem Start Date: 11/23/2015. I am at risk for alteration in fluid balance related to my having a fluid restriction and my diagnosis of CKD [chronic kidney disease] with recent ARF [acute renal failure]. Approach Start Date:		edema, or weight change per policy, and care plans where reviewed by 6/11/2016. All care plans were reviewed for accuracy & updated as needed by Vice President of Case Management on June 12, 2016. · Director of Health Services, Assistant Director of Health Services, Unit Manager, Med Records Nurse, staffing nurse, floor nurse did assess all current residents on campus to ensure no changes in condition by 6/11/2016 · All changes discovered upon assessment were reported to the MD and family, changes were documented, appropriate orders obtained and resident was added to pertinent charting for follow-up. · All Nurses (RN, LPN) were educated prior to working the floor, on head to toe assessment, identifying and documenting change in condition, notifying MD and family of changes as well as follow up documentation on	

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	11/23/2015. Assist with fluids as needed...Observe me for s/s [signs/symptoms] fluid overload such as edema, distended neck veins, edema. Notify my MD as needed...Weigh resident as ordered." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have a diagnosis of congestive heart failure, HTN [hypertension]...Approach: Administer oxygen as ordered. Monitor me for fluid excess, wt. gain, increased BP, full/bounding pulse, jugular vein distention, SOB [shortness of breath], rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...Please monitor me and report signs of respiratory distress, cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse. Please monitor my intake of food and fluids...." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have COPD/Emphysema...Approach: My care givers will monitor my lung sounds daily. My care givers will observe me for changes in my breathing or level of consciousness and report to my doctor...."		any change in condition by 6/11/2016, and a pre and post test on critical thinking questions on several clinical pathways was completed. All licensed nurses were also required to take a pre and post test on critical thinking questions, related to several clinical pathways prior to working the floor starting 6/11/2016 educated on prior to working the floor. All licensed nurses were educated prior to working the floor on skilled documentation & notifying on call nurse of any change of condition by 6/12/2016. In addition a list of all licensed nurses has been developed and no nurse will be allowed to work the floor without completing this education prior to assuming the floor. · Director Health Services, Assistant Director Health Services, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification.	

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	Resident B's Skilled Charting - Admission Assessment, dated 11/10/2015 at 11:22 p.m., indicated the resident was alert and oriented to person, place, time and situation, did not have difficulty sleeping at night, did not use oxygen, denied shortness of breath, and did not have anxiety present. The assessment indicated Resident B's respirations were regular and unlabored, he did not have a cough, and lung sounds were clear in all fields. The resident had 1 + pitting edema in his left and right lower extremities. The resident had a Foley catheter and no urinary symptoms. The resident denied pain. Initial Nutrition Plan of Care indicated, "observe weight...daily...Vitals: Pulse: 67/per minute. Respirations: 20/per minute. Blood Pressure: 146/77. O2 Saturation: 95%. Activity: Resting...Oxygen Use: No...." A Progress Note for Resident B, dated 11/21/2015 at 1:45 p.m., indicated, "Resident has 3+ swelling to bilateral feet, Resident in recliner with feet elevated." A Progress Note for Resident B, dated 11/22/2015 at 11:41 p.m., indicated, "Resident continues to have bilateral lower leg edema..."		Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by Director Health Services, Assistant Director Health Services or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy. · A random sample of 5 care plans will be reviewed in morning Clinical Care Meeting for accuracy of execution by Director of Health Services, Assistant Director of Health Services, MDS Coordinator & or Designee for 5 times a week x 4 weeks then 3 times a week x 4 weeks then quarterly thereafter. · The results of the assessments/audits will be	

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	There were no additional assessments, events, or physician notification related to these progress notes dated 11/21-22/2015. Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on 11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015. Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked, associated assessments were competed, the physician was notified, or a change of condition/event was initiated. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him		reported & reviewed for compliance thru the campus Quality Assurance Committee. QA will occur weekly X 4 weeks and then monthly thereafter	

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	down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L], tried repeatedly to have him do pursed lip breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhalation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the pursed lip breathing several times. Increased the O2 to 3.5L via nasal canula [sic]. Resident is very anxious...has not slept all night." There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's respiratory status being assessed (lung sounds), edema being assessed, or the physician or family being no tified on 12/4/2015, 12/5/2015 or 12/6/2015. On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow: 2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated,			

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	"Resident frequently c/o shortness of breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure 191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated, "Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood			

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	pressure] and increase in respirations as well." The following vital signs, dated 12/6/2015 at 8:04 p.m., indicated, "Blood Pressure 152/74 mmHg. Pulse: 66. 02 Saturation: 95%. Resting. Oxygen Use: Yes - Liter Flow: 3.5 Liter. Activity: Low. Respirations: 26/minute. Resting." There were no Progress Notes, Events, or other evidence in the record to indicate that additional assessments related to Resident B's respiratory status and/or edema, follow up, or physician notification were completed. There was no evidence of, and facility staff were unable to provide any evidence of skilled charting or nursing assessments for Resident B on November 14, 21 or 25, 2015 or December 2 or 5, 2015. Daily skilled nursing assessment documentation routinely did not address/left blank edema and/or lung sounds. There were no additional events or progress notes related to resident assessment of lung sounds, edema, or physician notification. The last documented breath sounds for Resident B were 12/1/2015 at 11:09 a.m., which indicated, "CTA [clear to			

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	auscultation]." Resident B's Urine Output Record indicated the following: 12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the decreased urine output. The resident had no evidence anywhere in the Medication Administration Record (MAR) or Treatment Administration Record (TAR) that lung sounds were assessed related to small volume nebulizer treatments. Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated that monitoring for fluid overload would			

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	include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be notified of a 5 pound weight gain in one day. 2. During an initial tour with the Medical Records Coordinator (MRC) and the Executive Director (ED) on 6/8/2016 at 9:50 a.m., the MRC indicated Resident F had Clostridium difficile (C. diff; infectious bacteria which causes loose stools) and was on "isolation." There was no sign observed on or around the doorway to indicate special precautions were to be observed. During an interview on 6/8/2016 at 9:50 a.m., the ED indicated there should have been a sign posted on Resident F's door to alert visitors to check with the nurse. A Care Plan for Resident F indicated, " Problem: I have c-diff ...Approach: ...Isolation precautions to be taken for c-diff. Follow protocol. Discipline [responsible]: Administrative ...Medical Records, Nursing ..." Resident F's Admission Nursing Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "Cardiovascular Plan of Care:...Assess vital signs q [every] - 8 [hours]...Disease Plan of Care: Observe			

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	vital signs per protocol ...Implement isolation precautions per protocol..." Resident F's Event - Change In Physical Condition Circumstance dated 6/6/2016 at 9:49 p.m., indicated, " Describe change in condition: admitted with 2+-3+ edema to BLE [bilateral lower extremities] ...Treatments: CHANGE IN CONDITION CIRCUMSTANCE: Follow up monitoring and vital signs x 72 hours or until resolved. On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events, changes in condition, or physician notification associated with this abnormal value. A Progress Note for Resident F, dated 6/7/2016 at 1:20 p.m., indicated, New order received...to send Resident to ER to be evaluated for decreased appetite and difficulty swallowing. Family member...very concerned about Resident's current state of health and would like her sent to ER for eval [evaluation]." A Progress Note for Resident F, dated 6/7/2016 at 6:20 p.m., indicated, "resident			

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	returned from emergency room with peripheral IV [PIV] in left wrist. no s/s [signs/symptoms] infiltration noted. has normal saline running at 100 cc per hour for dehydration...is oriented to person and place. alert. asking for television to be turned on the news...nonpitting edema noted in both hands. 2-3+ pitting edema noted in bilateral legs...." A Progress Note for Resident F, dated 6/8/2016 at 3:30 p.m., indicated, "Edema continues with no draining or open areas ...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat." Resident F's Progress Note, dated			

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	6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%." A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request." There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was discontinued. On 6/9/2016 at 2:51 p.m., the CNC indicated nursing staff did not have time to complete or document an assessment related to Resident F's change in condition prior to being sent to the Emergency Department on 6/8/2016 at 11:32 a.m. On 6/9/2016 at 3:25 p.m., CNA # 14 indicated that, prior to this date, Resident F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her			

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	legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON, DON, Executive Director (ED) indicated they were not aware Resident F had been unresponsive or her IV had infiltrated. On 6/9/2016 at 5:37 p.m., the ADHS indicated she had just gotten off the phone with RN # 7, who cared for Resident F the morning the resident went to the Emergency Department on 6/8/2016. The ADHS indicated the resident was sleeping "normally" when the nurse checked on the resident and the resident was at baseline. Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident			

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	F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably should have called the on-call...Her swelling was terrible...a lot of third spacing...her legs, her feet, all over. Her skin was cool....I would just chart it [change of condition] under Progress Notes." RN # 11 was interviewed on 6/10/2016 at 2:00 p.m. regarding assessing residents with CHF and edema who were at risk for fluid overload. RN # 11 indicated, "I wouldn't listen to lungs everyday, but I would check swelling and temperature." 3. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder,			

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	surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery. Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. A Care Plan, initiated 4/20/2016, indicated, "Problem: High Risk Medications. I have potential for decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure..." Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated his blood pressure was "138/83 mmHg..." On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]." There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was			

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	done, or the physician was notified. The next recorded vital signs were on 5/7/2016, when Resident E's blood pressure was indicated to be 111/82 mmHg. Resident D was observed to have 3+ edema to bilateral lower extremities during random observations on 06/08, 06/09 and 06/10/2016. Resident D was interviewed 6/10/2016 at 4:10 p.m. She indicated nursing staff did not listen to her lungs/chest every day and indicated the CNAs checked the swelling in her bilateral extremities when they helped her with her nightly routine before bed. Resident D indicated that, prior to her admission, she had intermittent bilateral lower extremity edema that "came and went." Resident D indicated her lower extremity edema had been worse since she had been in the facility and more so over the past two weeks. On 6/10/2016 at 3:46 p.m., the DHS indicated resident alerts abnormal vital signs (highlighted in red) go the the DHS in the form of "messages." On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure			

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	(above). 4. Resident D's Admission Nursing Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift... Cardiovascular: Heart Rate: irregular...Edema present: Yes. Location of edema: Right upper extremity. Other: lyphedema /t radical mastectomy. Left leg edema: [blank]. Right leg edema: [blank]...Initial Cardiovascular Plan of Care: ...Pacemaker checks..." Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." A current Care Plan for Resident D indicated, "Problem: I have a diagnosis/history of congestive heart failure...Approach: Administer oxygen at 2L Q HS, PRN....Monitor me for fluid excess (wt. gain, increased BP;			

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	full/bounding pulse...SOB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...." A current Care Plan for Resident D indicated, "Problem: I have COPD...Approach: My care givers will monitor my lung sounds as indicated. My care givers will monitor my 02 sat..." A current Care Plan for Resident D indicated, "Problem: I have a pacemaker...Approach: Please monitor my apical pulse as needed and report abnormalities to my physician...." A Progress Note dated 4/17/16 at 6:30 p.m. indicated, "...audible wheezes noted throughout lung fields...O2 sats 96 % on 2 lpm per nasal cannula..." There was no evidence of additional documentation or assessment related to lung sounds, respiratory status, or edema in resident progress notes, events, skilled nursing assessments/observations, MAR or TAR until 6/12/2016. MAR review indicated Resident D received as-needed SVN treatments related to wheezing and shortness of breath during her admission.			

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	On 6/10/2016 at 12:53 p.m., the ADHS indicated nursing staff are required to assess breath sounds with SVN treatments. The ADHS indicated she could not find evidence in Resident D's clinical record that assessment of breath sounds had been done. Resident D's documented weights indicated the following significant weight gains: 3/07/2016 - 3/09/2016: 26 pound gain. (no weight check 3/8/2016) 3/23/2016 - 3/24/2016: 5.6 pound gain. 4/10/2016 - 4/11/2016: 100.8 pound gain 4/29/2016 - 4/30/2016: 5.5 pound gain 5/02/2016 - 5/03/2016: 5.2 pound gain 5/10/2016 - 5/12/2016: 7.8 pound gain (no weight check 5/11/2016) 5/31/2016 - 6/01/2016: 7.8 pound gain There was no documentation of verification of weights, re-weights, notification of change, events, progress notes, or follow up related to weight gain. No skilled nursing assessments on 3/8, 3/11, 3/15, 3/21, 3/22, 3/25. 4/5, 4/13, 4/15, 4/21, 4/26, 4/30, 5/3, 5/6, 5/10, 5/17, 5/20, 5/24, 5/27, 6/3/2016. There were no nursing assessments located in the resident's progress notes related to			

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	these dates. On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident D over the last three months and/or with small volume nebulizer treatments (SVN's). The ADHS was interviewed on 6/9/2016 at 4:12 p.m. regarding Resident D's 100.8 pound gain between 4/10/2016 and 4/11/2016. She indicated, "It was probably an error. She probably should have had a re-weight." The ADHS indicated that "best practices" for reporting weight gain in residents being monitored for fluid overload or CHF would be 3 pounds in a day or 5 pounds in a week. On 6/13/2016 at 12:31 p.m., the Chief			

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	Nursing Officer (CNO) indicated Resident D's weight changes were related to transcription errors and that the resident's admission weight was incorrect. 5. Resident C's clinical record was reviewed on 6/9/2016 at 3:20 p.m. Diagnoses included but not limited to, chronic kidney disease, stage III, neuromuscular dysfunction of bladder, Parkinson's disease, and history of urinary tract infection (UTI). Quarterly MDS assessment, dated 3/8/2016, indicated BIMS score of 7; indicating moderate cognitive impairment. The resident required extensive 2+ person assist for transfers and all ADL's except eating. The resident had no behaviors and no rejection of care. A Care Plan for Resident C, initiated 6/4/2016, indicated, "I have edema to my bilateral lower extremities. Goal: My goal is to have decreased edema. Approach: Administer diuretic as ordered. Daily weight...." Resident C was observed on 6/8/2016 at 9:46 a.m. in her wheelchair. She was observed to have 3+ edema in her left lower extremity and a shoe on her right extremity with ankle edema visible. The			

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	resident's legs were dependent (hanging down) in the wheelchair. During multiple observations throughout the survey, including 6/8/2016 at 9:46 a.m., 6/8/2016 at 2:50 p.m., 6/9/2016 at 10:09 a.m., 6/9/2016 at 4:00 p.m., and 6/10/2016 at 11:12 a.m., Resident C was observed to have 3+ edema in her bilateral lower ankles and feet, with his legs dependent (hanging down) in her wheelchair. LPN # 11 was interviewed on 6/9/2016 at 10:10 a.m. She indicated interventions related to Resident C's edema included laying her down between meals and daily weights. She indicated Resident C did not have a recliner in her room and she did not like to sit in the recliner in the common area. LPN # 11 indicated they were not able to contact family about bringing in a recliner because the resident's [family member] had health issues for the previous two weeks. She indicated the resident had been at the facility "about three years." LPN # 11 indicated the resident had an 8 pound weight gain that morning, she re-weighed her, and noted a two pounds weight gain. LPN # 11 indicated, "That's not unusual for her. She hasn't had a bowel movement in 2 days, her lungs are clear, and she has no more edema than			

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	usual...sometimes the girls don't calibrate or zero the scale before each time [weight]." Resident C's Vital Signs Report indicated the resident experienced a 5.5 pounds weight gain after the re-check indicated by LPN # 11 (above). Resident C's Progress Notes, dated 6/9/2016 at 10:31 a.m., indicated, "Resident has had a 5 pound weight gain, lungs are clear and edema is at baseline. COC [change of condition] sent to [physician] asking for direction..." Resident C's Progress Note, dated 6/9/2016 at 11:43 p.m., indicated, "N.O. [new order] Lasix [diuretic] 40 mg...No edema noted..." On 6/9/2016 at 3:20 p.m., Resident C was observed lying flat in bed, with the foot of the bed in the lowest position with feet appearing to be in a lower position than the head and upper torso. On 6/10/2016 at 11:12 a.m., LPN # 20, the Medical Records Coordinator, indicated that nurses are required to do a skilled nursing assessment (Observation Report) every twenty-four hours on each resident.			

