STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for the investigation of Complaint IN00412136. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00412136- Federal/State deficiencies related to the allegations are cited at F580, F658 and F684. Survey dates: July 6, 7, 8, 9, and 10, 2023. Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF: 11 SNF/NF: 109 Total: 120 Census Payor Type: Medicare: 15 Medicaid: 89 Other: 16 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 16, 2023.	F 0000	July 28, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 7QCF11 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Complaint Survey conducted on July 10,2023. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance on July 20,2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely, Kim Povinelli, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Povinelli	Administrator	08/01/2023

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			Lincoln Hills of New Albany Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure prompt physician notification of a resident's change in condition for 1 of 3 residents reviewed for change in condition. (Resident E) Findings include: The clinical record for Resident E was reviewed on 7/7/23 at 10:00 a.m. The diagnoses included, but were not limited to, arteriovenous fistula, chronic kidney disease (CKD) stage 4, hypertensive heart and chronic kidney disease, end stage renal disease, altered mental status, acute and chronic respiratory failure with hypercapnia and hypoxia, hypotension, hypo-osmolality and hyponatremia, dependence on renal dialysis, hyperkalemia, wheezing, insomnia, hypokalemia, difficulty walking, COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), HTN (hypertension), and dependence on supplemental oxygen. The care plan, dated 1/9/23 and last revised 6/29/23, indicated the resident had a potential for respiratory distress related to COPD/chronic respiratory failure. She had shortness of air while lying flat as evidenced by increased respirations. The goal was for the resident to not exhibit unrecognized signs of respiratory distress such as restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds thru her next review. The interventions included, but were not limited to; administer medications and oxygen per physician's order; elevate the	F 0580	**F 580 Notify of Changes** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident E's physician was notified for low BP and lethargic at 9:30am with interventions put in place. Resident suffered no ill effects from this alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills have the potential to be affected by this alleged deficient practice. Resident's events have been audited to ensure physicians have been notified of any new changes **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Licensed nurses, IDT team, and	07/20/2023

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	head of the bed to alleviate shortness of breath while lying flat; and report signs of respiratory distress. The vitals report indicated, on 6/11/23 at 7:56 a.m., the resident's blood pressure measured as 88/59 mmHg (millimeters of mercury) and was flagged in red as out of range. The acceptable range was indicated to be 100 to 180 mmHg over 60 to 90 mmHg. The clinical record lacked documentation of any notification to the physician until 10:30 a.m. The physician's note, dated 6/11/23 at 10:30 a.m., indicated the physician was contacted for a new onset of mental status. The nurse's note, dated 6/11/23 at 10:37 a.m., indicated the nurse went to check the resident's vitals prior to and found the resident in bed with no nasal cannula or BIPAP in place. This nurse applied a nasal cannula and obtained vitals. The resident's vitals included a blood pressure of 88/58 mm/Hg, a heart rate of 79, an O2 (oxygen) saturation rate of 95% on 3 lpm (liters per minute.) The resident was very confused, and weak. She was unable to stand. The nurse had to crush her morning medications to administer them. The nurse then had the resident lay back down and her BIPAP was applied. After 2 hours of wearing the BIPAP, the nurse entered to recheck the resident's vitals. Her vitals included a blood pressure of 110/57 mm/Hg, a heart rate of 84, a temperature of 97.9, and O2 saturation rate of 94% on 3 lpm. The nurse listened to the resident's lung sounds which were diminished. The RLE (right lower extremity) was observed with 2 to 3 plus edema. The resident indicated she was short of air. The nurse asked the resident some questions.		nurse managers were re-educated on notifying physicians of any resident changes. **IV The facility will monitor the corrective action by implementing the following measures.** DON/Designee will audit 5 random residents records at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly for an additional 3 months to ensure physicians are notified of any resident condition changes. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve a 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date. July 20,2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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	She was unable to answer where she was, what month it was, what year it was, and she was unable to name her children. The nurse then put a call in to the on-call physician who ordered stat CBC (complete blood count), CMP (complete metabolic panel), UA (urinalysis), venous doppler on BLE (bilateral lower extremities), and a CXR (chest x-ray) and gave orders to check the resident's vitals every four hours and to call back if the resident worsened. The nurse's note, dated 6/11/23 at 2:10 p.m., indicated the nurse contacted the on-call physician due to the resident not waking to eat or drink. The nurse was attempting to get the resident to drink and was unsuccessful. The nurse spoke to the physician who ordered to administer 1 liter of IV (intravenous) fluids at a rate of 125 mL/hr (milliliters per hour). The nurse's note, dated 6/11/23 at 3:46 p.m., indicated the nurse administered the resident's IV antibiotic at 2:20 p.m. and went in to run her IV fluids at 3:30 p.m. When the nurse entered, the resident was unresponsive. The nurse contacted her supervisor who came to the resident's room and ordered the nurse to call 911. The emergency transport 911 was called and they arrived at 3:50 p.m. The Hospital note, dated 6/11/23, indicated the resident was admitted to the hospital on 6/11/23 complaining of altered mental status. The resident presented due to unresponsiveness and low blood pressure. The resident's family member was present and indicated the resident had experienced worsening mental status since the day prior. She was admitted for an acute exacerbation of COPD. The resident's assessment and plan indicated she had acute metabolic			

