STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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F 000	INITIAL COMMENTS Nursing home requested IDR for F 157 G and F 327 G. The team deleted F 157 after review of the facility submitted written information. The IDR panel upheld the F 327 G.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		9/11/14

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

Electronically Signed | 08/30/2014

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F 278	Continued From page 1 by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment on 4 of 19 sampled residents in the area of antipsychotic medication (Resident #245), falls (Resident #118), diuretic medication (Resident #150) and bowel and bladder continence (Resident # 103). The findings included: 1. Resident #245 was originally admitted to the facility on 5/2/13 and was readmitted on 4/9/14 with multiple diagnoses including Psychosis. Review of the physician's orders for August, 2014 revealed that Resident # 245 was on Seroquel (an antipsychotic medication) 50 milligrams (mgs) at bedtime since 2/26/14 for psychosis. The quarterly MDS assessment dated 6/9/14 indicated that Resident #245 had not received an antipsychotic medication. On 8/4/14 at 8:15 AM, the MDS Nurse coordinator was interviewed. She acknowledged that the MDS was not coded accurately for the use of the antipsychotic medication. She agreed that Resident #245 was on Seroquel and antipsychotic medication should have been coded but it was not. 2. Resident # 118 was admitted to the facility on 2/23/12 with multiple diagnoses including Parkinson's Disease. Review of the nurse's notes and incident reports revealed that Resident #118 had a fall on 5/4/14 at 8:20 PM.	F 278	1. a. Resident #245's MDS assessment has been updated to reflect antipsychotic use. b. Residnet # 118's MDS assessment has been corrected to include a fall on 5/4/14. c. Resident # 103's MDS assessment has been updated to code the correct level of Bowel and Bladder incontinence. d. Resident # 150 has been discharged from the facility, so it cannot be retroactively changed. 2. Current residents charts have been reviewed for bowel & bladder incontinence, antipsychotic use and fall status to be sure that they were properly coded on the MDS. All MDS assessments were audited for accuracy by the Lead MDS coordinator and MDS Educator prior to August 30, 2014. There were no other inaccuracies noted. The in-services for the MDS coordinators and MDS nurses were performed by the Lead MDS coordinator and the Corporate Regional Clinical Manager for MDS prior to 9/10/14. Any retraining will be conducted by the Lead MDS Coordinator. The audits will include all long term care residents. The audits will be done weekly for three months, the monthly ongoing. The MD will be notified routinely during his/her visits and immediately for critical labs by the nurse supervisor. Monitoring of labs will be ongoing indefinitely.	

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F 278	Continued From page 2 The significant change in status MDS assessment dated 5/19/14 indicated that Resident #118 had no falls since prior assessment. On 8/14/14 at 8:15 AM, the MDS Nurse coordinator was interviewed. She acknowledged that Resident #118 had a fall on 5/4/14 and should have been coded on the MDS. She added that it was missed. 3. Resident #150 was admitted to the facility on 5/23/14 and discharged to the hospital on 6/15/14. Cumulative diagnoses included: hypotension, hypertension, insulin dependent diabetes and history of stroke. Physician Admission orders dated 5/23/14 revealed an order for Chlorthalidone (a diuretic medication) 25 mg (milligrams) by mouth daily. An Admission Minimum Data Set (MDS) Dated 5/30/14 indicated Resident #150 had not received any diuretic medication during the assessment period. On 8/14/14 at 8:18AM, MDS nurse coordinator #1 was interviewed and stated the diuretic medication must have been missed. She agreed that Chlorthalidone was a diuretic medication and should have been coded on the MDS but it was not. 4. Resident # 103 was admitted to the facility on 2/20/14 with multiple diagnoses including	F 278	3. MDS□s will be audited by the Lead MDS Coordinator so that all assessments are checked and reviewed for accuracy prior to being locked. This Audit for accuracy will continue each week for 6months, then monthly thereafter. Results of the audit will be reported to the Director of Nursing every Monday for six months and monthly thereafter. a. Audit of MDS accuracy will be completed by Lead MDS Coordinator and include reviewing assessments prior to being locked to ensure items are captured and coded appropriately. The Director of Nursing will be monitoring labs for increased BUN/increased creatinine and decreased NA every week by reviewing daily lab reports. This monitoring will be ongoing indefinitely. 4. The results of the audit will be reported to the quarterly QA meeting by Director of Nursing for ongoing compliance for six months.	