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	On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Residents B, C, D, E and F were cognitively intact and could alert staff of any changes in condition. The CNC #2 was interviewed on 6/15/2016 at 5:37 p.m. She indicated admission nursing assessments identified resident care areas at risk and auto-populated into the care plan to target things they would look at. Regarding the Events and "artificial intelligence" indicated by the CNO, she indicated, "It pops up and says this is the assessment you should complete." She indicated if there is no event initiated, there are no prompts and no follow up. The CNC #2 indicated abnormal vital signs are highlighted in red to indicate to nursing staff that they are abnormal. She indicated nurses are supposed to re-assess or re-check abnormal vital signs. A report is available for the DHS and any abnormal vital signs or events were supposed to be reviewed in daily morning meetings. Regarding assessing for changes in condition or abnormal vital signs, the CNC # 2 indicated, "Ultimately the nurses are responsible for that. You can't teach that." On 6/15/2016 at 6:12 p.m., CNC # 2 indicated residents with diagnoses such			

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	as CHF, COPD and renal failure who were being assessed for shortness of air or fluid overload should have their lungs auscultated (listened to with a stethoscope for abnormalities) and their weight checked. She indicated what may be considered advantageous [abnormal] lung sounds for one resident may not be for another if that is the resident's baseline. She indicated, "The Event screen guidelines are there to make the process easier. If there's something out of the ordinary, it's critical thinking [on the part of the nurses] to know what to do next." She indicated if a resident experienced a change in condition, the physician should be notified. A copy of the current Vital Signs Guidelines Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. and it was reviewed at that time. The document indicated, "Purpose: To document and track vital signs to monitor changes in condition...Procedure: 1. Vital signs will be taken at the following times: ...c. Change in condition...e. Per physician order...4. The physician will be notified of a significant change in vitals...5. The nurse shall utilize critical think [sic] skills and nursing assessments/evaluation of vital signs to monitor resident condition."			

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	A copy of the current Guidelines for Change in Resident Condition Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. The document indicated, "Purpose: To identify resident changes in condition...reassess the resident's risk factors, evaluate the current care plan interventions for effectiveness and select additional interventions if required. Policy: 1. Upon assessment of resident change in condition, the ...nurse will initiate the appropriate 'Event' ...in order to fully reflect and document the nursing process. 2. The appropriate Event should be used to facilitate the thorough and consistent evaluation of the resident's condition, follow-up documentation should be completed shiftly...which should include vital signs. 3. Notification of the resident physician and responsible party will be documented...." A copy of the current Guidelines for Lung Auscultation Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 6:12 p.m. The document indicated, "Purpose: To evaluate the air flow through the lungs, presence of fluid or mucus and determine the condition of the lungs...Procedure: 7. A complete assessment should be performed...8. Diminished or absent sounds indicate inability to ventilate the lungs sufficiently...9. Wheezing indicates			

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	bronchospasms. 10: Rhonchi and crackles indicate ineffective secretion clearance...15. Document the results...16. Notify the physician and family of and [sic] change in condition." A copy of the current Resident Rights Policy and Procedure was provided by the Medical Records Coordinator on 6/8/2016 at 11:15 a.m. and reviewed at that time. The policy indicated, "...You have the right to receive services with reasonable accommodation of individual needs...3. The facility will provide nursing care and accommodations that meets your needs...." A copy of the current Abuse and Neglect Procedural Guidelines Policy and Procedure was provided by the Executive Director on 6/8/2016 at 11:05 a.m. and reviewed at that time. The procedure indicated, "...j. NEGLECT - means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...." A current copy of the Guidelines for Acute Care Transfer Policy and Procedure was provided by the ED on 6/9/2016 at 1:35 p.m. and reviewed at that time. The document indicated, "Purpose: To ensure residents are provided with the appropriate care setting			

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	for adequate treatment. Procedure: 1. A thorough assessment shall be completed when a change in resident condition is noted. 2. Assessment information shall be communicated to the attending/on-call physician...." A copy of the current Guidelines for Administration of Oxygen Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 5:55 p.m. The document indicated, "Procedure: 1. Verify physician's order for the procedure...9. Before administering emergency oxygen...asses for the following: b. Signs or symptoms of hypoxia (i.e. rapid breathing, rapid pulse rate, restlessness, confusion); c. Signs or symptoms of oxygen toxicity (i.e. ...difficulty breathing, or...shallow rate of breathing); d. Vital signs; e. Lung sounds..." A current copy of the [Facility] Guide to Documentation was provided by the CNC #2 on 6/15/2016 at 6:05 p.m. The document indicated, "Admission Observation: Physical Assessment, Vitals...within 12 hours...Post Admission Assessment: ...Vital Signs: Q shift [every 8 hours] x 72 hours...Skilled residents: Daily Skilled Observation. Vital Signs. Recommend Progress Notes Each Shift Following Daily Skilled Observation..."			

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	The Immediate Jeopardy that began on 11/21/2015 was removed on 6/13/2016 when the facility completed resident assessments and staff education on identifying and documenting change in condition, following physician orders, notifying MD and family of changes, follow up documentation on any resident change in condition, and resident positioning. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on identifying and documenting change in condition, following physician orders, notifying MD and family of changes, follow up documentation on any resident change in condition, and resident positioning. This Federal tag relates to Complaint IN00200175. 3.1-35(g)(2)			

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F 0309 SS=K Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to provide nursing assessments, physician notification of significant change in condition, and follow physician's orders and individualized care plans for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4	F 0309	F 309: Failure to provide nursing assessments, physician notification of significant change in condition, and follow physician's orders and individualized care plans for 5 of 5 residents reviewed. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B) and the delay in	07/08/2016

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	residents (Residents C, D, E, and F). This Immediate Jeopardy began on 11/21/2015 when the facility failed to assess vital signs for a period between 11/20/2015 at 9:37 a.m. and 11/22/2015 at 6:51 a.m. and a 5.2 pound weight gain between 11/22/2015 and 11/23/2015 was not reported to the physician and was identified on 6/10/2016. The Executive Director, Assistant Director of Health Services, the Interim Director of Health Services, Clinical Support RN # 1, Clinical Support RNA# 2, and the Medical Records Coordinator were notified of the Immediate Jeopardy at 1:42 p.m. on 6/10/2016. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident B's closed clinical record was reviewed on 6/8/2016 at 11:10 a.m. Diagnoses included, but were not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, hypertension, urinary retention, benign prostatic hypertrophy (BPH) with lower urinary		medical care for 4 residents (Resident C, D, E and F). · Resident B was discharged from facility · Resident C & E were assessed and md & family notified · Resident F expired on 6/12/16 · All residents have the potential to be effected All residents with CHF were assessed to ensure current pulmonary status was captured and MD notified immediately of anyone with adventitious breath sounds, edema, or weight change per policy, and care plans ere reviewed by 6/11/2016. All care plans were reviewed for accuracy & updated as needed by Vice President of Case Management on June 12, 2016. · Director of Health Services, Assistant Director of Health Services, Unit Manager, Med Records Nurse, staffing nurse, and floor nurse did assess all current residents on campus to ensure no	

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	symptoms/retention, history of venous thrombosis, peripheral vascular disease, and localized edema. Resident B was admitted to the facility on 11/10/2015 for rehabilitation following hospitalization for acute on (top of) chronic renal injury related to BPH with obstructive uropathy and urinary retention. The resident was discharged 26 days later on 12/6/2015. Resident B's admission Minimum Data Set (MDS) assessment, dated 11/17/2015, indicated a Brief Interview for Mental Status (BIMS) score of 14; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ person physical assist for transfers and was non-ambulatory. The resident had an indwelling Foley catheter and received oxygen therapy. Hospital Extended Care Admitting Orders for Resident B, dated 11/10/2015 at 2:15 p.m., indicated, "...Diet: 1500 ml [milliliter] fluid [restriction]...No Longer Take the Following Medications: ...furosemide [Lasix] 40 mg [milligram] oral tablet, 1 tablet by mouth every day...Discharge Instructions/Patient Education Materials: ...weigh yourself every day, at the same time of day, and in		changes in condition by 6/11/2016 a. All changes discovered upon assessment were reported to the MD and family, changes were documented, appropriate orders obtained and resident was added to pertinent charting for follow-up. · All Nurses (RN, LPN) were educated prior to working the floor, on head to toe assessment, identifying and documenting change in condition, notifying MD and family of changes as well as follow up documentation on any change in condition by 6/11/2016. All licensed nurses were also required to take a pre and post test on critical thinking questions, related to several clinical pathways prior to working the floor starting 6/11/2016. All licensed nurses were educated prior to working the floor on skilled documentation & notifying on call nurse of any change of condition by 6/11/2016.	

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	the same kind of clothes. When to call your doctor: Call your doctor right away if you have any of these signs of worsening heart failure: sudden weight gain (more than 2 pounds in 1 day or 5 pounds in 1 week, or whatever weight gain you were told by your doctor). Trouble breathing related to not being active. New or increased swelling in your legs or ankles...Breathing trouble at night...." Resident B's Hospital Nephrology Discharge Note, dated 11/10/2015, indicated, "...Chronic SOA [shortness of air] - [at] baseline. Chronic LE [lower extremity] swelling - states at baseline...ext [extremities] trace BLE [edema bilateral lower extremities]...hesitant to start...diuretic for now, but should he develop sig [significant] edema or worsening breathing, a loop diuretic could be restarted...." Resident B's Physician Order Report for 11/10/2015 to 12/6/2015 indicated, "Start Date: 11/16/2015: check weight daily. Once a day; p.m...Fluid restriction of 1500 ml per day...Foley cath output every shift...." Resident B's written Physician's Orders, dated 11/10/2015, and signed by the		In addition a list of all licensed nurses has been developed and no nurse will be allowed to work the floor without completing this education prior to assuming the floor. All Nursing staff will be educated on following MD orders and care plans by 7/08/2016. · Director Health Services, Assistant Director Health Services, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by Director Health Services, Assistant Director Health Services or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a	

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	primary care physician 1/12/2016, indicated no orders for oxygen administration. There was no evidence in the clinical record of physician's orders for oxygen administration from Resident B's admission on 11/10/2015 through 12/06/2015 . Resident B's Skilled Charting - Admission Assessment, dated 11/10/2015 at 11:22 p.m., indicated the resident was alert and oriented to person, place, time and situation, did not have difficulty sleeping at night, did not use oxygen, denied shortness of breath, and did not have anxiety present. The assessment indicated Resident B's respirations were regular and unlabored, he did not have a cough, and lung sounds were clear in all fields. The resident had 1 + pitting edema in his left and right lower extremities. The resident had a Foley catheter and no urinary symptoms. The resident denied pain. Initial Nutrition Plan of Care indicated, "observe weight...daily...Vitals: Pulse: 67/per minute. Respirations: 20/per minute. Blood Pressure: 146/77. O2 Saturation: 95%. Activity: Resting...Oxygen Use: No...." A Care Plan for Resident B indicated,		change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy. · A random sample residents' care plans and new MD orders will be reviewed in morning Clinical Care Meeting for accuracy of execution by Director of Health Services, Assistant Director of Health Services, MDS Coordinator or Designee 5 residents per week x 4 weeks, 3 residents per week times 4 weeks, 1 resident per week times 4 weeks and then 5 residents per month x 3 months. · All new admissions and re-admissions will be reviewed for appropriate care plans and MD orders daily in clinical care meeting. · All residents who have a current order for daily weights will require a physician order for parameters for Physician notification as of 6/11/16.	

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	"Problem Start Date: 11/23/2015. I am at risk for alteration in fluid balance related to my having a fluid restriction and my diagnosis of CKD [chronic kidney disease] with recent ARF [acute renal failure]. Approach Start Date: 11/23/2015. Assist with fluids as needed...Observe me for s/s [signs/symptoms] fluid overload such as edema, distended neck veins, edema. Notify my MD as needed...Weigh resident as ordered." A Care Plan for Resident B, initiated 11/23/2015, indicated, "Problem: I have a diagnosis of congestive heart failure, HTN [hypertension]...Approach: Administer oxygen as ordered. Monitor me for fluid excess, wt. gain, increased BP, full/bounding pulse, jugular vein distention, SOB [shortness of breath], rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...Please monitor me and report signs of respiratory distress, cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse. Please monitor my intake of food and fluids...." A Care Plan for Resident B, initiated		All future residents that obtain a Physician order for daily weights will require MD to provide parameters as to when facility shall notify MD. All residents currently with daily weights will have MD orders for parameters regarding when to notify physician by 6/14/16. Until then, all residents on daily weights with a weight gain of 3 pounds or greater in one day or 5 pounds or greater in one week will require MD notification. · The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee. QA will occur weekly X 4 weeks and then monthly thereafter.	

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	11/23/2015, indicated, "Problem: I have COPD/Emphysema...Approach: My care givers will monitor my lung sounds daily. My care givers will observe me for changes in my breathing or level of consciousness and report to my doctor...." Physician's Progress Notes for Resident B, signed by the resident's primary care physician (PCP), dated 11/11/2015 at 4:15 p.m., indicated, "...breathing at baseline...Lungs - CTA [clear to auscultation] B [bilaterally]...Ext [extremities] - 2+ edema on R [right], 1+ [edema] on L [left]...CHF - stable - monitor for fluid overload. Daily weights." A Progress Note for Resident B, dated 11/21/2015 at 1:45 p.m., indicated, "Resident has 3+ swelling to bilateral feet, Resident in recliner with feet elevated." A Progress Note for Resident B, dated 11/22/2015 at 11:41 p.m., indicated, "Resident continues to have bilateral lower leg edema..." There were no additional assessments, events, or physician notification related to these progress notes dated 11/21-22/2015.			

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	Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on 11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015. Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked, associated assessments were competed, the physician was notified, or a change of condition/event was initiated. Resident B's Vitals Report indicated his intake of fluids was 1840 ml fluids on 12/3/2015. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L],			

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	tried repeatedly to have him do pursed lip breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhalation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the pursed lip breathing several times. Increased the O2 to 3.5L via nasal canula [sic]. Resident is very anxious...has not slept all night." Resident B's Vital Sign Report indicated the following: 12/4/15 at 0300: RR 26/minute, BP 172/82, O2 sat 92% on 3.0 L 12/4/15 at 0400: RR 32/minute [red], 154/74, O2 sat 93% on 3.5 L The following Progress Note, dated 12/4/2015 at 8:04 a.m., "Given MOM [Milk of Magnesia] this shift...." The following Progress Note, dated, 12/4/2015 at 1:33 p.m., indicated, "Resident has small BM [bowel movement]." The following Progress Note, dated 12/4/2016 at 8:55 p.m., indicated, "No BM this shift."			

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	There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's respiratory status being assessed (lung sounds), shortness of air, or edema being assessed, or the physician or family being notified on 12/4/2015, 12/5/2015 or 12/6/ 2015. On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow: 2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated, "Resident frequently c/o shortness of breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure 191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter			

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	flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated, "Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood pressure] and increase in respirations as well." The following vital signs, dated 12/6/2015 at 8:04 p.m., indicated, "Blood Pressure 152/74 mmHg. Pulse: 66. 02 Saturation: 95%. Resting. Oxygen Use: Yes - Liter Flow: 3.5 Liter. Activity: Low. Respirations: 26/minute. Resting." There were no Progress Notes, Events, or other evidence in the record to indicate that additional assessments related to Resident B's respiratory status and/or edema, follow up, or physician notification were completed.			