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	encephalopathy, acute hypoxic hypercapnic respiratory failure, and a UTI (urinary tract infection). The resident was a high risk for further or rapid decline and her family was aware. During an interview on 7/7/23 at 10:55 a.m., NP 9 indicated she did recall the resident. She had end stage renal disease, COPD with hypercapnia, respiratory failure, she had been in and out of the hospital for her respiratory issues, and she had the BIPAP, which was fairly new for her. She was always hypercapnic to some degree. There were one or two instances where she wound up in the hospital, and at least one instance since she had the BIPAP. On 6/11/23 there should have been a call to the doctor when the resident had a change in condition. She found out about the change of condition after the fact. She reviewed the note from 6/11/23 at 10:37 a.m., and indicated someone should have been notified immediately, when she was weak and unable to stand, and her blood pressure was that low. They shouldn't have even administered her medications. Knowing her history she would have sent her out to the hospital. During an interview on 7/10/23 at 10:00 a.m., the DON (Director of Nursing) indicated she expected staff to notify the physician of any acute change in condition. There were not certain parameters for blood pressures. If the blood pressure was abnormal from the resident's normal they would notify the physician. She would expect notification if the resident's blood pressure was low and they were symptomatic. If the resident had symptoms and a change in condition she would expect the physician to be notified as soon as staff were able to. It would depend on what was going on with the resident, they would need to do a full assessment and notify the physician.			

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	The most current Change in a Resident's Condition or Status policy, last revised 10/2010, provided on 7/7/23 at 2:00 p.m. by the DON, included but was not limited to, " ... Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status ... The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been ... d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly; f. A need to transfer the resident to a hospital/treatment center ... h. Instructions to notify the physician of changes in the resident's condition ... 2. A 'Significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions ..." This Federal Tag relates to Complaint IN00412136. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on record review and interview, the facility failed to ensure professional standards of care related to implementation of physician orders and	F 0658	**F 658 Services Provided Meet Professional Standards**	07/20/2023

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	provision of medically necessary emergent care for 1 of 3 residents reviewed for professional standards of care. (Resident E) Findings include: The clinical record for Resident E was reviewed on 7/7/23 at 10:00 a.m. The diagnoses included, but were not limited to, arteriovenous fistula, chronic kidney disease (CKD) stage 4, hypertensive heart and chronic kidney disease, end stage renal disease (ESRD), altered mental status, acute and chronic respiratory failure with hypercapnia and hypoxia, hypotension, hypo-osmolality and hyponatremia, dependence on renal dialysis, hyperkalemia, wheezing, insomnia, hypokalemia, difficulty walking, COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), HTN (hypertension), and dependence on supplemental oxygen. The care plan, dated 1/9/23 and last revised 6/29/23, indicated the resident had a potential for respiratory distress related to COPD/chronic respiratory failure. She had shortness of air while lying flat as evidenced by increased respirations. The goal was for the resident to not exhibit unrecognized signs of respiratory distress such as restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds thru her next review. The interventions included but were not limited to; administer medications and oxygen per physician's order; elevate the head of the bed to alleviate shortness of breath while lying flat; and report signs of respiratory distress. The nurse's note, dated 6/16/23 at 12:05 p.m., indicated the resident was in dialysis and was not		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident E conditioned stabilized and the Physician was notified with interventions put in place **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Current residents have the potential to be affected by this alleged deficient practice. Residents residing at Lincoln Hills physician orders have been audited to ensure the orders were carried out and resident's records have been audited for provision of medically necessary emergent care have been implemented. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Nursing staff have been educated on implementing and carrying out physicians orders, implementing medically necessary emergent care, and professional standards related to nursing and following physicians/NP orders.	

