STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, physician and staff interviews, the facility failed to notify the physician when 1 of 3 residents (Resident #1) receiving	F 157	Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	1/15/14

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

Electronically Signed | 01/15/2014

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F 157	Continued From page 1 gastrostomy feedings and/or on thickened liquids, experienced projectile vomiting, after consuming food on a regular texture diet and thinned liquids. The findings included: Resident #1 was admitted to the facility on 10/8/13 with the following diagnoses: traumatic brain injury, dysphagia, gastrostomy tube and a history of respiratory failure post tracheotomy. The admission Minimum Data Set (MDS) dated 10/15/13, determined that she had severe cognitive impairments, needed extensive assistance with eating, tube fed, on a mechanically altered diet and had no swallowing problem. A record review was conducted of Resident #1's medical chart. It indicated that a physician telephone order, transcribed on 10/8/13, stated that her diet include a pureed with nectar thick liquids. She would receive a bolus feeding at 8 am, 12 pm and 4 pm, only if she didn't eat 50% of her meals. Her gastrostomy tube would be flushed with 60 cc (cubic centimeter) before and after feedings. A Care Plan was developed on 10/18/13 to address the tube (gastrostomy) feeding, required to assist her in maintaining nutritional status characterized by weight loss related to cognitive deficit and dysphagia (difficulty with swallowing). The goal read that Resident #1 would receive adequate nutritional and fluid intake as evidenced by stable weight, and no signs or symptoms of malnutritiona or dehydration through the next review. Interventions included: tube feed formula and water flushes as ordered by the physician; maintain g-tube for feeding purposes; monitor for	F 157	and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F157 Criteria 1: On 11/25/13 the assigned nurse assessed resident # 1 for a change in condition. On 11/25/13 the assigned nurse contacted Resident # 1's Medical Doctor (MD) for an order and Resident□s Responsible Party (RP) to notify of resident being sent out via Emergency Medical Services (EMS) due to change in condition. Criteria 2: A 100 percent audit was started on	

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F 157	Continued From page 2 signs and symptoms of tube feeding complicatons, for example aspiration, dyspnea (shortness of breath) or fever, formula intolerance-nausea, vomitting or diarreha; infection or irritation to stoma site. Another care plan was developed on 10/18/13 to address nourishment related to less than body requirement characterized by weight loss, inadequate intake, decreased appetite related to cognitive impairment, and pressure area. Goals included that the total intake would meet the resident's nutritional needs as evidenced by stable weight, increased food intake and documented improvement in wounds thru next review. Interventions listed were: diet and thickened liquids as ordered; monitor and observe for signs and symptoms of gagging or choking during meals and report to unit nurse. On 11/23/13, the 24 hours shift reported noted that Resident #1 didn't eat dinner on 2nd shift (3-11 pm) and had 1 episode of vomitting. On 12/15/13 at 3:15 pm, in an interview with Nurse Aide #1 (NA#1), who worked with Resident #1 on 11/23/13 during 1st shift (7 am to 3 pm), she stated that Resident #1 was able to feed herself breakfast that morning, eating 100% of her meal and she ate 50% of her meal for lunch. She recalled that Resident #1 had a visitor that day, who brought her in regular soda to drink, although she remained on a nectar thickened diet. During her shift, she did not see her experience vomitting. Nurse #1 was interviewed by phone on 12/16/13 at 5:25 pm. She shared that she worked with Resident #1, every other weekend and that she received a bolus feeding if she ate less than 50%	F 157	12/17/13 by the Facility Nurse Consultants of all nurse progress notes back to 10/25/2013 to ensure that significant changes in a resident's condition noted includes documentation of MD and RP notification as appropriate. 37 residents were identified as needing MD/RP notification. All areas found were immediately followed up with notification of MD and/or RP. A 100 percent audit was completed on 12/18/13 by Facility Nurse Consultants, Director of Nursing, Assistant Director of Nursing, Quality Improvement (QI) nurse, Minimum Data Set (MDS) nurse, treatment nurse, and Staff Facilitator on all nurse's notes back to 10/25/13 to assure that any changes in resident condition noted had documentation of a physical assessment. Audit revealed there were no residents with changes in condition needing documentation of a physical assessment. A 100 percent education to include in-servicing and testing of all nursing staff and non-nursing staff was initiated by Staff Facilitator on 12/17/13 in regards to any changes in resident condition. Staff were educated to notify the assigned nurse of changes in resident condition. Criteria 3: On 12/17/13, the Staff Facilitator initiated in-servicing for all nurses that included "In the event of a medication change, incident/accident, any new orders, any	