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	A Progress Note for Resident B, dated 12/6/2015 at 7:48 p.m., indicated, "Res. [resident] c/o SOB [shortness of breath], SpO2 recorded at 88%/3L/NC [liter/nasal cannula]. Assessment revealed oxygen tubing had beside [sic] table sitting on it, Resident's w/c was also parked on top of and crushing the oxygen tubing. Additionally the oxygen line had become completely separated the water trap by the w/c rolling over it...new tubing installed...saturations hold steady at 95%...." A Progress Note for Resident B, dated 12/6/2015 at 7:58 p.m., indicated, "Res. stated he feels "like I need to go to the hospital." Res. spoke with [family member] on the phone and states his [family member] is on the way here. Assessment completed (See vitals)." There was no evidence of an assessment related to this Progress Note anywhere in Resident B's record. A Progress Note for Resident B, dated 12/6/2015 at 8:21 p.m., indicated, "Res POA [family member] arrived at the facility...POA states he wants the resident to go to the ER [emergency room]...N.O. [new order]...to send to...ER for eval and Tx."			

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	There was no evidence of, and facility staff were unable to provide any evidence of skilled charting or nursing assessments for Resident B on November 14, 21 or 25, 2015 or December 2 or 5, 2015. Resident B's skilled nursing assessment documentation from 11/10/2015 through 12/6/2015 routinely indicated the resident was on a diuretic and had no side effects as a result of that diuretic. Daily skilled nursing assessment documentation routinely did not address/left blank edema and/or lung sounds. There were no additional events or progress notes related to resident assessment of lung sounds, edema, or physician notification. The last documented breath sounds for Resident B were 12/1/2015 at 11:09 a.m., which indicated, "CTA [clear to auscultation]." Resident B's Urine Output Record indicated the following: 12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL			

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	There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the decreased urine output. The resident had no evidence anywhere in the Medication Administration Record (MAR) or Treatment Administration Record (TAR) that lung sounds were assessed related to small volume nebulizer treatments. Resident B's Emergency Medical Services (EMS) Ambulance Report, dated 12/6/2015, indicated they were dispatched at 8:38 p.m., arrived at the facility at 8:42 p.m., and arrived at the Emergency Department at 9:04 p.m. The report indicated, "Pt [patient] is shorter of breath than normal...pt with obvious edema globally...Respiratory: Effort: Distressed. Sounds: L: Diminished bases. R: Diminished bases. Oxygen: 3.5 lpm via NC Healthcare Provider [facility]...." EMS records indicated the resident did not receive any intravenous fluids or diuretic medication en route to the Emergency Department. Resident B's Emergency Room Record, dated 12/6/2015 at 9:10 p.m., indicated, "CC [chief complaint]: [up arrow] SOB, edema x 3 days. Location:			

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	chest/respiratory...Severity: severe. Duration: last 2-3 days. Timing: Constant...Associated signs: leg swelling...CXR [chest x-ray]: CHF...Diagnosis; exacerbation CHF, CRF...." A Hospital Emergency Department Primary Nursing Assessment for Resident B, dated 12/6/2015, indicated, "...Respiratory: Labored, Dyspnea,Increased rate, Cough - moist/nonproductive. Breath sounds: Left: Rhonchi, wheezing. Right: Rhonchi, wheezing...Peripheral edema: Feet, Ankles 4+...Neurological: Alert. Oriented x 3. Anxious...Nursing Problem List: 1. SOB [shortness of breath]. 2. Edema...2106 [9:06 p.m.] pt sent from [facility]...increased SOB, along with edema for 3 days, report states it is increasingly getting worse. Pt. has 4+ pitting edema...." Resident B's Hospital History and Physical Examination (Hospital 1), dated 12/6/2015, indicated, "...He presented to the emergency department with significant shortness of breath and tight lungs. He was admitted with an exacerbation of his chronic obstructive pulmonary disease and congestive heart failure, diuresed, and states he is starting to feel better already...."			

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	Resident B's Cardiology Consultation (Hospital 1), dated 12/7/2015, indicated, "...The patient had been doing relatively well and participating in rehab at [facility]. In the last 3 to 4 days, he started having some increasing shortness of breath and noted some ankle swelling. Yesterday, he became orthopneic with PND [paroxysmal nocturnal dyspnea] and had shortness of breath at rest...came to the emergency department where he was found to have evidence of heart failure. He has received IV [intravenous] Lasix and is already feeling improved...." Hospital 1 documentation indicated the resident required on-going Nephrology consultation/care and was transferred/admitted to Hospital 2 on 12/11/2015. Resident B's Clinical Documents Progress Note (Hospital 2), dated 12/11/2015, indicated, "...History of present illness: ...recently here...between the dates of 11/5/2015 through 11/10/2015 for acute kidney injury superimposed on chronic kidney disease. He also had issues with systolic heart failure during that time. On discharge...as [renal function] improved patient gradually developed worsening weight gain and fluid retention. He			

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	presented to [Hospital 1] 12/7 [sic]/2015 and was diuresed...Unfortunately with aggressive diuresis at that time his creatinine continued to steadily increase...Assessment/Plan: 1. Acute kidney injury on chronic kidney disease stage 3-4. This is most likely in relation to requirements for aggressive diuresis in light of his issues with CHF exacerbation...2. Acute exacerbation on chronic systolic congestive heart failure...." Nephrology Clinical Consultation (Hospital 2), dated 12/12/2015, indicated, "...Assessment/Plan: ...had diuresis just over 2L [at Hospital 1] given his fairly massive volume expansion....Acutely decompensated systolic congestive heart failure." Resident B was discharged to Hospice on 12/18/2015 and expired 12/24/2015. Discharge Diagnoses indicated, "1. Acute kidney failure, unspecified. 2. Acute on chronic systolic (congestive heart failure). 3. Chronic obstructive pulmonary disease with (acute) exacerbation...." Resident B's [family member], primary care giver and Power of Attorney (POA), was interviewed on 6/8/2016 at 1:16 p.m. Resident B's [family member] indicated he was not notified that [Resident B] was			

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	not on Lasix while he was at the facility and Resident B's [family member] indicated he raised repeated concerns over [Resident B's] increased lower extremity edema and increasing shortness of breath to staff and was told [Resident B] was "fine." Resident B's [family member] indicated the resident and family alerted staff multiple times throughout his stay that his ankles and feet were more swollen than usual and the family took the resident's recliner into him. The [family member] indicated he had never seen [Resident B] with that much swelling. Resident B's [family member] indicated [Resident B] called him 12/6/2015 and indicated to him that he had spent the previous 2 nights and 3 days sitting up in his wheelchair and not in his recliner due to shortness of breath. The [family member] indicated, "He [Resident B] said, 'I felt like I was going to drown if I laid back [in my recliner].'" Resident B's [family member] indicated he was not notified by the facility of [Resident B's] additional increased swelling and increasing shortness of breath 12/3/2015 through 12/6/2015. He indicated [Resident B] called him related to his decline and he requested his physician be called and he be sent to the emergency room for evaluation on 12/6/2015.			

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	Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated that monitoring for fluid overload would include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be notified of a 5 pound weight gain in one day. Licensed Practical Nurse (LPN) # 2 was interviewed on 6/8/2016 at 3:06 p.m. He indicated he cared for Resident B periodically and was on duty on 12/6/2016 when Resident B was sent to the Emergency Department. LPN # 2 indicated, "[Resident B] was just not doing good...he wasn't in good condition. He had swelling issues." LPN # 2 indicated, "If [a resident's] sats are not doing well, we [nursing] would put on our report sheet and in [resident] progress notes." LPN # 2 indicated daily assessments and documentation were based on the resident's primary admitting diagnosis. Regarding monitoring for fluid overload, weight fluctuations, and edema, LPN # 2 indicated the physician			

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	would order parameters regarding notification. The LPN indicated, "If the weight exceeds the parameters, I would send a fax...unless it says call." LPN # 2 indicated, "The staff would catch a 5 pound weight gain in a day...if there's a change [in resident condition] from the norm, I don't know if that would be an event, but I would let somebody know. I would just do a progress note." The Interim Director of Health Services (IDHS) and the Assistant Director of Health Services (ADHS) were interviewed on 6/8/2016 at 4:12 p.m. The Interim DHS indicated that Resident B was being assessed related to his renal failure because that was his admitting diagnoses. The ADHS indicated nursing staff would be charting on the renal diagnoses because that was their "number one concern." The DHS indicated all residents were assessed daily related to their primary admitting diagnosis. She indicated a resident who was admitted for a foot fracture, but had co-morbidities such as COPD, CHF, or kidney failure, would be prompted to do a daily orthopedic assessment. She indicated orthopedic assessments did not include assessments of edema, breath sounds, or respiratory status. Both the DHS and ADHS indicated there were no policies or procedures related to			

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	monitoring for fluid overload, monitoring for changes in condition, documentation or assessment and that they relied on "best [nursing] practices." The Director of Health Services (DHS) was interviewed on 6/9/2015 at 1:50 p.m. regarding expectations for monitoring for fluid overload. The DHS indicated there was no policy and procedure related to edema, monitoring for fluid overload, CHF, or COPD. The DHS indicated, "Just monitor their intake and edema. That's what I would do." On 6/9/2015 at 4:25 p.m., the DHS indicated she "probably would not" document an event or change in condition for a weight change." The DHS indicated the facility relied on "best practices" to direct nursing staff when to do assessments, under what category to document them, and when to notify the physician of changes. The ADHS was interviewed on 6/9/2016 at 4:31 p.m. regarding the policy and procedure related to documenting and reporting changes in condition, events, and monitoring for fluid overload. She indicated there were no policies and procedures. The ADHS indicated, "That's nursing judgement whether to do an event, a change in condition, or a			

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	progress note." On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) provided a current copy of [facility] Guide to Event Notification Critical Thinking. She indicated that when changes in condition are observed, an "event" is initiated. She indicated that "artificial intelligence" indicated to the nursing staff when to notify the physician. The CNO indicated a section of the document which was circled and indicated the residents reviewed did not meet any of the criteria related to edema. The circled documentation indicated, "New Onset Edema Event. Notification Guidelines. Notify MD/NP immediately...for any of the following...Abrupt pt onset of edema in one leg with loss of sensation. Abrupt onset edema with tenderness and redness. Edema with sudden onset of shortness of breath, and/or chest pain." The notification guideline not circled by the CNO indicated, "Weight gain of 3 or more pounds in last 7 days." On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before			

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	and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident B over the last three months and/or with small volume nebulizer treatments (SVN's). On 6/10/2015 at 10:06 a.m., the CNC indicated the facility did not have a specific policy or procedure related to change in condition. The CNC provided a current copy of [Facility] Guide to Events, which was reviewed at that time. The document indicated, "...Category of Observation: Cardiovascular. Event Name: ...New Onset Edema. Possible Reasons: Increased Or New Edema...Category of Observation: ...Other Events: ...Event Name: Other Physical Changes in Condition: Possible Reasons: Non-specified physical changes...Category of Observation: Respiratory/EENT: Event Name: Respiratory: Possible Reasons: Breathing/Respiration Changes..." On 6/8/2016 at 4:15 p.m., the ADHS was queried regarding the new onset/new documentation of Resident B's 3 + pitting			

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	edema on 11/21/2015 at 1:45 p.m. (above) and why event/change in condition documentation was not initiated or the physician notified of the change. The ADHS indicated, "It [edema] depends on other factors. It could just be the time of day." On 6/8/2016 at 4:25 p.m. the ADHS and DHS provided a copy of the current Guidelines for Weight Tracking Policy and Procedure and it was reviewed at that time. They indicated there were no additional policies or procedures related to weight tracking and/or specific to edema and/or respiratory diagnoses. The Procedure indicated, "...6. The weight should be recorded in the individual resident medical record. 7. Residents who have a weight that seem [sic] out of normal range shall be re-weighed to determine the accuracy of the original weight..." On 6/8/2016 at 4:36 p.m., the ADHS provided a copy of the current Physician Notification of Diagnostic Testing and Change in Condition Policy and Procedure and it was reviewed at that time. The document indicated, "Purpose: To ensure the...physician is aware of all...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for			

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	care. Procedure: 1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known....10. Attempts to notify the physician and their response should be documented in the resident record...." On 6/10/2016 at 4:42 p.m., LPN # 8 indicated she would document any significant change in resident condition in the progress notes. On 6/15/2016 at 5:37 p.m., the CNC # 2 indicated oxygen did not require a physician's order and was a "standing order." 2. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, Alzheimer's disease, hypertension, and localized edema. Resident F was admitted to the facility on 6/5/2016 following hospitalization for a fecal transplant. The resident was admitted to Hospice on 6/9/2016 and expired on 6/12/16. Resident F's Admission Assessment,			

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	dated 6/5/2016 at 6:29 p.m., indicated, "...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place...Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]. Sacral edema: [blank]. Left upper extremity edema: [blank]. Right upper extremity edema: [blank]...Comments: [blank]...." Resident F, who was admitted 6/5/2016 at 3:45 p.m., had no vital signs documented until 6/6/2016 at 3:55 a.m. A Care Plan for Resident F indicated, "I have edema...monitor and record my edema...." A Progress Note for Resident F, dated 6/5/2016 at 3:45 p.m., indicated, "Admitted...alert [and] oriented x 3, mood pleasant...." A Progress Note for Resident F, dated 6/7/2016 at 6:20 p.m., indicated, "resident returned from emergency room with peripheral IV [PIV] in left wrist. no s/s [signs/symptoms] infiltration noted. has normal saline running at 100 cc per hour for dehydration...is oriented to person and place. alert. asking for television to be turned on the news...nonpitting edema noted in both hands. 2-3+ pitting edema			

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	noted in bilateral legs...." The following Progress Note, dated 6/8/2016 at 3:30 a.m., indicated, "...Edema continues...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat." Resident F's Progress Note, dated 6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%." A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request." On 6/9/2016 at 2:51 p.m., the CNC			

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	indicated nursing staff did not have time to complete or document an assessment related to Resident F's change in condition prior to being sent to the Emergency Department on 6/8/2016 at 11:32 a.m. On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events, changes in condition, or physician notification associated with this abnormal value. The next blood pressure assessment was not until 6/7/2016 at 7:07 p.m. There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was discontinued. There was no documentation anywhere in Resident F's clinical record to indicate Resident F's left upper extremity was assessed following the 6/8/2016 at 6:46 a.m. progress note. On 6/9/2016 at 3:25 p.m., CNA # 14 indicated that, prior to this date, Resident			

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	F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. CNA # 10 was interviewed on 6/9/2016 at 9:50 a.m. She indicated, "[Resident F has] been in the hospital. They sent her out yesterday because she was unresponsive. She had an IV for dehydration, but it wasn't working. It caused her to swell up like a balloon...." Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON, DON, Executive Director (ED) indicated they were not aware Resident F had been			

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	unresponsive or her IV had infiltrated. On 6/9/2016 at 5:37 p.m., the ADHS indicated she had just gotten off the phone with RN # 7, who cared for Resident F the morning the resident went to the Emergency Department on 6/8/2016. The ADHS indicated the resident was sleeping "normally" when the nurse checked on the resident and the resident was at baseline. Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably should have called the on-call...Her swelling was terrible...a lot of third			

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	spacing...her legs, her feet, all over. Her skin was cool....I would just chart it [change of condition] under Progress Notes." Resident F was interviewed on 6/10/2016 at 11:50 a.m. She was observed to be awake and alert, but hard of hearing. When queried as to how she felt, she indicated, "Better." RN # 11 was interviewed on 6/10/2016 at 2:00 p.m. regarding assessing residents with CHF and edema who were at risk for fluid overload. RN # 11 indicated, "I wouldn't listen to lungs everyday, but I would check swelling and temperature." 3. Resident E was interviewed on 6/8/2016 at 3:12 p.m. The resident was observed wearing cotton athletic socks and open sandals with 3+ edema in his bilateral lower ankles and feet. He was sitting up with his legs (hanging down) in his wheelchair. The resident indicated he had occasional lower extremity edema/swelling at baseline, but worsening edema since he had been in the facility. The resident indicated he had notified staff he was concerned regarding his increased edema in recent weeks. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses			