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	responding to verbal or tactile stimuli for the NP. However, when the DON (Director of Nursing) went in to see the resident her eyes were open, and the resident was mumbling. The DON asked the resident if she wanted to go to hospital and the resident indicated no, and shook her head no. The NP (Nurse Practitioner) was made aware that the resident did not want to go to hospital. A call was placed to the resident's family member and there was no answer. The nurse from dialysis kept stating Resident E's speech was slurred and she needed to go to the hospital. The DON explained to her that the resident had stated that she did not want to go to the hospital. The NP's note, dated 6/16/23, indicated the resident's provider was alerted by dialysis RNs to the resident's status when checking on another resident. The provider was told the patient was not as alert as usual before dialysis and had continued to decompensate. Her BP (blood pressure) had been stable, but during their assessment, the resident's BP was low at 77/55 mm/Hg (millimeters of mercury), and it was currently at 124/94 mm/Hg. The NP was unable to awaken the resident with deep, painful stimuli. The NP gave an order to send the resident to the hospital and EMS (Emergency Medical Services) was called. The EMS call was canceled by the DON who indicated she was able to awaken the patient and she did not want to go to the hospital. Dialysis RNs insisted she needed to go to hospital due to slurred speech and AMS (altered mental status). The NP was concerned that the patient was unable to make decisions at the time due to AMS and likely hypercapnia. The NP was called back to the facility after leaving for the day to sign a POST (physician orders for scope of treatment) form (a form which outlines treatments that a person would like to receive or not receive		**IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit 5 random residents 5 times a week times 4 weeks, then weekly times 4 weeks, then monthly times 4 months to ensure residents physicians orders were carried out and implementation of medically necessary emergent care were completed. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve a 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date. July 20, 2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting. **Request for Informal Dispute Resolution** We respectfully request an Informal Dispute Resolution of the assessment for the deficiency cited during a complaint survey	

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	related to end of life) for the resident to have comfort measure only. The NP discussed what was documented on the form with the resident and what decisions were checked that she elected. The resident indicated she never made those decisions and she wanted to go to the hospital because she wanted to live. The NP did not sign the POST form and informed the unit manager she would not sign the form. The NP indicated the resident likely needed an evaluation for capacity to make medical decisions. During an interview on 7/6/23 at 11:22 a.m., Resident E's family member indicated Resident E was a DNR (Do Not Resuscitate), but she was not opposed to going to the hospital. She went to the hospital many times. Resident E had an episode in dialysis where staff couldn't get her to come around. She was at work and didn't have access to a phone. She didn't know why an ambulance was not called then. Anytime she went to the hospital, they put the BIPAP on her and she would come out of it. They knew it from experience. When she had her episodes, she was not in the capacity to make decisions. She would not be in a state to say she didn't want to go to the hospital. On 7/7/23 at 10:32 a.m., the facility was not able to get a hold of her because she was at work and they had left messages, all they said was they needed her to call them. They did not have any conversations about hospice, she wasn't said to be dying. Nobody had ever mentioned hospice to her, and she had never consented to bringing on hospice services. No one ever talked to her about putting her family member on hospice. During an interview on 7/7/23 at 10:45 a.m., Dialysis RN 8 indicated she was working on 6/16/23 and recalled the incident with Resident E. While she was on dialysis and doing vital signs,		dated 07/10/2023. The deficiency F 658 was cited. The facility disagrees with the subjective assessment of the surveyor for these deficiencies. We respectfully request that the deficiency F658 be deleted. The IDOH guidelines for Professional Standards states “The facility must assure that services being provided meet professional standards of quality” There is an absence of objective information to support these findings.	

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	she tried to wake her, and she was not waking up. She was pinching and tapping the resident's shoulder, but she wasn't waking up. They called the NP who was just around the corner. The NP did recommend for the resident to go to the hospital. She did believe the resident needed to go to the ER and the NP gave orders for it. She did start to wake up before sending her back to her room, but her speech was slurred, and she was not her normal self. She was saying yes and no, but she was not sure how much she was comprehending and if she was in her right state of mind. She said no to the hospital, but she could not be certain that she was in her full mental capacity. The resident had a history where she could go hypercapnic, and it was a possibility that could alter her mental state. The resident was not waking up and it was not safe for them to do the dialysis in that condition. During an interview on 7/7/23 at 10:55 a.m., NP 9 indicated she did recall the resident. She had end stage renal disease, COPD with hypercapnia, respiratory failure, and she had been in and out of the hospital for respiratory issues. She had the BIPAP, which was recently new for her. There was one episode recently, about 2 weeks prior where she was unresponsive in dialysis. The NP went to round on a different patient and the main Dialysis RN 8 voiced concern that Resident E was less responsive than what she was usually, so she went to see her. She would not open her eyes; she was kind of in and out of it. She did a deep sternal rub on her and she was just barely moving her head. She listened to her lungs, and she was very concerned with her condition. She had the nurse check her sugar, but it wasn't low. When she came back into the room the resident was even less responsive. She did another deep sternal rub, and she wasn't even flickering her eyelids. She made			