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F 157	Continued From page 3 of her pureed diet. She normally ate well, at about 75-100%, so she only had to give her a bolus feeding once. On 11/23/13, a visitor brought Resident #1 in food from the outside. She recalled seeing a large can of soda in her room and advised the visitor that Resident #1 was on thickened liquids. She said the visitor commented to her, that she drunk fine. Later that shift, Nurse #1 stated Resident #1 wouldn't eat her lunch well and appeared to be full. The following day, 11/24/13, she was told in her shift report that Resident #1 had vomitted Saturday evening but seemed okay during the night, although the therapist reported to her Sunday morning, that she appeared lethargic. She shared that she thought that maybe Resident #1 had volume overload, since she had consumed food and beverages from an outside source. Nurse #1 stated that she did not consult the physician, nor recorded any vital signs because she knew she didn't have a temperature and her respirations seemed to be fine. On Sunday, she shared that Resident #1, continued to eat poorly. Nurse Aide #2 was interviewed on 12/16/13 at 3:58 pm. He stated that he worked with Resident #1 on 11/23/13 during 2nd shift and she ate poorly for him, and needed a bolus feeding. Nurse # 2 was interviewed by phone on 12/17/13 at 5:11 pm. She worked 2nd shift on 11/23/13 and 11/24/13 and was assigned to Resident #1. She shared that normally, Resident #1 did not eat well for supper. That weekend, she recalled that she was informed that Resident #1 had eaten food earlier that day, from outside sources. She stated that the nurse told her in the shift report, that she had consumed hamburger, chips and soda,	F 157	change in condition, transfer or discharge out of facility, death, or anything out of normal for resident to include vomiting, you need to notify the MD and RP, as appropriate, anytime of the day to include third shift. If not sure when to notify MD or RP call the on-call nurse, Director of Nursing (DON), or Administrator for directions. Documentation of time and person contacted must be completed. Documentation of MD and RP notification must occur at all times". This in-service will continue until all nurses, Certified Nursing Assistants (C.N.A□s) and non-nursing staff to include dietary, therapy, and housekeeping are trained. No employee will be allowed to work without completion of this in-service. On 12/17/13, the Regional Vice President (RVP) in-serviced the administrator and Director of Nursing on how to use the Quality Improvement Incident/Accident Review Audit Tool to show that any significant change in a resident□s condition has documentation of the nurse□s assessment of the resident and the MD and RP notification. This QI tool will continue to be utilized when an event occurs requiring staff to contact a supervisor, the director of nursing, or administrator regarding a significant change in a resident□s condition. On 12/17/13, the Administrator initiated an in-service for all Administrative Nurses who take nurse on call. The administrator in-serviced the administrative nurses on how to use the Quality Improvement	