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F 278	Continued From page 3 paralysis agitans and a history of a transient ischemia attack. A review of the Admission Minimum Data Set (MDS) dated 2/2/7/14 revealed resident #103 was coded as being occasionally incontinent of urine. A review of the Quarterly MDS dated 5/26/14 revealed resident #103 was coded as being frequently incontinent of urine. An interview was conducted with the MDS Nurse Coordinator #2 on 8/14/14 at 11:53 AM. MDS Nurse Coordinator #2 stated an interview with resident #103 was conducted and she denied an increase in number of incontinent episodes. MDS Nurse Coordinator #2 stated there was no documentation indicating an increase in the number of incontinent episodes. She stated resident #103 was incorrectly coded as being frequently incontinent of urine.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		9/11/14

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F 279	Continued From page 4 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a comprehensive care plan that addressed a low sodium level, elevated BUN (blood urea nitrogen) and creatinine levels and the use of diuretic medication for one of one residents reviewed for hydration (Resident #150). The findings included: Resident #150 was admitted to the facility on 5/23/14 and discharged to the hospital on 6/15/14. Cumulative diagnoses included: hypotension, left proximal femoral fracture, hypertension, insulin dependent diabetes, history of stroke. Physician Admission orders dated 5/23/14 stated, in part, the following: Renal (kidney panel and CBC (complete blood count) on 5/27/14 Aspirin 325 mg (milligrams) by mouth two times a day Chlorthalidone (diuretic medication) 25 mg by mouth daily Laboratory results for a renal panel dated 5/27/14 revealed a sodium level of 129 (normal --136--147), BUN 64 (normal is 7--24) and creatinine 1.70 (normal is 0.60--1.30).	F 279	1. Resident #150 has had care plan updated to reflect diuretic medication as of 8/28/14. 2. Current residents' medications have been reviewed by the Director of Nursing and the Pharmacist Consultant for diuretic use. Care plans have been revised systematically to include the monitoring of abnormal labs. Care plans will be in place for each new admission in the event a resident is on a diuretic. Care plans will be in place for residents who may be started on a diuretic post admission. MDS nurses and MDS coordinators were in-serviced on care plans by the Director of Nursing on 9/2/14. 3. Pharmacy is supplying weekly report of diuretics. Weekend supervisor will audit reports to be sure care plans are in place for resident on diuretic medications. Monitoring of abnormal labs such as increased BUN, creatinine, and decreased sodium will be done by the Director of Nursing daily. This monitoring will be ongoing. The weekend supervisor will audit all residents on diuretics for weight loss or gain and be sure that	

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F 279	Continued From page 5 A physician's progress note dated 5/28/14 was reviewed and stated a renal panel would be done on 5/30/14. They would wait for those results and continue to monitor her levels. Her creatinine at the hospital was 1.2 and was now up to 1.7. Encourage po (by mouth) fluids at this point in time and follow up based on her next renal panel. Laboratory results for a renal panel dated 5/30/14 revealed a sodium level of 122, BUN 82 and creatinine 1.80. Admission Minimum Data Set (MDS) Dated 5/30/14 indicated Resident #150 was cognitively intact. She required supervision with eating and extensive assistance with toilet use. The use of diuretic medication was not coded on the MDS. A care plan dated 5/28/14 and last revised on 6/2/14 indicated Resident #150 was independent with consuming fluids and eating. There was not a care plan that addressed the use of diuretic medication, the low sodium level, elevated BUN and creatinine. On 8/14/14 at 8:18AM, MDS nurse coordinator #1 stated the care plan was last reviewed on 6/2/14. She stated that, based on the use of a diuretic medication and Resident #150' s lab results, a care plan should have been put in place for dehydration.	F 279	proper care plans are in place based on the pharmacy report that are submitted weekly. 4. Results of the audits will be reported to the quarterly QA meeting by the Director of Nursing for 6 months.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		9/11/14

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F 280	Continued From page 6 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise care plans to reflect a change in conditions and/or treatments for 2 of 19 residents, (Residents #171 and #183) reviewed. The findings included: 1. Resident # 171 was admitted to the facility on 2/28/11 with the following cumulative diagnoses: dementia, major depressive disorder single episode, insomnia, dysphagia, and gastrostomy tube and ataxia late effect of cerebrovascular disease. His quarterly Minimum Data Set (MDS) assessment on 6/5/14 determined that he had moderate cognitive impairments in decision making, with no appetite issues. He could feed himself independently, once set up was offered. He stood at 66 inches and weighed 180 pounds. A record review was conducted of Resident #17's chart. It revealed that a Care Plan was originally	F 280	1. Residents #171 & 183 have had care plans updated to reflect change in condition and treatment. 2. All care plans were reviewed to capture any changes in weights. This was completed by the Dietician and the Lead MDS Coordinator on 9/5/14. There were no further revisions needed. Any residents that have a weight gain or loss of more than 5% will be reweighed within 48 hours. The reweights will be reviewed by the Clinical Coordinators. If the reweight shows a weight gain or loss of more than 5% , the Clinical Coordinator will notify the Dietician, MD and Speech Therapy and MDS coordinators. 3. All licensed staff will record change of	