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	included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery. Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated, "Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]...Vitals: Pulse: 96/per minute. Respirations: 18 per minute. Blood Pressure: 138/83 mmHg...." There was no evidence in Resident E's clinical record that he had a care plan related to edema. A Care Plan, initiated 4/20/2016, indicated, "Problem: High Risk Medications. I have potential for decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please			

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	monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure...." LPN # 16 was interviewed on 6/9/2016 at 3:15 p.m. at Resident E's bedside. She touched resident E's foot lightly over his socked foot and indicated his edema was, "3+ pitting." LPN # 16 indicated the resident had edema since admission and it starting getting worse approximately two weeks ago. LPN # 16 indicated a form had been sent in to Resident E's physician to notify him/her of the resident's change in condition that day. LPN # 16 indicated that nursing staff assisted Resident E to elevate his legs during the day, pointing to a bench against the wall. During an interview on 6/9/2016 at 3:06 p.m., Resident E indicated he was not encouraged or assisted to elevate his legs during the day and that the edema in his bilateral lower extremities had become progressively worse in recent weeks. The resident indicated he had pain and "tingling" related to the edema. During multiple observations on 6/8/2016 at 9:59 a.m., 6/8/2016 at 3:12 p.m., 6/9/2016 at 3:06 p.m., and 6/10/2016 at 11:15 a.m., Resident E was observed to have 3+ edema in his bilateral lower ankles and feet, with his legs dependent			

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	(hanging down) in his wheelchair. There was no evidence in the clinical record that Resident E's lower extremity edema was fully assessed or monitored, or that the physician was notified of changes. There were no events or changes in condition related to Resident E's edema. Resident E did not have evidence of daily skilled assessments on 5/24, 5/29, or 6/3/2016. Resident E's recorded weights were as follows: 4/2/2016: 172.6 pounds 4/3/2016: 172.3 pounds 4/10/2016: 176.4 pounds 5/11/2016: 184.2 pounds There was no evidence anywhere in Resident E's clinical record that the physician was notified related to Resident E's weight gain. On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]." There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was			

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	done, or the physician was notified. The next recorded vital signs were on 5/7/2016, when Resident E's blood pressure was indicated to be 111/82 mmHg. A Progress Note for Resident E, dated 5/30/2016, indicated the resident was "extremely edematous" with no additional values/assessments/comparisons related to the edema, vital signs, or respiratory assessments. On 6/10/2016 at 3:46 p.m., the DHS indicated resident alerts abnormal vital signs (highlighted in red) go the the DHS in the form of "messages." On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure (above). 4. Resident D's clinical record was reviewed on 6/9/2016 at 2:15 p.m. Diagnoses included, but not limited to, COPD, CHF, acute kidney failure, and recent foot fracture. The resident was admitted to the facility 3/7/2016 for rehabilitation following a foot fracture.			

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	Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." Resident D's Admission Nursing Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift... Cardiovascular: H			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent the potential for a fall with serious injury for 1 resident (Resident F). Findings include:	F 0323	F323: Failure to provide adequate supervision to prevent the potential for a fall with serious injury for 1 resident (Resident F). · CCRA returned to Resident F room and residents	07/15/2016

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	1. During an observation on 6/9/2016 at 3:24 p.m., Resident F's door was observed to be open with the resident's bare feet visible from the doorway. Upon entering the doorway, Resident F was observed to be alone in the room, with the air mattress in the high position, legs apart, completely exposed except for an adult brief. The resident's arms were crossing her chest to cover her breasts. At 3:25 p.m., CNA #14 entered the room and indicated, "My nurse was just in here." CNA # 14 indicated she left the room to answer a call light across the hall. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, and Alzheimer's disease. Resident F's Admission Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "...Staff assist with transfer: 2 person facility staff assist...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place...Safety Review and Considerations: Has cognitive impairment that effects safety/judgement...Requires assistance to		F bed was lowered to appropriate bed height immediately on 6/9/16. · All residents have the potential to be effected · All Nursing staff will be in serviced on when leaving a resident in safe position including call light and bed height before leaving. Rounds will be conducted every shift for 12 weeks and documented with any concerns addressed and corrected immediately with staff re-education. Then 10 resident rooms daily x 4 weeks then 10 resident rooms per month x 2 months. · All nursing staff will be in-serviced on resident care procedures: Procedure 1 Initial Steps, Procedure 2 final steps, from the Indiana State Department of Health CNA curriculum paying attention to safety check and bed height & positioning of the resident.	

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	transfer. Takes meds that may affect balance, cognition or gait. Incontinent of bowel and/or bladder. Has disease or condition that predisposes to falls..." On 6/10/2016 at 1:30 p.m., CNC # 1 indicated the observation of Resident F's bed in the elevated position unattended was "a big safety concern" and management needed to educate staff. On 6/15/2016 at 5:37 p.m., CNC # 2 indicated Resident F's Admission Nursing Assessment identified the resident as a fall risk. A current copy of the Falls Management Program Guidelines was provided by the Executive Director (ED) on 6/15/2016 at 5:10 p.m. The document indicated, "Purpose: [Facility] ...maintain a hazard free environment, mitigate fall risk factors and implement preventative measures..." This Federal tag relates to Complaint IN00200175. 3.1-45(a)(2)			
F 0441	483.65			

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SS=D Bldg. 00	INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure	F 0441	F441: Failure to ensure proper signage for a resident on	07/08/2016

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	proper signage for a resident on contact precautions and proper handling of soiled linens (Resident F), maintaining a resident's catheter bag to prevent the potential for infection (Resident E), and handwashing (Resident M). Findings include: 1. During an initial tour with the Medical Records Coordinator (MRC) and the Executive Director (ED) on 6/8/2016 at 9:50 a.m., the MRC indicated Resident F had Clostridium difficile (C. diff; infectious bacteria which causes loose stools) and was on "isolation." There was no sign observed on or around the doorway to indicate special precautions were to be observed. During an interview on 6/8/2016 at 9:50 a.m., the ED indicated there should have been a sign posted on Resident F's door to alert visitors to check with the nurse. A copy of the current Precaution Categories Policy and Procedure was provided by the ED on 6/8/2016 at 3:34 p.m. The document indicated, "....4. When isolation precautions are implemented and [sic] appropriate sign that has the words "Visitors Report to the Nursing Station Before Entering"...will be posted on the entrance doorway of the		contact precautions and proper handling of soiled linens (Resident F), maintaining a resident's catheter bag to prevent the potential for infection (Resident E), and hand washing (Resident M). · Immediately staff placed proper signage on Resident F's door · Resident E was immediately taken to his room and catheter covering was applied to maintain resident's dignity. · All residents have the potential to be effected. · All staff will be in-serviced on Hand washing and Hand rub procedures by 7/08/2016. · All nursing staff will be in-serviced on precaution guidelines which includes proper signage, infection control and catheter bag and dignity by 7/08/16. · Audit 3 residents x 4 weeks, then 2 residents x 4 weeks then 2 residents monthly x 2 months	

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	resident room...6. Contact Precautions should be used for individuals...infected with...2. Diarrhea associated with Clostridium difficile..." 2. During an observation on 6/9/2016 at 3:24 p.m., Resident F's door was observed to be open with a large pile of sheets, gowns, towels, disposable underpad, and yellow isolation gowns soiled with a brown, wet, foul-smelling substance on the carpeted floor at the foot of the bed. A bare,blue pillow was on the floor partially on top of the pile of soiled linens. During an observation and interview on 9/9/2016 at 3:25 p.m., CNA # 14 entered the room and indicated Resident F had C. diff and had been incontinent of a large, bloody liquid stool and she had been providing incontinent care. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile. A copy of the current Guidelines for Handling Linen Policy and Procedure was provided by the ED on 6/9/2016 at 10:41 a.m. The document indicated, "Dirty Linen: ...2. Place soiled linens in a plastic bag if wet or soiled with feces...4.			

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	Do not place soiled linen on furniture or floor..." 3. During an observation on 6/8/2016 at 3:12 p.m., Resident E was observed self-propelling in his wheelchair down the main hallway of the facility with his urninary catheter bag partially full of urine, exposed, and dragging on the floor under his wheelchair. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Admission Minimum Data Set (MDS) assessment, dated 2/27/2016, indicated a Brief Interview for Mental Status (BIMS) score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. The resident had a Foley catheter. A copy of the current Guidelines for the Use of Indwelling Catheter Policy and Procedure was provided by the Executive Director (ED) on 6/9/2016 at 10:41 a.m. The document indicated, "A resident with...a catheter, receives the appropriate care and services to prevent infections to the extent possible..." 4. During an observation on 6/9/2016 at 10:05 a.m., CNA # 23 was observe			

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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
	assisting Resident H down the hallway with a bag of soiled linens in her bare left hand. She entered the dirty utility room, disposed of the soiled linens, did not perform handwashing, and left the dirty utility room. CNA # 23 then approached Resident M in the common area near the dirty utility room and touched her hair and adjusted her shirt. A copy of the current Guidelines for Handwashing/Hand Hygiene Policy and Procedure was provided by the ED on 6/9/2016 at 10:41 a.m. The document indicated, "...Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [long term care facilities]...Procedure: Health Care Workers shall wash hands at times such as: ...c. Before/after having direct physical contact with residents. d. After removing gloves...7. Wet hands...8. Wash well for 20 seconds..." This Federal tag relates to Complaint IN00200175. 3.1-18(a) 3.1-18(l) 3.1-19(g)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155797		06/15/2016

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F 0490 SS=K Bldg. 00	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure administration effectively ensured the highest practicable physical, mental, and psychosocial well-being of 5 of 5 residents reviewed for quality of care. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4 residents (Residents C, D, E, and F). This Immediate Jeopardy began on 11/21/2015 when the facility failed to assess vital signs for a period between 11/20/2015 at 9:37 a.m. and 11/22/2015 at 6:51 a.m. and a 5.2 pound weight gain between 11/22/2015 and 11/23/2015 was not reported to the physician and was identified on 6/10/2016. The Executive Director, Assistant Director of Health Services, the Interim Director of Health	F 0490	F490: Failure to ensure administration effectively ensured the highest practicable physical, mental and psychosocial well-being of 5 of 5 residents reviewed for quality of care. This failure resulted in a delay in medical care and hospitalization for 1 resident (Resident B), and the delay in medical care for 4 residents (Resident C, D, E and F). · Resident B was discharged from the facility · Resident C & E were assessed and md & family notified · Resident D was discharged on 6/14/16 · Resident F expired on 6/12/16 · All residents have the potential to be effected · All Staff will be in-serviced on Abuse and Neglect & Resident Rights by 7/08/2016 · The results of the assessments/audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. QA will occur weekly X 4 weeks and then	07/08/2016

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	Services, Clinical Support RN # 1, Clinical Support RNA# 2, and the Medical Records Coordinator were notified of the Immediate Jeopardy at 1:42 p.m. on 6/10/2016. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident B's [family member], primary care giver and Power of Attorney (POA), was interviewed on 6/8/2016 at 1:16 p.m. Resident B's [family member] indicated he was not notified that [Resident B] was not on Lasix while he was at the facility and Resident B's [family member] indicated he raised repeated concerns over [Resident B's] increased lower extremity edema and increasing shortness of breath to staff and was told [Resident B] was "fine." Resident B's [family member] indicated the resident and family alerted staff multiple times throughout his stay that his ankles and feet were more swollen than usual and the family took the resident's recliner into him. The [family member] indicated he had never seen [Resident B] with that much swelling. Resident B's [family		monthly thereafter. · Director of Health Service, Assistant Director Health Service, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by DHS, ADHS or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy · The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee. QA will occur weekly X 4 weeks and then monthly thereafter. · A special QAA meeting including Administrator, Director of Health Services, Assistant Director of Health Services, MDS Coordinator, Medical Records, Business Office Manager, Life Enrichment, Director of Food Services, Director of Environmental Services, Director of Plant Operations was conducted on June, 30 2016 that validated completion of all	

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	member] indicated [Resident B] called him 12/6/2015 and indicated to him that he had spent the previous 2 nights and 3 days sitting up in his wheelchair and not in his recliner due to shortness of breath. The [family member] indicated, "He [Resident B] said, 'I felt like I was going to drown if I laid back [in my recliner].'" Resident B's [family member] indicated he was not notified by the facility of [Resident B's] additional increased swelling and increasing shortness of breath 12/3/2015 through 12/6/2015. He indicated [Resident B] called him related to his decline and he requested his physician be called and he be sent to the emergency room for evaluation on 12/6/2015. Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated that monitoring for fluid overload would include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be notified of a 5 pound weight gain in one day.		education including but not limited to (list of education, assessments attached) all residents currently residing in facility and was validated as completed within this statement on 06/30/2016. The Divisional Vice President from Home office will provide oversight to the administrator monthly x 3months then quarterly times 6 months. **Abatement Plan – Assessment and Notification of Acute Changes Aspen Place Health Campus 6/10/16 – 6 PM** **1.** All residents with CHF will be assessed to ensure current pulmonary status is captured and MD notified immediately of anyone with adventitious breath sounds, edema, or weight change per policy, and care plan reviewed by **6/11/2016.** 2. DHS, ADHS, UM, Medical Records nurse, staffing nurse, floor nurse will assess all current residents on campus to ensure no changes in condition by 6/11/2016. · If any changes in condition are discovered upon assessment the nurse will: Notify Physician and family of	

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	Resident B's Skilled Charting - Admission Assessment, dated 11/10/2015 at 11:22 p.m., indicated the resident was alert and oriented to person, place, time and situation, did not have difficulty sleeping at night, did not use oxygen, denied shortness of breath, and did not have anxiety present. The assessment indicated Resident B's respirations were regular and unlabored, he did not have a cough, and lung sounds were clear in all fields. The resident had 1 + pitting edema in his left and right lower extremities. The resident had a Foley catheter and no urinary symptoms. The resident denied pain. Initial Nutrition Plan of Care indicated, "observe weight...daily...Vitals: Pulse: 67/per minute. Respirations: 20/per minute. Blood Pressure: 146/77. O2 Saturation: 95%. Activity: Resting...Oxygen Use: No...." Resident B's Hospital Nephrology Discharge Note, dated 11/10/2015, indicated, "...Chronic SOA [shortness of air] - [at] baseline. Chronic LE [lower extremity] swelling - states at baseline...ext [extremities] trace BLE [edema bilateral lower extremities]...hesitant to start...diuretic for now, but should he develop sig [significant] edema or worsening		changes, as well as, document changes and obtain appropriate orders if warranted. Resident will be added to pertinent charting for follow up 3. All Nurses (RN, LPN) will be educated on head to toe assessment, identifying and documenting change in condition, notifying MD and family of changes as well as follow up documentation on any change in condition. All nurses will be educated and require pre and post test on critical thinking questions on several clinical pathways. All licensed nurses will be educated on completing skilled documentation and notifying on call nurse of any change of condition by 06/12/16. **In addition, a list of all licensed nurses has been developed and no nurse will be allowed to work on the floor without having completed this education prior to assuming the floor.** 4. DHS, ADHS, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by DHS, ADHS or	

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	breathing, a loop diuretic could be restarted...." Resident B's skilled nursing assessment documentation from 11/10/2015 through 12/6/2015 routinely indicated the resident was on a diuretic and had no side effects as a result of that diuretic. Resident B's Physician Order Report for 11/10/2015 to 12/6/2015 indicated, "Start Date: 11/16/2015: check weight daily. Once a day; p.m...Fluid restriction of 1500 ml per day...Foley cath output every shift...." Resident B's Vitals Report indicated his intake of fluids was 1840 ml fluids on 12/3/2015. Resident B's Urine Output Record indicated the following: 12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the decreased urine output.		designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had md and family notification as well as appropriate assessment documented x12 weeks then continue to review daily per facility policy. 5. Nursing staff will be in serviced on resident positioning including bed height to ensure resident's safety. Rounds will be conducted every shift for 12 weeks and documented with any concerns addressed and corrected immediately with staff re-education. **6.** All residents who have a current order for daily weights will require a physician order for parameters for Physician notification as of 6/11/16. All future residents that obtain a Physician order for daily	

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	Physician's Progress Notes for Resident B, signed by the resident's primary care physician (PCP), dated 11/11/2015 at 4:15 p.m., indicated, "...breathing at baseline...Lungs - CTA [clear to auscultation] B [bilaterally]...Ext [extremities] - 2+ edema on R [right], 1+ [edema] on L [left]...CHF - stable - monitor for fluid overload. Daily weights." Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on 11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015. Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked, associated assessments were competed, the physician was notified, or		weights will require MD to provide parameters as to when facility shall notify MD. All residents currently with daily weights will have MD orders for parameters regarding when to notify physician by 6/14/16. Until then, all residents on daily weights with a weight gain of 3 pounds or greater in one day or 5 pounds or greater in one week will require MD notification. **7.** The results of the assessments/audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. QA will occur weekly X 4 weeks and then monthly thereafter.	