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F 157	Continued From page 4 although staff had advised visitors that she was on a pureed diet with thickened liquids. At dinner, Resident #1 had zero intake of food, so she gave her a bolus, thinning it with water, which went in very slowly. After dinner, she went into Resident #1's room and noticed a small amount of vomit on her right side, with her head facing the wall. She walked out of the room, to get linens to clean her up. When she began to wipe her face, she stated that large volume of food, not pureed texture, came out forcefully. It smelled sour and was yellow-brown in color. After this emesis, she observed that Resident #1 seemed to feel better. She commented that "I never seen her get sick like that before and I wondered if she had a virus or ate food that she was unfamiliar with. " She shared that she gave her a nebulizer (breathing) treatment that night and her breathing was good. (The physician order for November, 2013, listed nebulizer treatment, every 6 hours, as needed for shortness of breath.) The nurse also said that she took the temperature under Resident #1's arm, and it seemed normal, but she didn't record it in her notes. She felt that everything seemed normal, so she stated that she did not contact the doctor for this reason. In addition, Resident #1 seemed fine to her when she worked with her on Sunday evening too. She commented that she felt that whatever caused Resident #1's discomfort, she got rid of it, when she vomitted. Nurse Aide #4 was interviewed on 12/16/13 at 1:15 pm. She shared that she worked with Resident #1 on 11/25/13 and was in the room at 7:15 am, providing care to her roommate, when she noticed that she saw her head leaning to the right side, with stuff coming out of her mouth, like a clear substance with bits of food. Resident #1's	F 157	Incident/Accident Review Audit Tool to show that any significant change in a resident□s condition has documentation of the nurse□s assessment of the resident and the MD and RP notification The administrative nurse team will meet five times per week permanently to review the nursing progress notes to ensure that any significant change in a resident□s condition has documentation that includes assessment of the resident, MD notification, and RP notification. Any areas of concern identified during these reviews will be addressed by assessments and notifications as appropriate for situation. Criteria 4: The Administrator and/or DON will review all completed Quality Improvement Incident/Accident Review Audit Tool three times a week ongoing to assure they are completed and functioning as appropriate. The Quality Improvement Executive Committee will review all audit information monthly for recommendations, take actions as appropriate, and to monitor continued compliance in this area.	

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F 157	Continued From page 5	F 157		

breathing was shallow and she had blue splotches all over her body. She left the room, to get the nurse, who returned to assess her. Resident #1 had a body temperature of 105 degrees and orders were sought from the physician, to send her to the emergency room.

The Director of Nursing (DON) was interviewed on 12/17/13 at 10:50 am. She mentioned that when she spoke to Nurse #2, she told her that Resident #1 had vomitted (on 11/23/13) like anyone else would, who was too full and that it didn't create any extraordinary concerns. On 12/18/13 at 12:40 pm, the DON commented that in retrospect, the nurse should have contacted the physician when Resident #1 had projectile vomitting.

The Physician was interviewed by phone on 12/17/13 at 11:00 am and shared that he was not aware that Resident #1 had projectile vomiting on 11/23/13 and that he would assume that staff would contact him if it occurred. He mentioned that had he known that Resident #1 had experienced projectile vomiting, he would have wanted to rule out complications from dysphasia and to make sure that she didn't aspirate. He would have ordered a chest x-ray to make sure the tube was patent, and also to make sure she didn't have esophagus obstruction.

The hospital records, from 11/25/13 to 11/26/13 were reviewed and read as follows: Resident #1 arrived to the hospital and was admitted for acute bronchial pneumonia, clinical sepsis and benign hypertension. She was noted to have acute respiratory failure to right upper lobe pneumonia decrease in responsiveness. She was septic, secondary to the pneumonia. She was

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F 157	Continued From page 6 transferred to Hospice, within the hospital later that day and expired at the hospital on 11/26/13. The death certificate was obtained on 12/18/13 and recorded the cause of death as pneumonia and sepsis, with two days onset before death.	F 157		
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on record review, physician and staff interviews, the facility failed to thoroughly assess 1 of 3 residents (Resident #1) receiving tube feeding, after projectile vomiting was first detected, and seek medical guidance from physician, so that evaluation and treatment could be obtained. The findings included: Resident #1 was admitted to the facility on 10/8/13 with the following diagnoses: traumatic brain injury, dysphagia, gastrostomy tube and a history of respiratory failure post tracheotomy. The admission Minimum Data Set (MDS) dated 10/15/13, determined that she had severe cognitive impairments, needed extensive	F 309	F309 Criteria 1: On 11/25/13 the assigned nurse assessed resident # 1 for a change in condition. On 11/25/13 the assigned nurse contacted Resident # 1's Medical Doctor (MD) for an order and Resident□s Responsible Party (RP) to notify of resident being sent out via Emergency Medical Services (EMS) due to change in condition. Criteria 2: A 100 percent audit was started on 12/17/13 by the Facility Nurse Consultants of all nurse progress notes back to	1/15/14