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F 280	Continued From page 7 developed for him on 3/7/11, then revised on 12/10/12 to reflect that he was at risk for weight loss due to inadequate intake. The goal stated that he would consume 75% or more of 2 out of 3 meals daily or maintain/show improvement with my current weight over the next 90 days (9/3/14). Interventions to be used, as of 6/2/14 were providing him a mechanical soft diet as ordered by his physician. Assisting him with all of his meals. Allow him to eat at his own pace, encouraging him to eat 100% of his meals and providing him with adequate hydration every shift. He would be weighed as ordered with labs monitored, when needed. He would be offered snacks within his diet regimen between meals and given ice cream or health shake with his lunch, dinner or as desired. The Care Plan did not reflect that on 11/27/17 a physician order was written to add a can of a nutritional supplement at 6pm, 10pm as well as at breakfast and lunch if he consumed less than 50% at those meals. Nor did it reflect that an appetite stimulant had been added in May, 2013 to boost his weight. Review of Resident #171's weight record showed that he gained nearly 30 lbs. since last summer with the additional nutritional supplements used to counter weight loss. The Registered Dietician was interviewed on 8/14/14 at 9:20 am. She commented that she was aware of Resident #171's weight gain but didn't make any changes to his plan of care since his weight tended to fluctuate due to his diagnosis of dementia. She stated that overall, she was not concerned with his weight gain. On 8/14/14 at 10:30 am, the Administrative Staff #1 was interviewed. She shared that the facility ' s weight loss committee had not focused on weight	F 280	condition on residents on 24 hour report. Report will note change in weight. Staff will identify that physician and power of attorney have been notified on the 24 hour report. 24 hour report will be reviewed each by RN supervisor, including weekends and then reviewed at risk management daily. MDS coordinators were inserviced on care plan revisions by the Director of Nursing on 9/10/14. Record review of appetite stimulants that are being used as an appetite stimulant will be performed on a monthly basis to review for weight gain, effectiveness or need to continue, by the Clinical Supervisor. The care plans will be monitored by the Clinical Supervisor for needed changes. A report will be sent to the DON, MDS Coordinators, Dietician, and MD each month of findings for 6 months, then every 3 months thereafter. 4. Results of audits will be reported to quarterly QA meetings by the Director of Nursing for ongoing compliance for nine months.	

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F 280	Continued From page 8	F 280		

gain issues, so no changes were made on Resident #171's care plan in order to bring about changes.

The Unit Nurse was interviewed on 8/14/14 at 2:51 pm. She commented that once it's been established that a resident had a 5 lbs. plus weight gain, the physician and registered dietician are notified to determine the next course of action. Then she stated the MDS staff would update the care plan to reflect any changes.

2. Resident #183 was admitted to the facility on 5/27/14 with the following cumulative diagnoses: dementia, muscle weakness and anxiety. On his admission Minimum Data Set (MDS) assessment on 5/30/14, it was determined that he had severe cognitive impairments with no noted behavior problems or use of anti-anxiety, anti-depressants or anti-psychotic medications used.

The goals were written to allow him to show signs that his stress was being alleviated by active participation in his rehab process and discharge planning; positive interactions with others around him and having interest in his environment; ease verbalization in his concerns and needs throughout the next 90 days (8/22/14).

Interventions to be used included allowing him the opportunity and encourage him to verbalize his feelings about his placement, missing his friends, not being at home and feelings of having to be dependent on other for his needs. He would be observed for changes in mood/behavior. The medication regime to be reviewed per physician. Staff would offer validation and acknowledge his moods in their interactions. Assist him in identifying progress

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made and his strengths. Offer him praise and support in his rehab process. Involve him in discharge planning. Introduce him to resident with similar status and compatibility. Encourage Resident #171 to attend activities of interests.

Resident #183's medical chart was reviewed and reflected in the Nurse's notes that he had an increase in agitated behaviors nearly a month after his placement. On 7/22/14 at 8:45 am, after an episode of agitation, the nurse documented that Resident #183 a prn (as needed) dosage of Ativan, an anti-anxiety medication. On 8/5/14 at 11:30 pm, was given Ativan prn after he became extremely agitated and aggressive with staff. After the nurse observed that the medication was ineffective, the physician was contacted, and authorized a dose of Ativan to be injected. On 8/7/14, Trazodone 50 mg (milligram) was added to treat his insomnia and on 8/8/14 a new medication, Seroquel 25 mg to be taken at bedtime for psychosis was added to his regimen.

Resident #183's new medications, used to treat behavioral disturbances were not documented as additional interventions on his care plan.

On 8/14/14 at 8:35 am, the MDS Coordinator #1 was interviewed stated that the Unit Nurse as well as the assigned MDS coordinator were responsible for updating any changes to care plans, whenever a change occurred. She acknowledged that his care plan had not been updated since May, 2014 for the identified problem. Later that day, the MDS Coordinator returned to share that the care plan had been updated on 8/14/14 by Unit Nurse #1 to reflect

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F 280	Continued From page 10 that Resident #183 now received anti-anxiety and anti-psychotic medication and was at risk for potential adverse reactions/side effects. Unit Nurse #1 was interviewed on 8/14/14 at 2:51 pm regarding care plan updates. She commented that she only addressed matters that involved safety concerns. She handwrites on the hard copy of the care plan since it was reviewed by the nurse aides and tried to update the plan in the computer the same day, when she could. However, she explained that whenever a new telephone order was issued, that was also pertinent to treat behavior changes, the nurses gave the order to the MDS coordinator to update the care plans.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to secure the indwelling catheter tubing to prevent excessive tension or accidental displacement for 2 (Residents # 245 & # 52) of 2 sampled residents	F 315	1. Indwelling catheters have been secured for residents #245 and #52. 2. All residents with Foley catheters were assessed for further need to secure	9/11/14