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	a change of condition/event was initiated. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L], tried repeatedly to have him do pursed lip breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhilation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the pursed lip breathing several times. Increased the O2 to 3.5L via nasal canula [sic]. Resident is very anxious...has not slept all night." There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's respiratory status being assessed (lung sounds), shortness of air, or edema being assessed, or the physician or family being notified on 12/4/2015, 12/5/2015 or 12/6, 2015. On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow:			

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	2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated, "Resident frequently c/o shortness of breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure 191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated, "Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to			

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	perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood pressure] and increase in respirations as well." The following vital signs, dated 12/6/2015 at 8:04 p.m., indicated, "Blood Pressure 152/74 mmHg. Pulse: 66. 02 Saturation: 95%. Resting. Oxygen Use: Yes - Liter Flow: 3.5 Liter. Activity: Low. Respirations: 26/minute. Resting." There were no Progress Notes, Events, or other evidence in the record to indicate that additional assessments related to Resident B's respiratory status and/or edema, follow up, or physician notification were completed. A Progress Note for Resident B, dated 12/6/2015 at 7:48 p.m., indicated, "Res. [resident] c/o SOB [shortness of breath], SpO2 recorded at 88%/3L/NC [liter/nasal cannula]. Assessment revealed oxygen tubing had beside [sic] table sitting on it, Resident's w/c was also parked on top of and crushing the oxygen tubing. Additionally the oxygen line had become completely separated the water trap by the w/c rolling over it...new tubing installed...saturations hold steady at			

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	95%...." A Progress Note for Resident B, dated 12/6/2015 at 7:58 p.m., indicated, "Res. stated he feels "like I need to go to the hospital." Res. spoke with [family member] on the phone and states his [family member] is on the way here. Assessment completed (See vitals)." There was no evidence of an assessment related to this Progress Note anywhere in Resident B's record. A Progress Note for Resident B, dated 12/6/2015 at 8:21 p.m., indicated, "Res POA [family member] arrived at the facility...POA states he wants the resident to go to the ER [emergency room]...N.O. [new order]...to send to...ER for eval and Tx." There was no evidence of, and facility staff were unable to provide any evidence of skilled charting or nursing assessments for Resident B on November 14, 21 or 25, 2015 or December 2 or 5, 2015. Daily skilled nursing assessment documentation routinely did not address/left blank edema and/or lung sounds. There were no additional events or progress notes related to resident assessment of lung sounds, edema, or physician notification.			

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	The last documented breath sounds for Resident B were 12/1/2015 at 11:09 a.m., which indicated, "CTA [clear to auscultation]." Resident B's Emergency Medical Services (EMS) Ambulance Report, dated 12/6/2015, indicated they were dispatched at 8:38 p.m., arrived at the facility at 8:42 p.m., and arrived at the Emergency Department at 9:04 p.m. The report indicated, "Pt [patient] is shorter of breath than normal...pt with obvious edema globally...Respiratory: Effort: Distressed. Sounds: L: Diminished bases. R: Diminished bases. Oxygen: 3.5 lpm via NC Healthcare Provider [facility]...." EMS records indicated the resident did not receive any intravenous fluids or diuretic medication en route to the Emergency Department. Resident B's Emergency Room Record, dated 12/6/2015 at 9:10 p.m., indicated, "CC [chief complaint]: [up arrow] SOB, edema x 3 days. Location: chest/respiratory...Severity: severe. Duration: last 2-3 days. Timing: Constant...Associated signs: leg swelling...CXR [chest x-ray]: CHF...Diagnosis; exacerbation CHF, CRF...."			

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	A Hospital Emergency Department Primary Nursing Assessment for Resident B, dated 12/6/2015, indicated, "...Respiratory: Labored, Dyspnea,Increased rate, Cough - moist/nonproductive. Breath sounds: Left: Rhonchi, wheezing. Right: Rhonchi, wheezing...Peripheral edema: Feet, Ankles 4+...Neurological: Alert. Oriented x 3. Anxious...Nursing Problem List: 1. SOB [shortness of breath]. 2. Edema...2106 [9:06 p.m.] pt sent from [facility]...increased SOB, along with edema for 3 days, report states it is increasingly getting worse. Pt. has 4+ pitting edema...." Resident B's Hospital History and Physical Examination (Hospital 1), dated 12/6/2015, indicated, "...He presented to the emergency department with significant shortness of breath and tight lungs. He was admitted with an exacerbation of his chronic obstructive pulmonary disease and congestive heart failure, diuresed, and states he is starting to feel better already...." Resident B's Cardiology Consultation (Hospital 1), dated 12/7/2015, indicated, "...The patient had been doing relatively well and participating in rehab at [facility]. In the last 3 to 4 days, he started having some increasing shortness			

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	of breath and noted some ankle swelling. Yesterday, he became orthopneic with PND [paroxysmal nocturnal dyspnea] and had shortness of breath at rest...came to the emergency department where he was found to have evidence of heart failure. He has received IV [intravenous] Lasix and is already feeling improved...." Hospital 1 documentation indicated the resident required on-going Nephrology consultation/care and was transferred/admitted to Hospital 2 on 12/11/2015. Resident B's Clinical Documents Progress Note (Hospital 2), dated 12/11/2015, indicated, "...History of present illness: ...recently here...between the dates of 11/5/2015 through 11/10/2015 for acute kidney injury superimposed on chronic kidney disease. He also had issues with systolic heart failure during that time. On discharge...as [renal function] improved patient gradually developed worsening weight gain and fluid retention. He presented to [Hospital 1] 12/7 [sic]/2015 and was diuresed...Unfortunately with aggressive diuresis at that time his creatinine continued to steadily increase...Assessment/Plan: 1. Acute kidney injury on chronic kidney disease stage 3-4. This is most likely in relation			

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	to requirements for aggressive diuresis in light of his issues with CHF exacerbation...2. Acute exacerbation on chronic systolic congestive heart failure...." Nephrology Clinical Consultation (Hospital 2), dated 12/12/2015, indicated, "...Assessment/Plan: ...had diuresis just over 2L [at Hospital 1] given his fairly massive volume expansion....Acutely decompensated systolic congestive heart failure. Resident B was discharged to Hospice on 12/18/2015 and expired 12/24/2015. Discharge Diagnoses indicated, "1. Acute kidney failure, unspecified. 2. Acute on chronic systolic (congestive heart failure. 3. Chronic obstructive pulmonary disease with (acute) exacerbation...." Licensed Practical Nurse (LPN) # 2 was interviewed on 6/8/2016 at 3:06 p.m. He indicated he cared for Resident B periodically and was on duty on 12/6/2016 when Resident B was sent to the Emergency Department. LPN # 2 indicated, "[Resident B] was just not doing good...he wasn't in good condition. He had swelling issues." LPN # 2 indicated, "If [a resident's] sats are not doing well, we [nursing] would put on our report sheet and in [resident] progress			

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	notes." LPN # 2 indicated daily assessments and documentation were based on the resident's primary admitting diagnosis. Regarding monitoring for fluid overload, weight fluctuations, and edema, LPN # 2 indicated the physician would order parameters regarding notification. The LPN indicated, "If the weight exceeds the parameters, I would send a fax...unless it says call." LPN # 2 indicated, "The staff would catch a 5 pound weight gain in a day...if there's a change [in resident condition] from the norm, I don't know if that would be an event, but I would let somebody know. I would just do a progress note." The Interim Director of Health Services (DHS) and the Assistant Director of Health Services (ADHS) were interviewed on 6/8/2016 at 4:12 p.m. The Interim DHS indicated that Resident B was being assessed related to his renal failure because that was his admitting diagnoses. The ADHS indicated nursing staff would be charting on the renal diagnoses because that was their "number one concern." The DHS indicated all residents were assessed daily related to their primary admitting diagnosis. She indicated a resident who was admitted for a foot fracture, but had co-morbidities such as COPD, CHF, or kidney failure, would be prompted to do			

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	a daily orthopedic assessment. She indicated orthopedic assessments did not include assessments of edema, breath sounds, or respiratory status. Both the DHS and ADHS indicated there were no policies or procedures related to monitoring for fluid overload, monitoring for changes in condition, documentation or assessment and that they relied on "best [nursing] practices." The Director of Health Services (DHS) was interviewed on 6/9/2015 at 1:50 p.m. regarding expectations for monitoring for fluid overload. The DHS indicated there was no policy and procedure related to edema, monitoring for fluid overload, CHF, or COPD. The DHS indicated, "Just monitor their intake and edema. That's what I would do." On 6/9/2015 at 4:25 p.m., the DHS indicated she "probably would not" document an event or change in condition for a weight change." The DHS indicated the facility relied on "best practices" to direct nursing staff when to do assessments, under what category to document them, and when to notify the physician of changes. The Assistant Director of Health Services (ADHS) was interviewed on 6/9/2016 at 4:31 p.m. regarding the policy and			

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	procedure related to documenting and reporting changes in condition, events, and monitoring for fluid overload. She indicated there were no policies and procedures. The ADHS indicated, "That's nursing judgement whether to do an event, a change in condition, or a progress note." On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) provided a current copy of [facility] Guide to Event Notification Critical Thinking. She indicated that when changes in condition are observed, an "event" is initiated. She indicated that "artificial intelligence" indicated to the nursing staff when to notify the physician. The CNO indicated a section of the document which was circled and indicated the residents reviewed did not meet any of the criteria related to edema. The circled documentation indicated, "New Onset Edema Event. Notification Guidelines. Notify MD/NP immediately...for any of the following...Abrupt pt onset of edema in one leg with loss of sensation. Abrupt onset edema with tenderness and redness. Edema with sudden onset of shortness of breath, and/or chest pain." The notification guideline not circled by the CNO indicated, "Weight gain of 3 or more pounds in last 7 days."			

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	On 6/10/2015 at 10:06 a.m., the CNC indicated the facility did not have a specific policy or procedure related to change in condition. The CNC provided a current copy of [Facility] Guide to Events, which was reviewed at that time. The document indicated, "...Category of Observation: Cardiovascular. Event Name: ...New Onset Edema. Possible Reasons: Increased Or New Edema...Category of Observation: ...Other Events: ...Event Name: Other Physical Changes in Condition: Possible Reasons: Non-specified physical changes...Category of Observation: Respiratory/EENT: Event Name: Respiratory: Possible Reasons: Breathing/Respiration Changes..." On 6/8/2016 at 4:15 p.m., the ADHS was queried regarding the new onset/new documentation of Resident B's 3 + pitting edema on 11/21/2015 at 1:45 p.m. (above) and why event/change in condition documentation was not initiated or the physician notified of the change. The ADHS indicated, "It [edema] depends on other factors. It could just be the time of day." On 6/8/2016 at 4:25 p.m. the ADHS and DHS provided a copy of the current Guidelines for Weight Tracking Policy and Procedure and it was reviewed at that			

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	time. They indicated there were no additional policies or procedures related to weight tracking and/or specific to edema and/or respiratory diagnoses. The Procedure indicated, "...6. The weight should be recorded in the individual resident medical record. 7. Residents who have a weight that seem [sic] out of normal range shall be re-weighed to determine the accuracy of the original weight..." On 6/8/2016 at 4:36 p.m., the ADHS provided a copy of the current Physician Notification of Diagnostic Testing and Change in Condition Policy and Procedure and it was reviewed at that time. The document indicated, "Purpose: To ensure the...physician is aware of all...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure: 1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known....10. Attempts to notify the physician and their response should be documented in the resident record...." 2. Resident F ' s Admission Nursing Assessment, dated 6/5/2016 at 6:29 p.m.,			

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	indicated, " Cardiovascular: Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank] ...Comments: [blank]. Initial Cardiovascular Plan of Care: ...Assess vital signs q [every] - 8 [hours]. Administer medications per physician order ...Infectious Disease: Yes ...c-diff chronic. Initial Infectious Disease Plan of Care: Observe vital signs per protocol ...Implement isolation precautions per protocol. Administer medications per physician order. " A Care Plan for Resident F indicated, " Problem: I have c-diff ...Approach: ...Isolation precautions to be taken for c-diff. Follow protocol. Discipline [responsible]: Administrative ...Medical Records, Nursing. " A Progress Note for Resident F, dated 6/5/2016 at 3:45 p.m., indicated, "Admitted...alert [and] oriented x 3, mood pleasant...." Resident F, who was admitted 6/5/2016 at 3:45 p.m., had no vital signs documented until 6/6/2016 at 3:55 a.m. Resident F ' s Event - Change In Physical Condition Circumstance dated 6/6/2016 at 9:49 p.m., indicated, " Describe change in condition: admitted with 2+ -			

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	3+ edema to BLE [bilateral lower extremities] ...Treatments: CHANGE IN CONDITION CIRCUMSTANCE: Follow up monitoring and vital signs x 72 hours or until resolved. On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events, changes in condition, or physician notification associated with this abnormal value. The next blood pressure assessment was not until 6/7/2016 at 7:07 p.m. A Progress Note for Resident F, dated 6/7/2016 at 1:20 p.m., indicated, New order received...to send Resident to ER to be evaluated for decreased appetite and difficulty swallowing. Family member...very concerned about Resident's current state of health and would like her sent to ER for eval [evaluation]." A Progress Note for Resident F, dated 6/7/2016 at 6:20 p.m., indicated, "resident returned from emergency room with peripheral IV [PIV] in left wrist. no s/s [signs/symptoms] infiltration noted. has normal saline running at 100 cc per hour for dehydration...is oriented to			

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	person and place. alert. asking for television to be turned on the news...nonpitting edema noted in both hands. 2-3+ pitting edema noted in bilateral legs...." The following Progress Note, dated 6/8/2016 at 3:30 a.m., indicated, "...Edema continues...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." There was no documentation anywhere in Resident F's clinical record to indicate Resident F's left upper extremity was assessed following the 6/8/2016 at 6:46 a.m. progress note. Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat."			

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	Resident F's Progress Note, dated 6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%." A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request." There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was discontinued. A Progress Note for Resident F, dated 6/8/2016 at 3:30 p.m., indicated, " Edema continues with no draining or open areas .... " The following Progress Note for Resident F which related to edema was dated 6/9/2016 at 5:28 a.m., and indicated, " ...third spacing [unusual accumulation of fluid in a transcellular space] continues w/ 2-3 + edema to BLE, hips, and even in places in her BUE [bilateral upper extremities]... " There was no evidence that Resident F ' s physician was notified of the edema.			