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	the decision to send her to the hospital. Her nurse went out and called EMS. When she came back, the DON was at the nurses' station and was on the phone. When she walked up to her, she was hanging up the phone and said she canceled EMS. The NP asked her why, and she said because she went in, and the resident was alert and awake and didn't want to go to the hospital. The NP asked if she was awake, the DON said yes, and the NP relayed to the DON that the resident was completely unresponsive when she saw her. She told the DON the resident was likely hypercapnic and confused. And the DON said she's a DNR and she doesn't want to go to the hospital. The resident wasn't on hospice or receiving comfort measures only. She was concerned with that decision to cancel the emergency transport. Dialysis RN 8 had told her she was slurring her speech even when she said she didn't want to go to the hospital, and she felt she wasn't able to make that decision. It was her medical opinion she should have gone to the hospital and she never canceled her order to send the resident to the hospital. During an interview on 7/7/23 at 1:09 p.m., the CEO of Clinical indicated their company provided the NP services for the residents in the building. The NP ordered the resident to be sent out to the hospital and the DON canceled the EMS transport to the hospital. The NP did not reassess the resident at that time. The NP later in the day assessed the resident and she was then considered stable. "We have to come from a place of pure medical judgement and that can change." The resident had a right to refuse the order to go to the hospital and a hypercapnic patient can wake up and be back to baseline. If she refused, they rested on the facility.			

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	During an interview on 7/10/23 at 10:00 a.m., the DON indicated she expected nurses to follow a physician's orders, as nurses were taught to do that. If a nurse did not agree with a physician's order, then they would go and speak to the provider, and make them aware of what was going on and see if they were in agreement or not. If they were in agreement with the nurse, they would cancel the order. If the NP or the physician did not agree with the nurse they would follow the recommendation or the orders. When the NP ordered to send Resident E to the hospital, she went and talked to the NP. She went to her and let her know the resident did not want to go. The resident was her own person and she did not have a power-of-attorney put in place. She said she did not want to go to the hospital. When she went in to see the resident, she said her name and the resident responded. Previously, the dialysis nurse said she wasn't waking up. She told the resident she fell asleep and they wanted to send her to the hospital and asked her if she wanted to go. The resident said no, and shook her head. She did not do any other assessment to the residents cognitive status. She did not do any education to the risks or benefits of going to the hospital. She did not have the physician come in and reassess the resident, but she notified the physician that she did not want to go. The resident did later indicate she did want to go. Later on, she did say she changed her mind. The physician did not ever give her an order to cancel EMS. She asked the NP verbally if she was ok keeping the resident in the facility and the NP said yes, but she didn't document it and she should have. The Indiana State Board of Nursing Compilation of the Indiana code and Indiana Administrative Code 2013 Edition, included but was not limited to, " ... IC 25-23-1-1-.1 Additional definitions Sex			

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	1.1 ... (b) As used in this chapter, "registered nursing" means performance of services which include but are not limited to: (1) assessing health conditions; (2) deriving a nursing diagnosis; (3) executing a nursing regimen through the selection, performance, and management of nursing actions based on nursing diagnoses; (4) advocating the provision of health care services through collaboration with or referral to other health professionals; (5) executing regimens delegated by a physician with an unlimited license to practice medicine or osteopathic medicine, a licensed dentist, a licensed chiropractor, a licensed optometrist, or a licensed podiatrist ... (7) delegating tasks which assist in implementing the nursing, medical, or dental regimen; or (8) performing acts which are approved by the board or by the board in collaboration with the medical licensing board of Indiana. (c) As used in this chapter, 'assessing health conditions' means the collection of data through means such as interviews, observation, and inspection for the purpose of: (1) deriving a nursing diagnosis; (2) identifying the need for additional data collection by nursing personnel; and (3) identifying the need for additional data collection by other health professionals ... IC 25-23 Sec. 2. The registered nurse shall do the following: (1) Function within the legal boundaries of nursing practice based on the knowledge of statutes and rules governing nursing ... (3) Communicate, collaborate, and function with other members of the health team to provide safe and effective care ... (8) Delegate and supervise only those nursing measures which the nurse knows, or should know, that another person is prepared, qualified, or licensed to perform ... Unprofessional conduct Authority ... Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing nursing practice, which could			