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F 315	Continued From page 11 with an indwelling catheter. The facility's policy on catheter insertion dated October 1, 2006 was reviewed. The policy read in part " all foley catheter should be anchored to prevent excessive tension. " 1. Resident #245 was originally admitted on 5/2/13 and was readmitted on 4/9/14 with multiple diagnoses including malignant neoplasm of the bladder and urinary retention. The quarterly MDS assessment dated 6/9/14 indicated that Resident #245 had an indwelling catheter. The care plan dated 6/12/14 was reviewed. One of the care plan problems was " I have an indwelling catheter related to benign prostatic hypertrophy and urinary retention and urinary tract infection. " The approaches included " use a leg strap or other anchor to prevent dislodging. " On 8/13/14 at 10:49 AM and at 3:30 PM, Resident # 245 was observed. He was observed to have an indwelling catheter and the tubing was not secured with a leg strap. On 8/13/14 at 3:40 PM, Nurse #1 was observed providing incontinent care to Resident #245. After the incontinent care, Nurse #1 was interviewed. Nurse #1 acknowledged that Resident #245 had no leg strap on. She added that the night shift nurse was responsible in changing the catheter every three weeks and was supposed to secure the tubing with a leg strap.	F 315	catheters by the Clinical Coordinator and the Supervisor. No further residents were found to have needed to be further secured. This was completed on 8-14-14. An in-service was held to address the concerns with the Foley Catheters for all nurse aides level I and II, LPN□s and RN□s that perform direct patient care. The In-service was performed by the DON, evening Supervisor , midnight supervisor, and weekend supervisor to target all shifts and completed by 9-11-14. The policies were updated on 8/18/14. 3. Visual inspection and assessment audits will be performed and reported each week by afternoon supervisor to ensure that all catheters are secured. The Director of Nursing and Midnight Supervisor will monitor for correct procedure/placement/residual. This will be done weekly for three months and then monthly thereafter. Results of inspection and assessment will be reported to the Director of Nursing weekly. 4. Results of the audit will be reported by the Director of Nursing to quarterly QA committee for ongoing compliance.	

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2. A facility policy titled " Catheter insertion, Suprapubic dated October 1, 2006 stated in part, "15. All foley catheters should be anchored to prevent excessive tension on the catheter."

Resident #52 was admitted to the facility 12/5/13. Cumulative diagnoses included: urinary frequency, disorder of the kidney and ureter and other artificial opening to the urinary tract (suprapubic catheter that drains urine from the bladder. The catheter is inserted into the bladder from a small hole in the belly.

A Quarterly MDS (Minimum Data Set) dated 6/10/14 indicated Resident #52 was cognitively intact. An indwelling catheter was documented noted as yes.

A Care Plan dated 12/17/13 and last reviewed 6/10/14 stated Resident #52 had a suprapubic catheter related to retention and chronic kidney disease. Interventions included: Provide Resident #52 with catheter care every shift and prn.

On 8/14/14 at 12:07PM, Resident #52 stated he did not think the catheter tubing was anchored with anything and said that the tubing would get pinched in the stomach area at times and caused him to have pain and discomfort. Resident #52 stated he had not refused to have catheter tubing anchored and preferred that the staff would anchor the tubing so it would not pull.

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F 315	Continued From page 13 On 8/14/14 at 1:06PM, an observation of the suprapubic catheter site and catheter tubing was conducted with Nurse #4. Resident #52 was lying in bed and had just been transferred from the wheelchair to the bed using a mechanical lift. Nurse #4 pulled back the bed covers and observation revealed the suprapubic catheter was not secured to the body. The urinary catheter tubing with the clamp was not secured to the bed pad or the bed sheet. Nurse #4 stated the tubing clamp should be secured to the bed sheet or bed pad and the catheter itself should have been secured to the upper thigh. On 8/14/14 at 1:12PM, Administrative staff #1 stated she expected nursing staff to anchor all urinary catheters to avoid tension and pulling on the catheters.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		9/11/14

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F 322	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to check a gastrostomy tube for residual as ordered prior to medication administration for 1 of 2 residents observed for medication administration via a gastrostomy tube (Resident #216). The findings included: A facility policy titled "Medication Administration: Enteral Tubes" last revised November 2012 stated, in part, "Procedure and Key Points: 5. Verify tube placement using the following procedures: inject 15-20 cc (cubic centimeters) of air into the tube with the syringe and listen to stomach with stethoscope for distinct "whooshing" sound. Aspirate stomach contents with syringe." Resident #216 was admitted to the facility 4/11/14 and readmitted 6/12/14. Cumulative diagnoses included: dysphasia and gastrostomy tube (tube inserted in the stomach for nutrition and fluid intake). A physician's order dated 6/12/14 stated "Check residual and placement every shift and prior to med/ flush". The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August was reviewed and revealed an order for check residual and placement q shift and prior to	F 322	1.Resident #216 has had tube checked for residual by Clinical Coordinators. 2. All nursing staff are being re-in serviced on checking placement and residual prior to medication administration or flushing of feeding tube by the Evening supervisor, weekend supervisor and Midnight Supervisor. The in-services will include weekend and PRN staff. Nurses will not have to complete prior to working on unit, but will need to complete by 9/10/14. The nurse who did not follow proper procedure has been disciplined. 3. Audits will be performed by Night Supervisor, weekend Supervisors both during the week and on weekends, on procedure for G-tube medication administration. Four nurses will be monitored randomly each week by the midnight and weekend supervisors and the Director of Nursing. This will allow every nurse, on every shift, to be monitored at least once per month. This process will continue at least weekly for a period of six months. If there are any issues identified monitoring will be continued, until there are no mistakes for at least six months. 4. Audit results will be reported by the	