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	On 6/9/2016 at 3:25 p.m., CNA # 14 indicated that, prior to this date, Resident F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. CNA # 10 was interviewed on 6/9/2016 at 9:50 a.m. She indicated, "[Resident F has] been in the hospital. They sent her out yesterday because she was unresponsive. She had an IV for dehydration, but it wasn't working. It caused her to swell up like a balloon...." Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON,			

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	DON, Executive Director (ED) indicated they were not aware Resident F had been unresponsive or her IV had infiltrated. On 6/9/2016 at 5:37 p.m., the ADHS indicated she had just gotten off the phone with RN # 7, who cared for Resident F the morning the resident went to the Emergency Department on 6/8/2016. The ADHS indicated the resident was sleeping "normally" when the nurse checked on the resident and the resident was at baseline. Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably			

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	should have called the on-call...Her swelling was terrible...a lot of third spacing...her legs, her feet, all over. Her skin was cool....I would just chart it [change of condition] under Progress Notes." Resident F was interviewed on 6/10/2016 at 11:50 a.m. She was observed to be awake and alert, but hard of hearing. When queried as to how she felt, she indicated, "Better." RN # 11 was interviewed on 6/10/2016 at 2:00 p.m. regarding assessing residents with CHF and edema who were at risk for fluid overload. RN # 11 indicated, "I wouldn't listen to lungs everyday, but I would check swelling and temperature." 3. Resident E was interviewed on 6/8/2016 at 3:12 p.m. The resident was observed wearing cotton athletic socks and open sandals with 3+ edema in his bilateral lower ankles and feet. He was sitting up with his legs (hanging down) in his wheelchair. The resident indicated he had occasional lower extremity edema/swelling at baseline, but worsening edema since he had been in the facility. The resident indicated he had notified staff he was concerned regarding his increased edema in recent weeks.			

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	Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery. Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated, "Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]...Vitals: Pulse: 96/per minute. Respirations: 18 p er minute. Blood Pressure: 138/83 mmHg...." There was no evidence in Resident E's clinical record that he had a care plan related to edema. A Care Plan, initiated 4/20/2016, indicated, "Problem: High Risk Medications. I have potential for			

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	decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure...." LPN # 16 was interviewed on 6/9/2016 at 3:15 p.m. at Resident E's bedside. She touched resident E's foot lightly over his socked foot and indicated his edema was, "3+ pitting." LPN # 16 indicated the resident had edema since admission and it starting getting worse approximately two weeks ago. LPN # 16 indicated a form had been sent in to Resident E's physician to notify him/her of the resident's change in condition that day. LPN # 16 indicated that nursing staff assisted Resident E to elevate his legs during the day, pointing to a bench against the wall. During an interview on 6/9/2016 at 3:06 p.m., Resident E indicated he was not encouraged or assisted to elevate his legs during the day and that the edema in his bilateral lower extremities had become progressively worse in recent weeks. The resident indicated he had pain and "tingling" related to the edema. During multiple random observations throughout the survey, including 6/8/2016 at 9:59 a.m. 6/8/2016 at 3:12 p.m.,			

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	6/9/2016 at 3:06 p.m., and 6/10/2016 at 11:15 a.m., Resident E was observed to have 3+ edema in his bilateral lower ankles and feet, with his legs dependent (hanging down) in his wheelchair. There was no evidence in the clinical record that Resident E's lower extremity edema was fully assessed or monitored, or that the physician was notified of changes. There were no events or changes in condition related to Resident E's edema. Resident E did not have evidence of daily skilled assessments on 5/24, 5/29, or 6/3/2016. Resident E's recorded weights were as follows: 4/2/2016: 172.6 pounds 4/3/2016: 172.3 pounds 4/10/2016: 176.4 pounds 5/11/2016: 184.2 pounds There was no evidence anywhere in Resident E's clinical record that the physician was notified related to Resident E's weight gain. On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]."			

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	There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was done, or the physician was notified. The next recorded vital signs were on 5/7/2016, when Resident E's blood pressure was indicated to be 111/82 mmHg. A Progress Note for Resident E, dated 5/30/2016, indicated the resident was "extremely edematous" with no additional values/assessments/comparisons related to the edema, vital signs, or respiratory assessments. On 6/10/2016 at 3:46 p.m., the DHS indicated resident alerts abnormal vital signs (highlighted in red) go the the DHS in the form of "messages." On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure (above). 4. Resident D was interviewed 6/10/2016 at 4:10 p.m. She indicated nursing staff did not listen to her lungs/chest every day and indicated the CNAs checked the swelling in her bilateral extremities when			

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	they helped her with her nightly routine before bed. Resident D indicated that, prior to her admission, she had intermittent bilateral lower extremity edema that "came and went." Resident D indicated her lower extremity edema had been worse since she had been in the facility and more so over the past two weeks. The ADHS was interviewed on 6/9/2016 at 4:12 p.m. regarding Resident D's 100.8 pound gain between 4/10/2016 and 4/11/2016. She indicated, "It was probably an error. She probably should have had a re-weight." The ADHS indicated that "best practices" for reporting weight gain in residents being monitored for fluid overload or CHF would be 3 pounds in a day or 5 pounds in a week. On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Resident D's weight changes were related to transcription errors and that the resident's admission weight was incorrect. Resident D's clinical record was reviewed on 6/9/2016 at 2:15 p.m. Diagnoses included, but not limited to, COPD, CHF, acute kidney failure, and recent foot fracture. The resident was admitted to the			

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	facility 3/7/2016 for rehabilitation following a foot fracture. Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." Resident D's Admission Nursing Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift... Cardiovascular: Heart Rate: irregular...Edema present: Yes. Location of edema: Right upper extremity. Other: lyphedema /t radical mastectomy. Left leg edema: [blank]. Right leg edema: [blank]...Initial Cardiovascular Plan of Care: ...Pacemaker checks...." A current Care Plan for Resident D indicated, "Problem: I have a diagnosis/history of congestive heart failure...Approach: ...Monitor me for fluid excess (wt. gain, increased BP;			

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	full/bounding pulse...SOB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output...Monitor my weight per current order and notify physician as needed...." A current Care Plan for Resident D indicated, "Problem: I have COPD...Approach: My care givers will monitor my lung sounds as indicated. My care givers will monitor my 02 sat..." A current Care Plan for Resident D indicated, "Problem: I have a pacemaker...Approach: Please monitor my apical pulse as needed and report abnormalities to my physician...." Resident D was observed to have 3+ edema to bilateral lower extremities during random observations on 06/08, 06/09 and 06/10/2016. A Progress Note dated 4/17/16 at 6:30 p.m. indicated, "...audible wheezes noted throughout lung fields...O2 sats 96 % on 2 lpm per nasal cannula...." There was no evidence of additional documentation or assessment related to lung sounds, respiratory status, or edema in resident progress notes, events, skilled nursing assessments/observations, MAR or TAR until 6/12/2016.			

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	MAR review indicated Resident D received as-needed SVN treatments related to wheezing and shortness of breath during her admission. On 6/10/2016 at 12:53 p.m., the ADHS indicated nursing staff were required to assess breath sounds with SVN treatments. The ADHS indicated she could not find evidence in Resident D's clinical record that assessment of breath sounds had been done. Resident D's documented weights indicated the following significant weight gains: 3/07/2016 - 3/09/2016: 26 pound gain. (no weight check 3/8/2016) 3/23/2016 - 3/24/2016: 5.6 pound gain. 4/10/2016 - 4/11/2016: 100.8 pound gain 4/29/2016 - 4/30/2016: 5.5 pound gain 5/02/2016 - 5/03/2016: 5.2 pound gain 5/10/2016 - 5/12/2016: 7.8 pound gain (no weight check 5/11/2016) 5/31/2016 - 6/01/2016: 7.8 pound gain There was no documentation of verification of weights, re-weights, notification of change, events, progress notes, or follow up related to weight gain. No skilled nursing assessments on 3/8,			

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	3/11, 3/15, 3/21, 3/22, 3/25. 4/5, 4/13, 4/15, 4/21, 4/26, 4/30, 5/3, 5/6, 5/10, 5/17, 5/20, 5/24, 5/27, 6/3/2016. There were no nursing assessments located in the resident's progress notes related to these dates. On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident D over the last three months and/or with small volume nebulizer treatments (SVN's). 5. Resident C's clinical record was reviewed on 6/9/2016 at 3:20 p.m. Diagnoses included but not limited to, chronic kidney disease, stage III, neuromuscular dysfunction of bladder, Parkinson's disease, and history of urinary tract infection (UTI).			

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	Quarterly MDS assessment, dated 3/8/2016, indicated BIMS score of 7; indicating moderate cognitive impairment. The resident required extensive 2+ person assist for transfers and all ADL's except eating. The resident had no behaviors and no rejection of care. Admission Nursing Assessment, dated 2/16/2016, indicated, "Edema present: No...." A Care Plan for Resident C, initiated 6/4/2016, indicated, "I have edema to my bilateral lower extremities. Goal: My goal is to have decreased edema. Approach: Administer diuretic as ordered. Daily weight...." Resident C was observed on 6/8/2016 at 9:46 a.m. in her wheelchair. She was observed to have 3+ edema in her left lower extremity and a shoe on her right extremity with ankle edema visible. The resident's legs were dependent (hanging down) in the wheelchair. During multiple random observations throughout the survey, including 6/8/2016 at 9:46 a.m., 6/8/2016 at 2:50 p.m., 6/9/2016 at 10:09 a.m., 6/9/2016 at 4:00 p.m., and 6/10/2016 at 11:12 a.m., Resident C was observed to have 3+ edema in her bilateral lower ankles and			

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	feet, with his legs dependent (hanging down) in her wheelchair. LPN # 11 was interviewed on 6/9/2016 at 10:10 a.m. She indicated interventions related to Resident C's edema included laying her down between meals and daily weights. She indicated Resident C did not have a recliner in her room and she did not like to sit in the recliner in the common area. LPN # 11 indicated they were not able to contact family about bringing in a recliner because the resident's [family member] had health issues for the previous two weeks. She indicated the resident had been at the facility "about three years." LPN # 11 indicated the resident had an 8 pound weight gain that morning, she re-weighed her, and noted a two pounds weight gain. LPN # 11 indicated, "That's not unusual for her. She hasn't had a bowel movement in 2 days, her lungs are clear, and she has no more edema than usual...sometimes the girls don't calibrate or zero the scale before each time [weight]." Resident C's Vital Signs Report indicated the resident experienced a 5.5 pounds weight gain after the re-check indicated by LPN # 11 (above). Resident C's Progress Notes, dated			

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	6/9/2016 at 10:31 a.m., indicated, "Resident has had a 5 pound weight gain, lungs are clear and edema is at baseline. COC [change of condition] sent to [physician] asking for direction...." Resident C's Progress Note, dated 6/9/2016 at 11:43 p.m., indicated, "N.O. [new order] Lasix [diuretic] 40 mg...No edema noted...." On 6/9/2016 at 3:20 p.m., Resident C was observed lying flat in bed, with the foot of the bed in the lowest position with feet appearing to be in a lower position than the head and upper torso. On 6/10/2016 at 11:12 a.m., LPN # 20, the Medical Records Coordinator, indicated that nurses are required to do a skilled nursing assessment (Observation Report) every twenty-four hours on each resident. On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The			

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	CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident C over the last three months and/or with small volume nebulizer treatments (SVN's). On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Residents B, C, D, E and F were cognitively intact and could alert staff of any changes in condition. The CNC #2 was interviewed on 6/15/2016 at 5:37 p.m. She indicated admission nursing assessments identified resident care areas at risk and auto-populated into the care plan to target things they would look at. Regarding the Events and "artificial intelligence" indicated by the CNO, she indicated, "It pops up and says this is the assessment you should complete." She indicated if there is no event initiated, there are no prompts and no follow up. The CNC #2 indicated abnormal vital signs are highlighted in red to indicate to nursing staff that they are abnormal. She indicated nurses are supposed to re-assess or re-check abnormal vital signs. A report is available for the DHS and any abnormal vital signs or events were			

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	supposed to be reviewed in daily morning meetings. Regarding assessing for changes in condition or abnormal vital signs, the CNC # 2 indicated, "Ultimately the nurses are responsible for that. You can't teach that." On 6/15/2016 at 6:02 p.m., the CNC #2 indicated the Executive Director was the point of contact person for abuse and neglect prohibition. She indicated the interdisciplinary team (IDT) met daily to discuss any quality of care concerns. She indicated every concern is followed up within 24 hours or immediately if it needed to be addressed sooner. On 6/15/2016 at 6:12 p.m., CNC # 2 indicated residents with diagnoses such as CHF, COPD and renal failure who were being assessed for shortness of air or fluid overload should have their lungs auscultated (listened to with a stethoscope for abnormalities) and their weight checked. She indicated what may be considered advantageous [abnormal] lung sounds for one resident may not be for another if that is the resident's baseline. She indicated, "The Event screen guidelines are there to make the process easier. If there's something out of the ordinary, it's critical thinking [on the part of the nurses] to know what to do next." She indicated if a resident			

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	experienced a change in condition, the physician should be notified. A copy of the current Vital Signs Guidelines Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. and it was reviewed at that time. The document indicated, "Purpose: To document and track vital signs to monitor changes in condition...Procedure: 1. Vital signs will be taken at the following times: ...ac. Change in condition...e. Per physician order...4. The physician will be notified of a significant change in vitals...5. The nurse shall utilize critical think [sic] skills and nursing assessments/evaluation of vital signs to monitor resident condition." A copy of the current Guidelines for Change in Resident Condition Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. The document indicated, "Purpose: To identify resident changes in condition...reassess the resident's risk factors, evaluate the current care plan interventions for effectiveness and select additional interventions if required. Policy: 1. Upon assessment of resident change in condition, the ...nurse will initiate the appropriate 'Event' ...in order to fully reflect and document the nursing process. 2. The appropriate Event should be used to facilitate the thorough			

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	and consistent evaluation of the resident's condition, follow-up documentation should be completed shiftly...which should include vital signs. 3. Notification of the resident physician and responsible party will be documented...." A copy of the current Guidelines for Lung Auscultation Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 6:12 p.m. The document indicated, "Purpose: To evaluate the air flow through the lungs, presence of fluid or mucus and determine the condition of the lungs...Procedure: 7. A complete assessment should be performed...8. Diminished or absent sounds indicate inability to ventilate the lungs sufficiently...9. Wheezing indicates bronchospasms. 10: Rhonchi and crackles indicate ineffective secretion clearance...15. Document the results...16. Notify the physician and family of and [sic] change in condition." A copy of the current Resident Rights Policy and Procedure was provided by the Medical Records Coordinator on 6/8/2016 at 11:15 a.m. and reviewed at that time. The policy indicated, "...You have the right to receive services with reasonable accommodation of individual needs...3. The facility will provide nursing care and accommodations that			

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	meets your needs..." A copy of the current Abuse and Neglect Procedural Guidelines Policy and Procedure was provided by the Executive Director on 6/8/2016 at 11:05 a.m. and reviewed at that time. The procedure indicated, "...j. NEGLECT - means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..." A current copy of the Guidelines for Acute Care Transfer Policy and Procedure was provided by the ED on 6/9/2016 at 1:35 p.m. and reviewed at that time. The document indicated, "Purpose: To ensure residents are provided with the appropriate care setting for adequate treatment. Procedure: 1. A thorough assessment shall be completed when a change in resident condition is noted. 2. Assessment information shall be communicated to the attending/on-call physician..." A copy of the current Guidelines for Administration of Oxygen Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 5:55 p.m. The document indicated, "Procedure: 1. Verify physician's order for the procedure...9. Before administering emergency oxygen...asses for the following: b. Signs			

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	155797		06/15/2016

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ASPEN PLACE HEALTH CAMPUS	2320 N MONTGOMERY ROAD GREENSBURG, IN 47240

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	or symptoms of hypoxia (i.e. rapid breathing, rapid pulse rate, restlessness, confusion); c. Signs or symptoms of oxygen toxicity (i.e. ...difficulty breathing, or...shallow rate of breathing); d. Vital signs; e. Lung sounds..." A current copy of the [Facility] Guide to Documentation was provided by the CNC #2 on 6/15/2016 at 6:05 p.m. The document indicated, "Admission Observation: Physical Assessment, Vitals...within 12 hours...Post Admission Assessment: ...Vital Signs: Q shift [every 8 hours] x 72 hours...Skilled residents: Daily Skilled Observation. Vital Signs. Recommend Progress Notes Each Shift Following Daily Skilled Observation..." The Immediate Jeopardy that began on 11/21/2015 was removed on 6/13/2016 when the facility completed resident assessments and staff education on identifying and documenting change in condition, following physician orders, notifying MD and family of changes, follow up documentation on any resident change in condition, and resident positioning. The Immediate Jeopardy was removed on 6/11/2016, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate			