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	jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgment, technical skills, or inappropriate interpersonal behaviors in providing nursing care. (2) Performing any nursing technique or procedure for which the nurse is unprepared by education or experience ..." This Federal Tag relates to Complaint IN00412136. 3.1-35(g)(1)			
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident with a history of respiratory failure and hypercapnia, who had recently had a surgical procedure, received appropriate care and monitoring when she experienced a sudden change in condition and had complaints of not being able to breathe. The resident was found with blue discoloration around her mouth and no visible signs of life. (Resident E) The Immediate Jeopardy began on 7/1/23, when Resident E experienced a change in condition while in the dining room. She became weak and tired and requested to go to bed. The resident was	F 0684	**F 684 Quality of Care** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** All residents with potential to be affected by the alleged deficient practice were reviewed. Residents with respiratory devices/ change of condition, or post-operative were assessed to ensure respiratory	07/10/2023

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	slipping down in her chair. The resident was placed in her room and left in her wheelchair. She was not placed in bed or on her BIPAP (bilevel positive airway pressure, type of ventilator, a device that helps with breathing) machine. She yelled out for help and that she could not breathe for 20 minutes or more before becoming quiet. No staff were observed to enter her room until much later when she was found in her room with blue discoloration around her mouth and no visible signs of life. The ED (Executive Director) and DON (Director of Nursing) were notified of the Immediate Jeopardy at 3:03 p.m. on 7/7/23. The Immediate Jeopardy was removed on 7/8/23, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview on 7/6/23 at 9:25 a.m., Resident B indicated on 7/1/23 they had an incident where one of the other resident's was sitting at the dinner table in the activity room. He identified the resident as Resident E. He indicated her nasal cannula kept coming off. While she was eating, she started "falling out." She had her tray on the table and kept tipping it. He tried to find an aide, but he couldn't, so he found two nurses. They sat her up in her chair and took her to her room. A little bit later he kept hearing her holler, "I can't breathe! I can't breathe! Somebody help me! I'm dying!" He didn't believe anyone went in there. CNA (Certified Nurse Aide) 5 was running up and down the hall, he knew she had to have heard the resident. When someone was hollering like that, they should stop and go in and check on them. He could not remember how long she was		devices were in place and that they exhibited no s/s of distress or change of condition. All current residents in the facility with respiratory devices had a care plan review completed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills have potential to be affected by the alleged deficient practice were reviewed. Residents with respiratory devices/ change of condition, or post-operative were assessed to ensure respiratory devices were in place and that they exhibited no s/s of distress or change of condition. All current residents in the facility with respiratory devices had a care plan review completed. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All licensed nurses and CNAs that work at Lincoln Hills Health Center were educated regarding respiratory devices, change of condition, post-op monitoring, and the importance of assisting residents to bed in a timely	

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	hollering, but the next thing he knew, she got quiet. Later he heard them in there hollering the resident's name, telling her to wake up. Resident E had another episode the weekend before where she was physically weak and not herself for a few days. When she had the episodes, they'd put her mask on her, and she would wake up fine. She always complained to him that staff never put her mask on her. They left her sitting in that chair for 2 and a half hours knowing she couldn't breathe, on a nasal cannula. It bothered him that she sat there so long. He was told she didn't have a mask on by both CNA 5 and LPN 6. Several residents had complained about staff not helping Resident E. The Clinical Record for Resident B was reviewed on 7/7/23 at 12:46 p.m. The most recent Annual MDS (Minimum Data Set) Assessment, dated 6/5/23, indicated the resident was cognitively intact. During an interview on 7/6/23 at 11:22 a.m., Resident E's family member indicated LPN 7 told her the resident should have had her BIPAP on or she would die. The resident had been in the activity room eating dinner, and she started having one of her episodes. When she was not responding right it was because she wasn't getting enough oxygen. Staff knew to take her and put her in bed and put her BIPAP machine on her. A couple of hours later she would be back to being coherent. Her friends were in the activity room when the nurses got her. Her friends said she was having trouble, and they assumed staff had put her on her BIPAP machine, but they just left her in her wheelchair sitting in her room. Staff tried to tell her the resident was fine, coherent, and talking, but she never sat in her room in her wheelchair. An hour or so passed and suddenly, the other residents heard her screaming and		manner and assisting with the application of respiratory devices if needed. All licensed nurses completed the skills validations for assessing the thorax and lungs and the skills validation for oxygen administration. Licensed nurses and CNAs that have not received initial education will be provided education on the above, prior to working their next scheduled shift to obtain 100% of nurse and CNA re-education. Newly hired licensed staff nurses and CNAs will receive the above education upon hire. **IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit progress notes, vital signs, and post-op to identify five residents at risk for change of condition, respiratory distress, or post-op daily for 1 week, then weekly for implementation of interventions and prevention of negative outcomes then weekly for implementation of interventions and prevention of negative outcomes. **V. Plan of Correction completion date. July 10, 2023**	