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F 322	Continued From page 15 med/ flush. Medication administration observation was conducted on 8/13/14 at 9:38 AM. Nurse #3 was observed to stop the feeding, disconnect the feeding tube, insert a syringe into the gastrostomy tube and insert a small amount of air into the feeding tube while listening for air in the stomach to determine placement. Placement was determined and she proceeded to administer water and medications. She did not check for residual. On 8/13/14 at 1:39PM, Nurse #3 stated she did not always check for residual for Resident #216 because the tube feeding drained out of the gastrostomy tube when it was disconnected. She stated he was checked for residual every shift. She checked the TAR (treatment administration record) and noted that the order was for every shift and prior to medication and said she was not aware that residual should be checked prior to medication administration. She acknowledged that she did not check for residual this morning. On 8/13/14 at 3:18pm, Administrative staff #1 stated she expected nursing staff to check the gastrostomy tube for residual as per policy and physician orders.	F 322	Director of Nursing to the quarterly QA for ongoing compliance for six months.	
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325		9/11/14

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F 325	Continued From page 16 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to put effective interventions in place to prevent significant weight gain for 2 of 2 sampled residents (Residents #171 and #52) ; failed to ensure accurate weight monitoring for 2 of 2 sampled residents (Residents #52 and 64) as well as failed to initiate a nutritional supplement in a timely manner once weight loss was determined for 1 of 1 sampled resident (Resident #64). The findings included: 1. Resident # 171 was admitted to the facility on 2/28/11 with the following cumulative diagnoses: dementia, major depressive disorder single episode, insomnia, dysphagia, and gastrostomy tube and ataxia late effect of cerebrovascular disease. His quarterly Minimum Data Set (MDS) assessment on 6/5/14 determined that he had moderate cognitive impairments in decision making and no issues with his appetite. He could feed himself independently, once set up was offered. He stood at 66 inches and weighed 180 pounds. A record review was conducted of Resident #171's chart. It revealed that a Care Plan was originally developed for him on 3/7/11, then revised on 12/10/12 to reflect that he was at risk for weight loss due to inadequate intake. The goal stated that he would consume 75% or more of 2 out of 3 meals daily or maintain/show	F 325	1. Records for residents number #171, #52, #64 have been updated to include the change in condition as of 8/28/14. Resident #64 discharged from the facility on 8/11/14, therefore orders cannot be changed. Resident #52 is competent and recently suffered the loss of his wife. A decrease in his Remeron was recommended by pharmacy, but declined by physician because of resident's recent loss. The resident likes to eat sweets and is competent to make decisions about intake, so physician preferred not to compound loss of wife with diet restrictions at this time. Resident will continue to be monitored by Clinical Coordinator for weight gain. Resident #171 had Jevity reduced from BID to QD, if appropriate, based on oral intake for day. All other residents records were reviewed by ADON, clinical coordinator and dietician and completed by 9-5-14. 2. Each admission will be weighed each week for the first 4 weeks to audit for weight loss. Weights will be audited for significant weight gain or loss of >5% by the clinical coordinator for each unit every week. If any resident is found to have weight gain or loss of >5%, the resident will be	