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	jeopardy because not all staff had been educated on identifying and documenting change in condition, following physician orders, notifying MD and family of changes, follow up documentation on any resident change in condition, and resident positioning. This Federal tag relates to Complaint IN00200175. 3.1-13(q)			
F 0514 SS=E Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review and interview, the facility failed to ensure complete and accurate documentation for 4 of 5 residents reviewed for	F 0514	F514: Failure to ensure complete and accurate documentation for 4 of 5 residents reviewed for documentation and quality of	06/29/2016

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	documentation and quality of care (Residents B, D, E and F). Findings include: 1. Resident B's closed clinical record was reviewed on 6/8/2016 at 11:10 a.m. Diagnoses included, but were not limited to congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, hypertension, urinary retention, and localized edema. Resident B's Physician Order Report for 11/10/2015 to 12/6/2015 indicated, "Start Date: 11/16/2015: check weight daily. Once a day; p.m...Fluid restriction of 1500 ml per day...Foley cath output every shift..." Resident B's written Physician's Orders, dated 11/10/2015, and signed by the primary care physician 1/12/2016, indicated no orders for oxygen administration. There was no evidence in the clinical record of physician's orders for oxygen administration from Resident B's admission on 11/10/2015 through 12/06/2015 . Physician's Progress Notes for Resident B, signed by the resident's primary care		care (Residents B, D, E, and F). · Resident B was discharged · Resident D was discharged 6/14/2016 · Resident E was assessed MD & family notified · Resident F expired on 6/12/2016 · All residents have the potential to be effected · Director of Health Services, Assistant Director of Health Services, Unit Manager, Med Records Nurse, staffing nurse, floor nurse did assess all current residents on campus to ensure no changes in condition by 6/11/2016 · All changes discovered upon assessment were reported to the MD and family, changes were documented, appropriate orders obtained and resident was added to pertinent charting for follow-up. · All Nurses (RN, LPN) were educated prior to working the floor, on head to toe assessment, identifying and documenting change in	

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	physician (PCP), dated 11/11/2015 at 4:15 p.m., indicated, "...breathing at baseline...Lungs - CTA [clear to auscultation] B [bilaterally]...Ext [extremities] - 2+ edema on R [right], 1+ [edema] on L [left]...CHF - stable - monitor for fluid overload. Daily weights." A Progress Note for Resident B, dated 11/21/2015 at 1:45 p.m., indicated, "Resident has 3+ swelling to bilateral feet, Resident in recliner with feet elevated." A Progress Note for Resident B, dated 11/22/2015 at 11:41 p.m., indicated, "Resident continues to have bilateral lower leg edema..." There were no additional assessments, events, or physician notification related to these progress notes dated 11/21-22/2015. Resident B's admission weight, dated 11/10/2015 at 11:22 p.m., was 238.4 pounds. There were no weights recorded for November 11, 12, 14, 15, 16, 17 or 21, 2015; 7 of the 27 days he was at the facility. Resident B experienced a 5.2 pound weight gain between 11/22/2015 and 11/23/2015. Resident B experienced an additional 1.4 pound weight gain on		condition, notifying MD and family of changes as well as follow up documentation on any change in condition by 6/11/2016, and a pre and post test on critical thinking questions on several clinical pathways was completed. All licensed nurses were also required to take a pre and post test on critical thinking questions, related to several clinical pathways prior to working the floor starting 6/11/2016 educated on prior to working the floor. All licensed nurses were educated prior to working the floor on skilled documentation & notifying on call nurse, MD & family notification of any change of condition by 6/12/2016. In addition a list of all licensed nurses has been developed and no nurse will be allowed to work the floor without completing this education prior to assuming the floor. 100 % of all licensed nurses have been in serviced as of 6/29/16. Director Health Services,	

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	11/24/2015; which totaled a 6.6 pound weight gain in 2 days. The resident experienced a 4 pound weight gain between 12/3/2015 and 12/4/2015. Vitals Report, dated 12/4/2015 at 11:07 a.m., indicated, "Weight: 244.2 lbs [in red]...Acceptable Range: 5 percent change in weight in 30 days." There was no evidence in the clinical record that the recorded weights were re-checked, associated assessments were competed, the physician was notified, or a change of condition/event was initiated. Resident B's Vitals Report indicated his intake of fluids was 1840 ml fluids on 12/3/2015. A Progress Note for Resident B, dated 12/4/2015 at 4:35 a.m., indicated, "...He c/o [complaint of] SOB at 0300 [3:00 a.m.]. I tried to talk to him to calm him down, cracked his window, turned up his oxygen from 2.0 [L] to 2.5 [L] to 3.0 [L], tried repeatedly to have him do pursed lip breathing. At 0330 [3:30 a.m.] I gave PRN [as needed] albuterol inhilation [sic] therapy. Resident still c/o [complained of] short of breath and O2 sat at 92%. Resident refused to use face mask while having shortness of breath and [had] rapid mouth breathing. I had to walk him through the pursed lip breathing several		Assistant Director Health Services, or Designee will review daily in Clinical Meeting; Out of Range Vitals Report, nursing notes, events and observations for follow up, as well as MD notification. Admission assessments and residents on daily weights will be reviewed after Clinical Meeting by Director Health Services, Assistant Director Health Services or designee to ensure proper follow up and notification and to provide education if warranted. On weekends, the on-call nurse will be required to call each unit and speak with the charge nurse to ensure that any resident having a change in condition has had MD and family notification as well as appropriate assessment documented x12 weeks with any concerns addressed and corrected immediately with staff re-education. Then 5 times a week x 12 weeks then continue to review daily per facility policy.	

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	times. Increased the O2 to 3.5L via nasal canula [sic]. Resident is very anxious...has not slept all night." Resident B's Vital Sign Report indicated the following: 12/4/15 at 0300: RR 26/minute, BP 172/82, O2 sat 92% on 3.0 L 12/4/15 at 0400: RR 32/minute [red], 154/74, O2 sat 93% on 3.5 L On 12/6/2015 at 12:06 a.m., Resident B's vital signs indicated, "Respirations: 24/minute. O2 Saturation: 90% [in red] (acceptable range: 91-100%). Activity: Resting...Oxygen Use: Yes - Liter flow: 2. Respirations: 24/minute Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 12:44 a.m., indicated, "Resident frequently c/o shortness of breath. He recuses [sic] to sit up in his chair because he doesn't want his feet to be unelevated. The window will be cracked open to help with the feeling of air circulation to help calm his nerves...the resident is often confused with his diagnosis and doesn't understand why he has shortness of breath..." On 12/6/2015 at 2:00 a.m., Resident B's vital signs indicated, "Blood Pressure		· The results of the assessments/audits will be reported & reviewed for compliance thru the campus Quality Assurance Committee. QA will occur weekly X 4 weeks and then monthly thereafter	

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	191/157 mmHg [in red] (acceptable range: 98-190 mmHg/40-100 mmHg). Pulse: 68. Bounding. 02 Saturation: 91%. Activity: Low...Oxygen Use: Yes - Liter flow: 3.5. Respirations: 32/minute [in red] (Acceptable Range: 10-30 per minute). Activity: Low. Type: Mouth. Describe: Rapid." A Progress Note for Resident B, dated 12/6/2015 at 2:07 a.m., indicated, "Resident is currently on 3.5 l [liters] O2 [oxygen]. C/O SOB [shortness of breath], refused initial breathing tx [treatment] and inhailer [sic]. After attempted deep breathing and pursed lip breathing exercise resident was unable to perform, he requested to sit up in his wheel chair. Once he moved to wheel chair his SOB increased...He has very high anxiety when these episodes occur and has a [sic] increase in his BP [blood pressure] and increase in respirations as well." The following vital signs, dated 12/6/2015 at 8:04 p.m., indicated, "Blood Pressure 152/74 mmHg. Pulse: 66. 02 Saturation: 95%. Resting. Oxygen Use: Yes - Liter Flow: 3.5 Liter. Activity: Low. Respirations: 26/minute. Resting." A Progress Note for Resident B, dated 12/6/2015 at 7:48 p.m., indicated, "Res.			

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	[resident] c/o SOB [shortness of breath], SpO2 recorded at 88%/3L/NC [liter/nasal cannula]. Assessment revealed oxygen tubing had beside [sic] table sitting on it, Resident's w/c was also parked on top of and crushing the oxygen tubing. Additionally the oxygen line had become completely separated the water trap by the w/c rolling over it...new tubing installed...saturations hold steady at 95%...." A Progress Note for Resident B, dated 12/6/2015 at 7:58 p.m., indicated, "Res. stated he feels "like I need to go to the hospital." Res. spoke with [family member] on the phone and states his [family member] is on the way here. Assessment completed (See vitals)." There was no evidence of an assessment related to this Progress Note anywhere in Resident B's record. A Progress Note for Resident B, dated 12/6/2015 at 8:21 p.m., indicated, "Res POA [family member] arrived at the facility...POA states he wants the resident to go to the ER [emergency room]...N.O. [new order]...to send to...ER for eval and Tx." There was no evidence in the Progress Notes or anywhere in the clinical record of resident B's respiratory status being			

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	assessed (lung sounds), shortness of air, or edema being assessed, or the physician or family being notified on 12/4/2015, 12/5/2015 or 12/6, 2015. There was no evidence of, and facility staff were unable to provide any evidence of skilled charting or nursing assessments for Resident B on November 14, 21 or 25, 2015 or December 2 or 5, 2015. Resident B's skilled nursing assessment documentation from 11/10/2015 through 12/6/2015 routinely indicated the resident was on a diuretic and had no side effects as a result of that diuretic. The resident's diuretic was discontinued prior arrival from hospital. Daily skilled nursing assessment documentation routinely did not address/left blank edema and/or lung sounds. There were no additional events or progress notes related to resident assessment of lung sounds, edema, or physician notification. The last documented breath sounds for Resident B were 12/1/2015 at 11:09 a.m., which indicated, "CTA [clear to auscultation]." Resident B's Urine Output Record indicated the following:			

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	12/1/2015: 1,725 mL + "Large" 12/2/2015: 1,200 mL + "Large" 12/3/2015: 1,050 mL 12/4/2015: 850 mL 12/5/2015: 850 mL 12/6/2015: 725 mL There was no evidence in the clinical record from 12/1/2015 through 12/6/2016 that the physician was notified of the decreased urine output. The resident had no evidence anywhere in the Medication Administration Record (MAR) or Treatment Administration Record (TAR) that lung sounds were assessed related to small volume nebulizer treatments. Resident B's [family member], primary care giver and Power of Attorney (POA), was interviewed on 6/8/2016 at 1:16 p.m. Resident B's [family member] indicated he was not notified that [Resident B] was not on Lasix while he was at the facility and Resident B's [family member] indicated he raised repeated concerns over [Resident B's] increased lower extremity edema and increasing shortness of breath to staff and was told [Resident B] was "fine." Resident B's [family member] indicated the resident and family alerted staff multiple times			

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	throughout his stay that his ankles and feet were more swollen than usual and the family took the resident's recliner into him. The [family member] indicated he had never seen [Resident B] with that much swelling. Resident B's [family member] indicated [Resident B] called him 12/6/2015 and indicated to him that he had spent the previous 2 nights and 3 days sitting up in his wheelchair and not in his recliner due to shortness of breath. The [family member] indicated, "He [Resident B] said, 'I felt like I was going to drown if I laid back [in my recliner].'" Resident B's [family member] indicated he was not notified by the facility of [Resident B's] additional increased swelling and increasing shortness of breath 12/3/2015 through 12/6/2015. He indicated [Resident B] called him related to his decline and he requested his physician be called and he be sent to the emergency room for evaluation on 12/6/2015. Resident B's primary care physician was interviewed on 6/10/2016 at 11:45 a.m. He indicated his records did not indicate that he had been notified of any changes in the resident's condition until he was called on 12/6/2016 when the facility called because family was requesting the resident be sent to the Emergency Room for evaluation. The physician indicated			

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	that monitoring for fluid overload would include observing for increased swelling, shortness of breath, and weight gain. The physician indicated he would expect to be notified of a 5 pound weight gain in one day. Licensed Practical Nurse (LPN) # 2 was interviewed on 6/8/2016 at 3:06 p.m. He indicated he cared for Resident B periodically and was on duty on 12/6/2016 when Resident B was sent to the Emergency Department. LPN # 2 indicated, "[Resident B] was just not doing good...he wasn't in good condition. He had swelling issues." LPN # 2 indicated, "If [a resident's] sats are not doing well, we [nursing] would put on our report sheet and in [resident] progress notes." LPN # 2 indicated daily assessments and documentation were based on the resident's primary admitting diagnosis. Regarding monitoring for fluid overload, weight fluctuations, and edema, LPN # 2 indicated the physician would order parameters regarding notification. The LPN indicated, "If the weight exceeds the parameters, I would send a fax...unless it says call." LPN # 2 indicated, "The staff would catch a 5 pound weight gain in a day...if there's a change [in resident condition] from the norm, I don't know if that would be an event, but I would let somebody know. I			

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	would just do a progress note." The Interim Director of Health Services (DHS) and the Assistant Director of Health Services (ADHS) were interviewed on 6/8/2016 at 4:12 p.m. The Interim DHS indicated that Resident B was being assessed related to his renal failure because that was his admitting diagnoses. The ADHS indicated nursing staff would be charting on the renal diagnoses because that was their "number one concern." The DHS indicated all residents were assessed daily related to their primary admitting diagnosis. She indicated a resident who was admitted for a foot fracture, but had co-morbidities such as COPD, CHF, or kidney failure, would be prompted to do a daily orthopedic assessment. She indicated orthopedic assessments did not include assessments of edema, breath sounds, or respiratory status. Both the DHS and ADHS indicated there were no policies or procedures related to monitoring for fluid overload, monitoring for changes in condition, documentation or assessment and that they relied on "best [nursing] practices." The Director of Health Services (DHS) was interviewed on 6/9/2015 at 1:50 p.m. regarding expectations for monitoring for fluid overload. The DHS indicated there			

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	was no policy and procedure related to edema, monitoring for fluid overload, CHF, or COPD. The DHS indicated, "Just monitor their intake and edema. That's what I would do." On 6/9/2015 at 4:25 p.m., the DHS indicated she "probably would not" document an event or change in condition for a weight change." The DHS indicated the facility relied on "best practices" to direct nursing staff when to do assessments, under what category to document them, and when to notify the physician of changes. The Assistant Director of Health Services (ADHS) was interviewed on 6/9/2016 at 4:31 p.m. regarding the policy and procedure related to documenting and reporting changes in condition, events, and monitoring for fluid overload. She indicated there were no policies and procedures. The ADHS indicated, "That's nursing judgement whether to do an event, a change in condition, or a progress note." On 6/8/2016 at 4:25 p.m. the ADHS and DHS provided a copy of the current Guidelines for Weight Tracking Policy and Procedure and it was reviewed at that time. They indicated there were no additional policies or procedures related			

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	to weight tracking and/or specific to edema and/or respiratory diagnoses. The Procedure indicated, "...6. The weight should be recorded in the individual resident medical record. 7. Residents who have a weight that seem [sic] out of normal range shall be re-weighed to determine the accuracy of the original weight..." On 6/8/2016 at 4:36 p.m., the ADHS provided a copy of the current Physician Notification of Diagnostic Testing and Change in Condition Policy and Procedure and it was reviewed at that time. The document indicated, "Purpose: To ensure the...physician is aware of all...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedure: 1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known....10. Attempts to notify the physician and their response should be documented in the resident record...." On 6/10/2016 at 4:42 p.m., LPN # 8 indicated she would document any significant change in resident condition in the progress notes.			