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	crying "I'm dying! I'm dying! Somebody help me!" She was told that a nurse from the other end, thirty minutes later, went in and found her passed away in her chair. She always went to bed and was in bed by 7:30 p.m. She should have been on her machine at that time. During an interview on 7/6/23 at 11:43 a.m., Resident C indicated on 7/1/23 they had two new staff members of a nurse and an aide. One aid called in and everybody was busy. They had to wait for things. Resident E had died. She was on oxygen, and she needed to stay on it. The night before they had her on her BIPAP when she was really getting short of breath. On 7/1/23 she heard her hollering, "Help! I'm dying! Somebody come!" No one checked on her for a long time, then they went in there. She thought the aide went in there first, and then she came running out and got the nurse and then they were both in there. They shut the door a little bit so she couldn't see anything. When Resident E was yelling out, she was in her room, and she could see Resident E's room through the open door. She was in her wheelchair, and she just had a nasal cannula on. She was screaming out, on and off, the whole 20 minutes. The lights were going off, they pushed their own lights thinking maybe if they saw their lights, they could get her help. It was evening time, after supper and she didn't see any staff go into the room to help her during that time. Resident E was screaming as loud as she could. The record for Resident C was reviewed on 7/7/23 at 12:52 p.m. The most recent Quarterly MDS assessment, dated 6/12/23, indicated the resident was cognitively intact. During an interview on 7/6/23 at 11:49 a.m., Resident D indicated she heard Resident E yelling		This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting and require 100% compliance threshold to determine whether further monitoring is necessary or if monitoring will be ongoing. **Request for Informal Dispute Resolution** We respectfully request an Informal Dispute Resolution of the assessment for the deficiency cited during a complaint survey dated 07/10/2023. The deficiency F 684 was cited. The facility disagrees with the subjective assessment of the surveyor for these deficiencies. We respectfully request that the deficiency F684 be deleted. The IDOH guidelines for Quality-of-Care states “The facility must ensure that residents receive treatment and care in accordance with professional standards of practice” There is an absence of objective information to support these findings.	

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	for help for quite some time, and she didn't see any staff help her during the time. The record for Resident D was reviewed on 7/7/23 at 12:56 p.m. The most recent Quarterly MDS, dated 6/12/23, indicated the resident was cognitively intact. During an interview on 7/7/23 at 11:35 a.m., LPN 7 indicated the night Resident E passed, she was not her nurse when she passed, but she did care for her earlier in the day. She did see the resident at dinner time. She was sliding down in her chair and then Resident B came to get them. She was tired, but she was ok. Her and another nurse sat her up in her chair and brought her to her room. She connected her to the concentrator. She had oxygen on. They did not lay her down. She said she would look for someone to put her back to bed. They were changing shifts. She looked, but there was nobody around (no aides) and she was in the middle of report. The resident had told her she was tired between 6:00 p.m. and 6:10 p.m. She let her nurse know she wanted to go to bed, because the resident said she wanted to go back to bed. She did not know what time she passed; she went to see her after she passed around 9:00 p.m. She had not been put to bed. She did not hear the resident hollering, she worked on a different hall, there was no way she would have heard anything. If she had a BIPAP she would assume she needed to wear it at night During an interview on 7/7/23 at 11:46 a.m., CNA 5 indicated on 7/1/23 as she was taking trays to the dining room, Resident E had been yelling and her call light was on. She went in and answered her call light, and the resident indicated she was ready to go to bed. She said to give her a bit and someone would help her. They went ahead and			

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	got showers done and started getting other people to bed, and by the time she went to her room the resident had passed. The girl who was supposed to be her aide was on another hall. She did not know how long the resident was yelling, she didn't think it was long, but she could be wrong because she was in a room with other residents. She believed it was around 7:30 p.m. to 8:00 p.m. when she told the resident she would put her to bed. She didn't get back in there to put her to bed until 8:45 p.m. to 9:00 p.m. She did not hear her yelling out anymore. When she heard her yelling, she was yelling help. She just said she was ready to go to bed. She seemed tired but other than that she seemed normal. She was not on her BIPAP. During an interview on 7/7/23 at 11:59 a.m., LPN 10 indicated she started her medication pass at 7:00 p.m. The resident said she wanted to go to bed soon. She told the resident the CNA was almost to her room. The resident was sitting in her wheelchair. She told her she was tired when she went in there to give her medications, which was probably between 7:30 p.m. and 8:00 p.m. She was told about a procedure to do with her dialysis, that she had something new put in or fixed the Friday before. She was told in report that LPN 7 went in to see her because someone stated she wasn't acting the same earlier in the day. As far as surgery went, she knew they needed to be monitored. She was not given any specific instructions on post-op monitoring. She did not apply the resident's BIPAP that night. Generally, they put them on when they laid down and she was not in bed. During an interview on 7/7/23 at 10:55 a.m., NP 9 indicated she did recall the resident. She had end stage renal disease (ESRD), COPD (chronic			