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F 325	Continued From page 17 improvement with my current weight over the next 90 days (9/3/14). Interventions to be used, as of 6/2/14 were providing him a mechanical soft diet as ordered by his physician. Assisting him with all of his meals. Allow him to eat at his own pace, encouraging him to eat 100% of his meals and providing him with adequate hydration every shift. He would be weighed as ordered with labs monitored, when needed. He would be offered snacks within his diet regimen between meals and given ice cream or health shake with his lunch, dinner or as desired. Resident #171's weight history was examined. 6/3/13 weighed 157 lbs., 7/3/13 weighed 153 lbs., 8/1/113 weighed 152 lbs., 9/4/13 weighed 156 lbs. and 10/7/13 weighed 156 lbs. On 11/5/13 he weighed 161 lbs. On 11/27/13 a physician's order read: 1 can of Enteral Tube supplement giving one can of Jevity 1.2 (nutritional supplement) at 6 pm and 10 pm with 100 cc (cubic centimeter) water flush. Plus Remeron 15 mg (milligram) at bedtime for decreased appetite. Jevity 1.2 cal 1 can enteral tube supplement if meal intake less than 50%, give 1 can of Jevity 1.2 via g tube with 100 cc water flush for breakfast and lunch. On 12/4/13 he weighed 164 lbs. and on 1/2/14 he weighed 168 lbs. [a (-+) 10% weight change was noted on the record]. On 2/2/14 he weighed 170 lbs. and on 3/3/14 he weighed 173 lbs. [a (-+) 10% weight change] and on 4/2/14 he weighed 179 lbs. [a (-+) 10% weight change] was noted on the record. On 5/2/14 he weighed 180 lbs. [a (-+) 10% weight change] was noted on the record. A Consultation Report, 5/8/14, to Physician #2 mentioned that Resident #171 was requesting health shakes, " because he liked sweets,"	F 325	reweighed within 48hrs to confirm accuracy of weight. If the reweight confirms a weight gain or loss of more than 5% the dietician will evaluate within three business days and the MD will be notified. All current residents will be weighed monthly to assess weight gain or loss of more than 5%. Reweights will be requested by clinical coordinator and/or dietician. The reweights will be done by certified aides and recorded in electronic medical record. Dietary will be notified of %5 weight loss or gain on the day that the reweight occurs. The dietary staff, physician, Clinical Coordinators, assistant director of nursing and the admissions nurses were In-Serviced of this new change prior to 9-1-14 by the Director of Nursing. 3. All records will be audited for triggers of weight loss or gain by the Clinical Coordinator each week followed by a progress note. Dietary will be notified of any residents that trigger for significant weight change. Licensed staff will complete change of condition on residents on 24 hour report. Report will note change in weight. Staff will identify physician and power of attorney notification. Monitoring of significant weight loss or gain will occur with the 24 hour report each week. Clinical coordinators will review 24 hour report daily and bring to daily risk management meeting. This will be ongoing and indefinite. 4. Results of audits will be reported by	

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F 325	Continued From page 18 throughout the day. Staff requested an order for health shakes three times a day due to increase behaviors and to decrease agitation. He was noted to be stable from a mental health view point. A recommendation to follow up with physician #2 due to weight gain was suggested. The May 2014 Medication Administration Record (MAR) was reviewed. It showed that Resident #171 received additional Jevity at breakfast or lunch, due to poor meal intake, 9 out of 31 days in the month. On 6/3/14 he weighed 180 lbs. The Nutrition Quarterly Assessment, dated 6/4/14 by the Registered Dietician (RD) noted that Resident #171 weighed 164 lbs. six months ago and had a 4% weight gain in the past 90 days and a 9% increase in the last six months. He currently weighed 180 lbs. His current diet consisted of a mechanical soft diet and he received shakes or ice cream as needed, per his request. He was taking Remeron to stimulate his appetite. He had a solid foods meal intake of 26-50%. Resident #171 received 1152 of the estimated 2000 calories from tube feedings. Her findings were that he had an inadequate oral intake requiring tube feeding supplemental feedings with a mild weight gain for 180 days. He should continue his current diet and supplemental feedings, receiving assistance at meals, as needed and offer ice cream and shakes as requested. It was also noted that Resident #171 got off task easily and needed cueing and direction at meals. His diet might have to be altered as well as the tube feeding to avoid excessive weight gain. Will follow. The June 2014 MAR was reviewed. It documented that Resident #171 received additional Jevity at breakfast or lunch, due to poor meal intake, 15 out of 30 days.	F 325	the Director of Nursing to quarterly QA meetings for ongoing compliance for twelve months.	

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F 325	Continued From page 19 On 7/1/14 he weighed 179 lbs. A Drug Regimen Review was performed by Pharmacist #2 on 7/16/14. She recommended to the physician, a gradual dose reduction of anti-depressants (Lexapro 10mg daily and Remeron 15mg at bedtime). She stated that "Patient has currently gained roughly 30 lbs. since last initiation in June, 2013. Increased appetite can still occur at the lower 7.5mg dose. Please change order to Lexapro 5mg daily, discontinue Remeron 15 mg qhs (bedtime)." On 7/23/14, physician #2 responded to the pharmacist's request, but deferred the decision, to the psychiatrist, physician #3. Physician #3, decided on 7/29/14 to make no medication changes. The July 2014 MAR was reviewed. It documented that Resident #171 received additional Jevity, due to poor meal intake 16 out of 31 days. On 8/4/14 he weighed 181 lbs. On 8/11/14 at 12: 35 pm, Resident #171 was observed feeding himself in the dining room. He had a good appetite and his nutritional meal intake data reflected that he ate 75% at lunch. The August 2014 MAR was reviewed. It revealed that Resident #171 had received additional Jevity due to poor meal intake at breakfast and lunch, 6 out of 14 days. The RD was interviewed on 8/14/14 at 9:20 am. She stated that Resident #171 had periods of ups and downs with his weight and with a diagnosis of Dementia, a little bit of weight gain, doesn't bother her. She was a member of the facility's weight committee, and pointed out that their focus was more on weight loss issues. She reviewed his clinical data and shared that in August 2012, he weighed 165 pounds, August 2013 he weighed 151pounds and as of this August, he weighed 181 pounds. She mentioned	F 325		