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F 309	Continued From page 7 assistance with eating, tube fed, on a mechanically altered diet and had no swallowing problem. A record review was conducted of Resident #1's medical chart. It indicated that a physician telephone order, transcribed on 10/8/13, stated that her diet include a pureed with nectar thick liquids. She would receive a bolus feeding at 8 am, 12 pm and 4 pm, only if she didn't eat 50% of her meals. Her gastrostomy tube would be flushed with 60 cc (cubic centimeter) before and after feedings. A Care Plan was developed on 10/18/13 to address the tube (gastrostomy) feeding, required to assist her in maintaining nutritional status characterized by weight loss related to cognitive deficit and dysphagia (difficulty with swallowing). The goal read that Resident #1 would receive adequate nutritional and fluid intake as evidenced by stable weight, and no signs or symptoms of malnutritiona or dehydration through the next review. Interventions included: tube feed formula and water flushes as ordered by the physician; maintain g-tube for feeding purposes; monitor for signs and symptoms of tube feeding complicatons, for example aspiration, dyspnea (shortness of breath) or fever, formula intolerance-nausea, vomitting or diarreha; infection or irritation to stoma site. Another care plan was developed on 10/18/13 to address nourishment related to less than body requirement characterized by weight loss, inadequate intake, decreased appetite related to cognitive impairment, and pressure area. Goals included that the total intake would meet the resident's nutritional needs as evidenced by	F 309	10/25/2013 to ensure that significant changes in a resident□s condition noted includes documentation of MD and RP notification as appropriate. 37 residents were identified as needing MD/RP notification. All areas found were immediately followed up with notification of MD and/or RP. A 100 percent audit was completed on 12/18/13 by Facility Nurse Consultants, Director of Nursing, Assistant Director of Nursing, Quality Improvement (QI) nurse, Minimum Data Set (MDS) nurse, treatment nurse, and Staff Facilitator on all nurse's notes back to 1025/13 to assure that any changes in resident condition noted had documentation of a physical assessment. Audit revealed there were no residents with changes in condition needing documentation of a physical assessment. A 100 percent education to include in-servicing and testing of all nursing staff and non-nursing staff was initiated by Staff Facilitator on 12/17/13 in regards to any changes in resident condition. Staff were educated to notify the assigned nurse of changes in resident condition. Criteria 3: On 12/17/13, the Staff Facilitator initiated in-servicing for all nurses that included "In the event of a medication change, incident/accident, any new orders, any change in condition, transfer or discharge out of facility, death, or anything out of	

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F 309	Continued From page 8 stable weight, increased food intake and documented improvement in wounds thru next review. Interventions listed were: diet and thickened liquids as ordered; monitor and observe for signs and symptoms of gagging or choking during meals and report to unit nurse. On 11/23/13, the 24 hours shift reported noted that Resident #1 didn't eat dinner on 2nd shift (3-11 pm) and had 1 episode of vomitting. Nurse Aide #1 was interviewed on 12/15/13 at 3:15 pm. She worked with Resident#1, from 7 am to 3 pm on 11/23/13. She stated that Resident #1 was able to feed herself breakfast that morning, eating 100% of her meal and she ate 50% of her meal for lunch. She recalled that Resident #1 had a visitor that day, who brought her in regular soda to drink, although she remained on a nectar thickened diet. When she came in the room to check her for incontinence, she saw a red plastic cup, full of soda, that was left within reach of Resident #1, by her visitor. She reported that she did not see Resident #1 show any signs of distress during her shift. Nurse #1 was interviewed by phone on 12/16/13 at 5:25 pm. She shared that she worked with Resident #1, every other weekend and that she received a bolus feeding if she ate less than 50% of her pureed diet. She normally ate well, at about 75-100%, so she only had to give her a bolus feeding once. On 11/23/13, a visitor brought Resident #1 in food from the outside. She recalled seeing a large bottle (maybe 20oz) of soda in her room and advised the visitor that Resident #1 was on thickened liquids. She said the visitor commented to her, that she drunk fine when he gave her the beverage.	F 309	normal for resident to include vomiting, you need to notify the MD and RP, as appropriate, anytime of the day to include third shift. If not sure when to notify MD or RP call the on-call nurse, Director of Nursing (DON), or Administrator for directions. Documentation of time and person contacted must be completed. Documentation of MD and RP notification must occur at all times". This in-service will continue until all nurses, Certified Nursing Assistants (C.N.A□s) and non-nursing staff to include dietary, therapy, and housekeeping are trained. No employee will be allowed to work without completion of this in-service. On 12/17/13, the Regional Vice President (RVP) in-serviced the administrator and Director of Nursing on how to use the Quality Improvement Incident/Accident Review Audit Tool to show that any significant change in a resident□s condition has documentation of the nurse□s assessment of the resident and the MD and RP notification. This QI tool will continue to be utilized when an event occurs requiring staff to contact a supervisor, the director of nursing, or administrator regarding a significant change in a resident□s condition. On 12/17/13, the Administrator initiated an in-service for all Administrative Nurses who take nurse on call. The administrator in-serviced the administrative nurses on how to use the Quality Improvement Incident/Accident Review Audit Tool to show that any significant change in a	