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	obstructive pulmonary disease) with hypercapnia, respiratory failure, and she had been in and out of the hospital for respiratory issues. She had the BIPAP, which was recently new for her. Her understanding was sometimes she did refuse to wear it, but she had voiced to her as well that some of the nursing staff did not know how to use it appropriately, so she didn't always get to wear it. She was always hypercapnic to some degree, but there were one or two instances where she wound up in the hospital, and at least one instance since she had the BIPAP ordered. There was one episode recently, about 2 weeks prior when she was unresponsive in dialysis. She received a text close to 10:00 p.m. on 7/1/23 from the DON (Director of Nursing) saying the resident had passed and she didn't want her caught off guard. Post-op monitoring would be up to the hospital to let them know, but if it was general surgery and depending on how soon they sent her back, if someone came back under general anesthesia and they were still sedated somewhat and confused she would say to monitor them more closely, every hour or 2 hours vital signs to make sure their blood pressure was staying up and hold sedating medications. She should have been wearing her BIPAP. Her understanding was to have her wear it when she was napping and when she was sleeping. She had mentioned on stand-down the resident had complaints of staff not assisting to apply her BIPAP. She advised the nurses, supervisors, DON, ADON (Assistant Director of Nursing), and Social Worker of this concern. The clinical record for Resident E was reviewed on 7/7/23 at 10:00 a.m. The diagnoses included, but were not limited to, arteriovenous fistula, chronic kidney disease (CKD) stage 4, hypertensive heart and chronic kidney disease, end stage renal			

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	disease, altered mental status, acute and chronic respiratory failure with hypercapnia and hypoxia, hypotension, hypo-osmolality and hyponatremia, dependence on renal dialysis, hyperkalemia, wheezing, insomnia, hypokalemia, difficulty walking, COPD, CHF (congestive heart failure), HTN (hypertension), and dependence on supplemental oxygen. The care plan, dated 1/9/23 and last revised 6/29/23, indicated the resident had a potential for respiratory distress related to COPD/chronic respiratory failure. She had shortness of air while lying flat as evidenced by increased respirations. The goal was for the resident to not exhibit unrecognized signs of respiratory distress such as restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds thru her next review. The interventions included, but were not limited to; administer medications and oxygen per physician's order; elevate the head of the bed to alleviate shortness of breath while lying flat; and report signs of respiratory distress. The care plan did not include any interventions specific to the resident's BIPAP usage. The Hospital note, dated 5/8/23, indicated the resident was admitted with the inability to maintain wakefulness and an elevated CO2 (carbon dioxide) level. BIPAP was initiated with significant improvement and mentation. Pulmonary was consulted. She had severe OSA (obstructive sleep apnea) with pulmonary hypertension. The physician's order, dated 5/17/23, indicated the resident was to have her BIPAP with 2 lpm (liters			

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	155614	A. BUILDING 00 B. WING	07/10/2023

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per minute) bled in as needed every shift and at and before bedtime to be administered between 7:00 p.m. to 11:00 p.m. with special instructions for nursing to assist and document acceptance or refusal.

The nurse's note, dated 6/11/23 at 10:37 a.m., indicated the nurse went to check the resident's vitals prior to and found the resident in bed with no nasal cannula or BIPAP in place. This nurse applied a nasal cannula and obtained vitals. The resident's vitals included a heart rate of 88/58 mm/Hg (millimeters of mercury), a heart rate of 79 bpm (beats per minute), and an O2 (oxygen saturation) of 95% on 3 lpm. The resident was very confused, and weak. She was unable to stand. The nurse had to crush her morning medications to administer them. The nurse then had the resident lay back down and BIPAP was applied. After 2 hours of wearing BIPAP, the nurse entered to recheck the resident's vitals. The resident's vitals included a BP of 110/57, a heart rate of 84 bpm, a temperature of 97.9, and an O2 of 94% on 3 lpm. The nurse listened to the resident's lung sounds which were diminished. The RLE (right lower extremity) was observed with 2 to 3 plus edema. The resident indicated she was short of air. The nurse asked the resident some questions. She was unable to answer where she was, what month it was, what year it was, and she was unable to name her children. The nurse then put a call in to the on-call physician who ordered stat CBC (complete blood count), CMP (complete metabolic panel),UA (urinalysis), venous doppler on BLE (bilateral lower extremities), and a CXR (chest x-ray) and gave orders to check the resident's vitals every four hours and to call back if the resident worsened.