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that his current BMI (Body Mass Index) was 29 which considered him overweight. Once he reached 30, he would be considered obese.
Administrative Staff #1 was interviewed on 8/14/14 at 10:30 am. She shared that they would begin reviewing charts to determine if some residents are on an unnecessary use of appetite stimulants, although they are gaining weight. Mentioned that when the weight committee meets, they have only looked at weight loss and not weight gains.
Pharmacist #1 was interviewed on 8/14/14 at 2:00 pm. He stated that Remeron used for stimulating the appetite was prescribed at the dosage of 7.5 mg a day. Normally, when it's used at 15 mg, it's being used to treat depression and not weight loss. He reviewed the pharmacy clinical notes and realized that in July, they recommended discontinuing the Remeron due to weight gain. Pharmacist #2 who's been recently assigned to the facility, had made the recommendation to Physician #2 on 7/16/14, however the doctor did not make changes. Pharmacist #1 stated that originally, the Remeron was prescribed at 7.5mg on 5/9/13 but was increased to 15mg in June, 2013 by Physician #3 due to weight loss.
The Unit Nurse was interviewed on 8/14/14 at 2:51 pm. She shared that the nurse aides weigh the residents by the 5th of the month, then the nurses verify that the weight was accurate. If they notice a weight gain or loss, of more than 5 lbs. they ask for the resident to be reweighed. If the scale needed to be recalibrated, arrangements were made. Then the nurse would be responsible for notifying the RD and MD (medical doctor) to review the information to determine what needed to be done.
She then shared that they had noticed that

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F 325	Continued From page 21 Resident #171 was gaining weight because he wanted to snack on just ice cream all day. The doctor was aware that he was eating ice cream but never gave an order to restrict anything in his diet. Nurse #2 was interviewed on 8/14/14 at 3:20 pm. She worked regularly with Resident #171 and shared that he doesn't want to eat all day, just preferred to consume sweets. She then made a call to Physician #3, requesting that he clarify the purpose of Remeron at 15mg and was told that it was prescribed for Resident #171, to treat his major depressive disorder not for appetite stimulant. 2. Resident #52 was admitted to the facility on 12/5/13. Cumulative diagnoses included: coronary artery disease, hypertension, diabetes, chronic diastolic heart failure and chronic kidney disease. A Quarterly MDS (Minimum Data Set) dated 6/10/14 indicated Resident #52 had a documented height of 44 inches, weight of 203 pounds with no weight loss or gain noted. Physician orders were reviewed and revealed Resident #52 was receiving Mirtazapine (Remeron) 7.5 mg (milligrams) every night and was documented by the physician on 6/20/14 that it was being received as an appetite stimulant. Weight records from January through August 2014 were reviewed and revealed the following: 1/3/14- 194.7 pounds; 2/8/14-- 200.6 pounds; 3/3/14--198.6; 4/2/14-- 202.8 pounds;5/4/14--198.3 pounds; 5/26/14--203.3	F 325		

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F 325	Continued From page 22 pounds; 6/5/14-- 203.2 pounds; 6/13/14-- 202.0 pounds; 7/1/14--204.1 pounds; 7/6/14--204.1 pounds and 8/3/14-- 226.2 pounds. No further weights were recorded for August 2014. On 8/13/14 at 3:24PM, Administrative staff #1 stated the nursing assistants obtained the weights--monthly weights were started on the first of the month and were completed by the fifth of the month. The nursing assistants documented the weights in the computer. Dietary would check the weights after all weights had been entered into the computer. Also, the nursing supervisor checked the weights for weight loss or gain and, if any weight was abnormal, the resident would be reweighed for accuracy and dietary services would be notified of the corrected weight. Administrative staff #1 said she expected nursing staff to reweigh Resident #52 the same day the change in weight was noted to make sure it was an accurate weight. Administrative staff #1 reviewed Resident #52's record and indicated she did not see where Resident #52 had been reweighed or that dietary services had addressed the weight gain of twenty-two (22) pounds in August. The Unit Nurse was interviewed on 8/14/14 at 2:51 pm. She shared that the nurse aides weigh the residents by the 5th of the month, then the nurses verify that the weight was accurate. If they notice a weight gain or loss, of more than 5 lbs., they ask for the resident to be reweighed. If the scale needed to be recalibrated, arrangements were made. Then the nurse would be responsible for notifying the RD and MD (medical doctor) to review the information to determine what needed to be done.	F 325		

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F 325	Continued From page 23 3. Resident #64 was admitted to the facility on 3/17/14 with multiple diagnoses including Right Embolic Stroke with Left Sided Weakness, a history of Aspiration Pneumonia, Dysphagia, Congestive Heart Failure and Alzheimer ' s disease. A review of the Minimum Data Set (MDS) dated 3/24/14 listed the resident ' s weight as equal to 202 pounds. A review of the MDS dated 4/14/14 listed the resident ' s weight as equal to 158 pounds. The resident was assessed with a weight loss of 5% or more in the last month. A review of the Care Plans dated 3/25/14 was conducted. The plan of care indicated the resident was at risk for weight loss, inadequate intake, decreased appetite related to a diagnosis of Alzheimer ' s disease. The interventions included to provide a regular diet as ordered by the physician, to offer snacks within the diet regimen between meals and to weigh the resident as ordered. Weights for resident #64 were reviewed from 3/17/14 until 5/2/14. The review revealed the admission weight was equal to 201.6 pounds. The weight dated 4/2/14 was equal to 140.7 pounds. The weight dated 4/11/14 was equal to 158 pounds. The weight dated 4/21/14 was equal to 158 pounds. No further weights were recorded from 3/17/14 until 5/2/14. A review of the Nutrition Risk Assessment dated 3/18/14 was conducted. The review revealed resident # 64 was assessed with a weight equal	F 325		