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F 309	Continued From page 9 Later that shift, Nurse #1 stated Resident #1 wouldn't eat her lunch well and appeared to be full. The following day, 11/24/13, she was told in her shift report that Resident #1 had vomitted Saturday evening but seemed okay during the night, although the therapist reported to her Sunday morning, that she appeared lethargic. She shared that she thought that maybe Resident #1 had volume overload, since she had consumed food and beverages from an outside source. Nurse #1 stated that she did not consult the physician, nor recorded any vital signs because she knew she didn't have a temperature and her respirations seemed to be fine. On Sunday, she shared that Resident #1, continued to eat poorly. Nurse Aide #2 was interviewed on 12/16/13 at 3:58 pm. He stated that he worked with Resident #1 on 11/23/13 during 2nd shift and she ate poorly for him, and needed a bolus feeding. Nurse # 2 was interviewed by phone on 12/17/13 at 5:11 pm. She worked 2nd shift (3 pm to 11 pm) on 11/23/13 and 11/24/13 and was assigned to Resident #1. She shared that normally, Resident #1 did not eat well for supper. That weekend, she recalled that she was informed that Resident #1 had eaten food earlier that day, from outside sources. She stated that the nurse told her in the shift report, that she had consumed hamburger, chips and soda, although staff had advised her visitor that she was on a pureed diet with thickened liquids. At dinner, Resident #1 had zero intake of food, so she gave her a bolus, thinning it with water, which went in very slowly. After dinner, she went into Resident #1's room and noticed a small amount of vomit on her right side, with her head facing the wall. She walked	F 309	resident□s condition has documentation of the nurse□s assessment of the resident and the MD and RP notification The administrative nurse team will meet five times per week permanently to review the nursing progress notes to ensure that any significant change in a resident□s condition has documentation that includes assessment of the resident, MD notification, and RP notification. Any areas of concern identified during these reviews will be addressed by assessments and notifications as appropriate for situation. Criteria 4: The Administrator and/or DON will review all completed Quality Improvement Incident/Accident Review Audit Tool three times a week ongoing to assure they are completed and functioning as appropriate. The Quality Improvement Executive Committee will review all audit information monthly for recommendations, take actions as appropriate, and to monitor continued compliance in this area.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 12/18/2013

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out of the room, to get linens to clean her up. She re-entered the room, and began to wipe her face when she noted that large volume of food, not pureed texture, came out forcefully. She said it smelled sour and was yellow-brown in color. After the 2nd emesis, she observed that Resident #1 seemed to feel better. She commented that "I never seen her get sick like that before and I wondered if she had a virus or ate food that she was unfamiliar with." She shared that she gave her a nebulizer (breathing) treatment that night and her breathing was good. (The physician order for November, 2013, listed nebulizer treatment, every 6 hours, as needed for shortness of breath.) The nurse also said that she took the temperature under Resident #1's arm, and it seemed normal, but she didn't record it in her notes. She felt that everything seemed normal, so she stated that she did not contact the doctor for this reason. In addition, Resident #1 seemed fine to her when she worked with her on Sunday evening too. She commented that she felt that whatever caused Resident #1's discomfort, she got rid of it, when she vomitted.