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	On 6/15/2016 at 5:37 p.m., the CNC # 2 indicated oxygen did not require a physician's order and was a "standing order." 2. Resident F's clinical record was reviewed on 6/9/2016 at 2:45 p.m. Diagnoses included, but were not limited to, enterocolitis due to Clostridium difficile, Alzheimer's disease, hypertension, and localized edema. Resident F was admitted to the facility on 6/5/2016 following hospitalization for a fecal transplant. The resident was admitted to Hospice on 6/9/2016 and expired on 6/12/16. Resident F's Admission Assessment, dated 6/5/2016 at 6:29 p.m., indicated, "...Responsiveness: Responds to commands. Level of consciousness: Alert. Oriented to: Person and Place...Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]. Sacral edema: [blank]. Left upper extremity edema: [blank]. Right upper extremity edema: [blank]...Comments: [blank]...." Resident F, who was admitted 6/5/2016 at 3:45 p.m., had no vital signs documented until 6/6/2016 at 3:55 a.m.			

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	A Care Plan for Resident F indicated, "I have edema...monitor and record my edema...." The following Progress Note, dated 6/8/2016 at 6:46 a.m., indicated, "Res. on IV...w/o issue until approx. [4:15 a.m.] at a bed check. noted cool, puffiness to L [left] bicep. IV was turned off. Site checked for blood return w/o result. Res c/o burn at placement site...Oncoming nurse was notified that the IV was shut off shortly after 0400 and was unable to determine a possible site or attempt a stick d/t incontinent episode." Resident F's Progress Note, dated 6/8/2016 at 9:30 a.m., indicated, "Speech therapist at the bedside trying to feed resident breakfast, Resident not waking up to eat." Resident F's Progress Note, dated 6/8/2016 at 10:40 a.m., indicated, "Resident not responding to family. Vital signs P - 62. B/P - 127/80. O2 - 94%." There was no documentation anywhere in Resident F's clinical record to indicate the physician was notified related to the resident's decreased level of consciousness, increased edema, the PIV infiltration, or when the PIV was			

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	discontinued. A Progress Note, dated 6/8/2016 at 11:32 a.m., indicated, "Resident sent to ER per family request." On 6/7/2016 at 3:55 a.m., Resident F's Vitals Report indicated, "Blood Pressure: 171/102 mmHg [in red] (Acceptable Range: 98-190 mmHg / 40-100 mmHg). There were no Progress Notes, events, changes in condition, or physician notification associated with this abnormal value. The next blood pressure assessment was not until 6/7/2016 at 7:07 p.m. There was no documentation anywhere in Resident F's clinical record to indicate Resident F's left upper extremity was assessed following the 6/8/2016 at 6:46 a.m. progress note. On 6/9/2016 at 3:25 p.m., CNA # 14 indicated that, prior to this date, Resident F normally helped roll and assisted with bathing and/or incontinent care and was awake and alert. CNA # 10 was interviewed on 6/9/2016 at 9:50 a.m. She indicated, "[Resident F has] been in the hospital. They sent her out yesterday because she was			

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	unresponsive. She had an IV for dehydration, but it wasn't working. It caused her to swell up like a balloon...." On 6/9/2016 at 2:51 p.m., the CNC indicated nursing staff did not have time to complete or document an assessment related to Resident F's change in condition prior to being sent to the Emergency Department on 6/8/2016 at 11:32 a.m. Resident F's [family member] and POA was interviewed on 6/9/2016 at 3:35 p.m. She indicated, "I kept telling them she's not eating, she's got this swelling in her legs, but nobody's responding to me...My [family member] came in around ten [10:00] a.m. said she [Resident F] was unresponsive. My [family member] said the nurse told her that when she cleaned her up earlier that morning she wasn't waking up or responding and they said she had been like that on night shift....I'm here all the time. I live so close. I just don't understand why they wouldn't have called me." Resident F's [family member] indicated it was unusual for her mother to be unresponsive. She indicated, "She's usually very feisty." On 6/9/2016 at 5:10 p.m. The ADON, DON, Executive Director (ED) indicated they were not aware Resident F had been			

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	unresponsive or her IV had infiltrated. On 6/9/2016 at 5:37 p.m., the ADHS indicated she had just gotten off the phone with RN # 7, who cared for Resident F the morning the resident went to the Emergency Department on 6/8/2016. The ADHS indicated the resident was sleeping "normally" when the nurse checked on the resident and the resident was at baseline. Registered Nurse (RN) # 7 was interviewed on 6/10/2016 at 11:35 a.m. She indicated she worked day shift 6/8/2016 and was assigned as Resident F's nurse that day. RN # 7 indicated she came on duty at 6:00 a.m., and first encountered Resident F at approximately 7:00 a.m. She indicated, "When I went in that morning, she didn't respond when I turned and changed her. She wouldn't move her arms or help us turn her. The report I got was that she wasn't helping them [night shift] either...I assumed it [level of consciousness] was the same as when she was admitted. I knew her IV had infiltrated...there was pooling in that arm. There was third spacing...fluid filled...puffy. I called the doctor's office and left a message and she said she'd get back to me and she never did...I probably should have called the on-call...Her swelling was terrible...a lot of third			

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	spacing...her legs, her feet, all over. Her skin was cool....I would just chart it [change of condition] under Progress Notes." RN # 11 was interviewed on 6/10/2016 at 2:00 p.m. regarding assessing residents with CHF and edema who were at risk for fluid overload. RN # 11 indicated, "I wouldn't listen to lungs everyday, but I would check swelling and temperature." 3. Resident E was interviewed on 6/8/2016 at 3:12 p.m. The resident was observed wearing cotton athletic socks and open sandals with 3+ edema in his bilateral lower ankles and feet. He was sitting up with his legs (hanging down) in his wheelchair. The resident indicated he had occasional lower extremity edema/swelling at baseline, but worsening edema since he had been in the facility. The resident indicated he had notified staff he was concerned regarding his increased edema in recent weeks. Resident E's clinical record was reviewed on 6/9/2016 at 11:10 a.m. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, surgical aftercare following cervical fusion of the spine, and knee pain. The resident was admitted on 4/2/2016 for rehabilitation following spinal surgery.			

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	Admission MDS assessment, dated 2/27/2016, indicated a BIMS score of 15; indicating he was cognitively intact. The resident had no behaviors and did not reject care. The resident required extensive, 2+ physical assist for transfers and bed mobility. Resident E's Admission Nursing Assessment, dated 4/2/2016, indicated, "Edema present: Yes. Location of edema: [blank]. Left leg edema: [blank]. Right leg edema: [blank]...Vitals: Pulse: 96/per minute. Respirations: 18 per minute. Blood Pressure: 138/83 mmHg...." There was no evidence in Resident E's clinical record that he had a care plan related to edema. A Care Plan, initiated 4/20/2016, indicated, "Problem: High Risk Medications. I have potential for decreased cardiac output. Goal: My blood pressure will be maintained within normal limits. Approach: ...Please monitor my blood pressure as indicated. Please observe for signs of symptoms of elevated blood pressure...." LPN # 16 was interviewed on 6/9/2016 at 3:15 p.m. at Resident E's bedside. She			

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	touched resident E's foot lightly over his socked foot and indicated his edema was, "3+ pitting." LPN # 16 indicated the resident had edema since admission and it starting getting worse approximately two weeks ago. LPN # 16 indicated a form had been sent in to Resident E's physician to notify him/her of the resident's change in condition that day. LPN # 16 indicated that nursing staff assisted Resident E to elevate his legs during the day, pointing to a bench against the wall. During an interview on 6/9/2016 at 3:06 p.m., Resident E indicated he was not encouraged or assisted to elevate his legs during the day and that the edema in his bilateral lower extremities had become progressively worse in recent weeks. The resident indicated he had pain and "tingling" related to the edema. There was no evidence in the clinical record that Resident E's lower extremity edema was fully assessed or monitored, or that the physician was notified of changes. There were no events or changes in condition related to Resident E's edema. Resident E did not have evidence of daily skilled assessments on 5/24, 5/29, or 6/3/2016.			

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	Resident E's recorded weights were as follows: 4/2/2016: 172.6 pounds 4/3/2016: 172.3 pounds 4/10/2016: 176.4 pounds 5/11/2016: 184.2 pounds There was no evidence anywhere in Resident E's clinical record that the physician was notified related to Resident E's weight gain. On 5/2/2016 at 2:14 p.m., Resident E's vital signs indicated, "Blood Pressure: 88/53 mmHg [red]." There was no evidence in the clinical record to indicate Resident E's blood pressure was verified, an assessment was done, or the physician was notified. The next recorded vital signs were on 5/7/2016, when Resident E's blood pressure was indicated to be 111/82 mmHg. A Progress Note for Resident E, dated 5/30/2016, indicated the resident was "extremely edematous" with no additional values/assessments/comparisons related to the edema, vital signs, or respiratory assessments.			

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	On 6/10/2016 at 3:48 p.m., the CNC indicated no follow up was done related to Resident E's abnormal blood pressure (above). 4. Resident D's clinical record was reviewed on 6/9/2016 at 2:15 p.m. Diagnoses included, but not limited to, COPD, CHF, acute kidney failure, and recent foot fracture. The resident was admitted to the facility 3/7/2016 for rehabilitation following a foot fracture. Resident D's Quarterly MDS assessment, completed on 6/6/2016, indicated a BIMS score of 15; indicating the resident was cognitively intact. The resident had no behaviors and did not refuse care. Resident D's Physician's Orders indicated, "...daily weights...." Resident D's Admission Nursing Assessment, dated 3/7/2016, indicated, "Admission R Ankle Fx...Left lung: Crackles/Rales (describe location) - BLL. Right Lung: Crackles/Rales (describe location) - BLL...Initial Respiratory Plan of Care: ...Assess lung sounds q shift x 72 hours then daily...observe for decline in condition...Assess O2 sats q shift...			

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	Cardiovascular: Heart Rate: irregular...Edema present: Yes. Location of edema: Right upper extremity. Other: lyphedema /t radical mastectomy. Left leg edema: [blank]. Right leg edema: [blank]...Initial Cardiovascular Plan of Care: ...Pacemaker checks...." A Progress Note dated 4/17/16 at 6:30 p.m. indicated, "...audible wheezes noted throughout lung fields...O2 sats 96 % on 2 lpm per nasal cannula...." There was no evidence of additional documentation or assessment related to lung sounds, respiratory status, or edema in resident progress notes, events, skilled nursing assessments/observations, MAR or TAR until 6/12/2016. MAR review indicated Resident D received as-needed SVN treatments related to wheezing and shortness of breath during her admission. On 6/10/2016 at 12:53 p.m., the ADHS indicated nursing staff are required to assess breath sounds with SVN treatments. The ADHS indicated she could not find evidence in Resident D's clinical record that assessment of breath sounds had been done. Resident D's documented weights			

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	indicated the following significant weight gains: 3/07/2016 - 3/09/2016: 26 pound gain. (no weight check 3/8/2016) 3/23/2016 - 3/24/2016: 5.6 pound gain. 4/10/2016 - 4/11/2016: 100.8 pound gain 4/29/2016 - 4/30/2016: 5.5 pound gain 5/02/2016 - 5/03/2016: 5.2 pound gain 5/10/2016 - 5/12/2016: 7.8 pound gain (no weight check 5/11/2016) 5/31/2016 - 6/01/2016: 7.8 pound gain There was no documentation of verification of weights, re-weights, notification of change, events, progress notes, or follow up related to weight gain. No skilled nursing assessments on 3/8, 3/11, 3/15, 3/21, 3/22, 3/25. 4/5, 4/13, 4/15, 4/21, 4/26, 4/30, 5/3, 5/6, 5/10, 5/17, 5/20, 5/24, 5/27, 6/3/2016. There were no nursing assessments located in the resident's progress notes related to these dates. On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and			

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	document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident D over the last three months and/or with small volume nebulizer treatments (SVN's). The ADHS was interviewed on 6/9/2016 at 4:12 p.m. regarding Resident D's 100.8 pound gain between 4/10/2016 and 4/11/2016. She indicated, "It was probably an error. She probably should have had a re-weight." The ADHS indicated that "best practices" for reporting weight gain in residents being monitored for fluid overload or CHF would be 3 pounds in a day or 5 pounds in a week. On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Resident D's weight changes were related to transcription errors and that the resident's admission weight was incorrect. On 6/10/2016 at 11:12 a.m., LPN # 20, the Medical Records Coordinator, indicated that nurses are required to do a skilled nursing assessment (Observation			

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	Report) every twenty-four hours on each resident. On 6/10/2016 at 12:34 p.m., the Clinical Nurse Consultant (CNC) provided a copy of the current Specific Medication Administration Procedures - Nebulizer Policy and Procedure and it was reviewed at that time. The CNC indicated that nurses were to assess lung sounds before and after breathing treatments and document those on the Medication Administration Record (MAR). The CNC and Assistant Director of Nursing (ADON) indicated they could not find evidence of lung sounds and/or respiratory assessments being completed/documented for Resident C over the last three months and/or with small volume nebulizer treatments (SVN's). On 6/13/2016 at 12:31 p.m., the Chief Nursing Officer (CNO) indicated Residents B, D, E and F were cognitively intact and could alert staff of any changes in condition. The CNC #2 was interviewed on 6/15/2016 at 5:37 p.m. She indicated admission nursing assessments identified resident care areas at risk and auto-populated into the care plan to target things they would look at. Regarding the			

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	Events and "artificial intelligence" indicated by the CNO, she indicated, "It pops up and says this is the assessment you should complete." She indicated if there is no event initiated, there are no prompts and no follow up. The CNC #2 indicated abnormal vital signs are highlighted in red to indicate to nursing staff that they are abnormal. She indicated nurses are supposed to re-assess or re-check abnormal vital signs. A report is available for the DHS and any abnormal vital signs or events were supposed to be reviewed in daily morning meetings. Regarding assessing for changes in condition or abnormal vital signs, the CNC # 2 indicated, "Ultimately the nurses are responsible for that. You can't teach that." A copy of the current Vital Signs Guidelines Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. and it was reviewed at that time. The document indicated, "Purpose: To document and track vital signs to monitor changes in condition...Procedure: 1. Vital signs will be taken at the following times: ...c. Change in condition...e. Per physician order...4. The physician will be notified of a significant change in vitals...5. The nurse shall utilize critical think [sic] skills and nursing assessments/evaluation of vital signs to			

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NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240	

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	monitor resident condition." A copy of the current Guidelines for Change in Resident Condition Policy and Procedure was provided by the ED on 6/9/2016 at 10:40 a.m. The document indicated, "Purpose: To identify resident changes in condition...reassess the resident's risk factors, evaluate the current care plan interventions for effectiveness and select additional interventions if required. Policy: 1. Upon assessment of resident change in condition, the ...nurse will initiate the appropriate 'Event' ...in order to fully reflect and document the nursing process. 2. The appropriate Event should be used to facilitate the thorough and consistent evaluation of the resident's condition, follow-up documentation should be completed shiftly...which should include vital signs. 3. Notification of the resident physician and responsible party will be documented..." A current copy of the Guidelines for Acute Care Transfer Policy and Procedure was provided by the ED on 6/9/2016 at 1:35 p.m. and reviewed at that time. The document indicated, "Purpose: To ensure residents are provided with the appropriate care setting for adequate treatment. Procedure: 1. A thorough assessment shall be completed when a change in resident condition is			

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	noted. 2. Assessment information shall be communicated to the attending/on-call physician..." A copy of the current Guidelines for Administration of Oxygen Policy and Procedure was provided by the CNC # 2 on 6/15/2016 at 5:55 p.m. The document indicated, "Procedure: 1. Verify physician's order for the procedure...9. Before administering emergency oxygen...asses for the following: b. Signs or symptoms of hypoxia (i.e. rapid breathing, rapid pulse rate, restlessness, confusion); c. Signs or symptoms of oxygen toxicity (i.e. ...difficulty breathing, or...shallow rate of breathing); d. Vital signs; e. Lung sounds..." This Federal tag relates to Complaint IN00200175. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(f)(2)			