The Hospital note, dated 6/11/23, indicated the

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	resident was admitted to the hospital on 6/11/23 complaining of altered mental status. The resident presented due to unresponsiveness and low blood pressure. The resident's family member was present and indicated the resident had experienced worsening mental status since the day prior. She was admitted for an acute exacerbation of COPD. The resident's assessment and plan indicated she had acute metabolic encephalopathy, acute hypoxic hypercapnic respiratory failure, and a UTI (urinary tract infection). The resident was a high risk for further or rapid decline and her family was aware. The NP's note, dated 6/16/23, indicated the resident's provider was alerted by dialysis RNs that Resident E was not as alert as usual before dialysis and had continued to decompensate. Her BP had been stable, but during their assessment, the resident's BP was low at 77/55 mm/Hg, and it was currently at 124/94 mm/Hg. The NP was unable to awaken the resident with deep, painful stimuli. The NP gave an order to send the resident to the hospital and EMS was called. The EMS call was canceled by the DON who indicated she was able to awaken the patient and she did not want to go to the hospital. The Nurse's note, dated 6/18/23 at 5:31 a.m., indicated the resident was lethargic most of the shift. The nurse was able to wake the resident after much difficulty to take her medications around 11:30 p.m. Her vital signs were normal, and she was wearing her BIPAP. The resident experienced a fall because she was confused and was trying to get out of bed. The physician ordered for a CBC, CMP, and a UA to be obtained. The resident's family was notified. The hospital discharge summary, dated 6/30/23,			

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	indicated the resident had a surgical procedure to superficialize her dialysis fistula. The Monitored Anesthesia Care sheet, provided on discharge, indicated to have a responsible adult stay with the resident for the time she was told, and to have someone help take care of her until she was awake and alert. If the resident had sleep apnea, surgery and certain medications could increase her risk for breathing problems. She was to follow instructions from her provider about wearing her sleep device. The instructions included to wear the device any time she was sleeping, including during daytime naps, and while taking prescription pain medications, sleeping medicine or medication that could make her sleepy. She was to get help immediately if she had trouble breathing or a new onset of confusion at home. It was important to have someone help care for her until she was awake and alert. The nurse's note, dated 7/1/23 at 4:16 a.m., indicated the resident returned from the hospital from her surgery appointment and was alert and oriented. The clinical record lacked documentation of any respiratory, cognitive, or other nursing assessment at the time Resident B alerted LPN 7 to Resident E's condition in the activity room, until an hour and twenty-four minutes later. The vitals report indicated the resident's oxygen saturation, on 7/1/23 at 7:24 p.m., was 98% and her respirations were 18 breaths per minute. Her blood pressure at 7:26 p.m. was 132/66. There were no documented assessments of the resident's lung sounds or her cognitive status at the time. The clinical record lacked documentation of any further respiratory, cognitive, or other nursing			

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	assessment, or any follow-up vitals assessments, on 7/1/23 from 7:26 p.m., until the time the resident was discovered with no visible signs of life in her room. The Medication Administration Record, indicated LPN 10 had signed off on the resident's order to apply the resident's BIPAP between 7:00 p.m. and 11:00 p.m. on 7/1/23. The physician's note, dated 7/1/23 at 9:49 p.m., indicated the resident had been doing poorly over last several days, according to the nurse's report. The patient died unexpectedly while sitting in her chair and was found already expired when the nurse came back to put the patient to bed. The nurse's note, dated 7/2/23 at 12:12 a.m., indicated on 7/1/23 at 9:00 p.m. the resident was found sitting in her wheelchair in her room. She had slight blue discoloration around her mouth. She was non-responsive and all signs of life had ceased as verified by two nurses. The family and physician were notified. The immediate jeopardy, that began on 7/1/23 was removed on 7/8/23, when the facility conducted the following: All licensed Nurses and CNA's that worked at the facility were educated regarding respiratory devices, change of condition, post-operative monitoring, and the importance of assisting residents to bed in a timely manner and assisting with the application of respiratory devices if needed; All licensed nurses completed the skills validation for assessing the thorax and lungs and oxygen administration; The facility ensured all licensed nurses and CNAs that were not present to receive the initial education and would be provided education prior to working their next scheduled shift; All residents were			

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	reviewed for respiratory devices, change of condition, and post-operative to ensure respiratory devices were in place and they exhibited no signs or symptoms of distress; and All residents in the facility with respiratory devices had a care plan review. The most current Change in a Resident's Condition or Status policy, last revised 10/2010, provided on 7/7/23 at 2:00 p.m. by the DON, included but was not limited to, " ... Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status ... The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been ... d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly; f. A need to transfer the resident to a hospital/treatment center ... h. Instructions to notify the physician of changes in the resident's condition ... 2. A 'Significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions ..." This Federal Tag relates to Complaint IN00412136. 3.1-37(a)			