In a written statement, dated 11/28/13 from Nurse #3 she wrote, that each night (11/23/13 and 11/24/13), she checked on Resident #1 at midnight during her rounds and medication pass. On these occasions, she replaced her syringe and flushed her g-tubes and checked that her belly band was in place, as well as her boots were still in place. She wrote that she made sure that her head of bed was up, since 2nd shift had reported vomiting and thought that it occurred from too much feeding from visitor. When she touched her skin, the nurse felt that it was not hot to the touch, and her g-tube flushed well. She also commented that she did not see mottling

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with her skin. Resident #1's breathing was normal during her shifts and she appeared to be asleep. She wrote that she didn't notice anything unusual about Resident #1 that shift.

Nurse Aide #3 was interviewed by phone on 12/16/13 at 6:02 pm. She stated that she was newly hired and going through orientation when she was asked to bathe Resident #1, the morning of 11/25/13, around 7:15 am. She commented that Resident #1 was still asleep when she entered her room, lying in bed, with the head of the bed, slightly elevated. She raised the bed, to a taller height, so that she could stand to bathe her. As Resident #1 awoke, she noticed that she seemed upset and was gasping for air, having trouble breathing. She stated that " Resident #1 was real hot and her whole bed was wet from her sweating, which did not have an odor. I saw red splotches on her skin, like a rash. I didn't notice anything coming out of her mouth. I called out to Nurse Aide #4, who was also in the room, and asked her if it was common for Resident #1 to sweat so much and she responded, ' yes ' . To me, she didn't seem good, she was too hot." Then she said, Nurse Aide #4, came over to examine Resident #1 and saw the splotches on her skin and went to call the nurse. Nurse Aide #3 said that she tried to take Resident #1's blood pressure but was unsuccessful, as well as other nursing staff, when they tried. She mentioned that they were able to get a temperature under her arm and it was 105 degrees.

Nurse Aide #4 was interviewed on 12/16/13 at 1:15 pm. She shared that she worked with Resident #1 on 11/25/13 and was in the room at 7:15 am, providing care to her roommate, when she noticed that she saw her head leaning to the

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right side, with stuff coming out of her mouth, like a clear substance with bits of food. Resident #1's breathing was shallow and she had blue splotches all over her body. She left the room, to get the nurse, who returned to assess her. Resident #1 had a body temperature of 105 degrees and orders were sought from the physician, to send her to the emergency room.

The Director of Nursing (DON) was interviewed on 12/17/13 at 10:50 am. She mentioned that when she spoke to Nurse #2, she told her that Resident #1 had vomitted (on 11/23/13) like anyone else would, who was too full and that it didn't' create any extraordinary concerns. On 12/18/13 at 12:40 pm, the DON commented that in retrospect, the nurse should have contacted the physician when Resident #1 had projectile vomitting.

The Physician was interviewed by phone on 12/17/13 at 11:00 am and shared that he was not aware that Resident #1 had projectile vomiting on 11/23/13 and that he would assume that staff would contact him if it occurred. He mentioned that had he known that Resident #1 had experienced projectile vomiting, he would have wanted to rule out complications from dysphasia and to make sure that she didn't aspirate. He would have ordered a chest x-ray to make sure the tube was patent, and also to make sure she didn't have esophagus obstruction.

The hospital records, from 11/25/13 to 11/26/13 were reviewed and read as follows: Resident #1 arrived to the hospital and was admitted for acute bronchial pneumonia, clinical sepsis and benign hypertension. She was noted to have acute respiratory failure to right upper lobe pneumonia

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F 309	Continued From page 13 decrease in responsiveness. She was septic, secondary to the pneumonia. She was transferred to Hospice, within the hospital later that day and expired at the hospital on 11/26/13. The death certificate was obtained on 12/18/13 and recorded the cause of death as cardio pulmonary arrest with respiratory failure, pneumonia and sepsis developing two days before death.	F 309		