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to 201.6 pounds and with a height equal to 69.0 inches. The resident ' s usual body weight was listed as equal to 165 to 169 pounds. The resident was assessed as being able to feed himself with assistance in setting up his food tray. The resident was assessed as needing supervision and cues during meal time.

A review if the Physician ' s Orders revealed an order dated 4/14/14 which stated " Health shakes at Lunch and Dinner, document percentage of intake and weekly weights times four. "

An interview was conducted with the Registered Dietician (RD) on 8/14/14 at 8:59 AM. The RD stated the weekly weights were normally obtained on Monday and she reviewed the weights on Tuesday. She stated she would request to have a resident reweighed if she believed the first weight was incorrect. The RD stated she did not remember if she requested to have resident #64 reweighed from 3/17/14 until 5/2/14. The RD stated a weight was not obtained for resident # 64 on 4/28/14 as ordered by the physician.

An interview was conducted with Administrative Staff #1 on 8/14/14 at 11:19 AM. She stated the weekly weights were obtained on Monday by the nursing assistants. She expected the RD to review the weights on Tuesday. She expected the RD to reassess the resident within 24 hours after being notified of weight loss. Administrative Staff #1 also stated she expected the staff to reweigh the resident when requested and to obtain weekly weights as ordered by the physician.

An interview was conducted with Unit Nurse # 1 on 8/14/14 at 2:51 pm. She stated the nurse aides were expected to weigh the residents by

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F 325	Continued From page 25 the 5th day of each month. The nursing staff was expected to verify the accuracy of the weights. If a weight gain or loss of more than five pounds was identifed, they were expected to request to have the resident reweighed. If it was determined that the scale needed to be recalibrated, arrangements for recalibration were to be made. The nursing staff was responsible for notifying the RD and the Medical Doctor of the weight loss or gain.	F 325		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on medical record review, hospital record review, staff and physician interviews, the facility failed to identify signs of dehydration and intervene for one of one sampled residents (Resident #150) which resulted in hospitalization for dehydration. The findings included: Resident #150 was admitted to the facility on 5/23/14 and discharged to the hospital on 6/15/14. Cumulative diagnoses included: hypotension, left proximal femoral fracture, insulin dependent diabetes and history of stroke. Physician Admission orders dated 5/23/14 revealed the following: Regular diet renal panel and CBC (complete blood count) on 5/27/14	F 327	1. . Resident #150 has been discharged from the facility; therefore, orders cannot be changed retroactively. 2. Labs will be reviewed for possible signs of dehydration every day by the DON on Monday through Friday (lab days, labs are not done on the weekends at the facility. Critical lab needs are sent out to hospital). If any labs are found to be critical, the lab department will notify the floor nurse immediately. The floor nurse will notify the MD and await further instruction. The resident will be place into an alert charting so that each nurse is monitoring the resident each shift. Poor intake will be documented on the 24 hour report. This report will be reviewed daily by RN	9/11/14

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F 327	Continued From page 26 Aspirin 325 mg (milligrams) by mouth two times a day Chlorthalidone (diuretic medication) 25 mg by mouth daily Colace (stool softener) 100 mg by mouth two times daily Enalapril maleate (hypertensive medication) 20 mg by mouth daily Ferrous sulfate (iron medication) 325 mg by mouth two times daily insulin Determir 30 (thirty) units SQ (subcutaneous) at bedtime oxycodone-Acetaminophen (pain medication) 5-325 mg one tablet by mouth every four (4) hours as needed for pain. A Nutrition Risk Assessment dated 5/25/14 indicated Resident #150 received a regular diet and fed herself with set-up help only. Her food and fluid intake was 76--100%. Estimated nutritional needs for adequate fluid intake were 2600 ml (milliliters) based on a weight of 195. Fluid intake sheets for May and June 2014 were reviewed and revealed the following 24 hour fluid intake totals: 5/24/14--1140 ml; 5/25/14--830 ml; 5/26/14--720 ml; 5.27.14--960 ml; 5/28/14--900 ml; 5/29/14--880 ml; 5/30/14--800 ml; 5/31/14--1120 ml; 6/1/14--480 ml; 6/2/14--1220 ml; 6/3/14--720 ml; 6/4/14--1080 ml; 6/5/14--1080 ml; 6/6/14--1260 ml; 6/7/14--1200 ml; 6/8/14--780 ml; 6/9/14--840 ml; 6/10/14--240 ml; 6/11/14--360 ml; 6/12/14--960 ml; 6/13/14--840 ml; 6/14/14--700 ml and 6/15/14 75 ml. Meal Intake sheets for June 2014 were reviewed and revealed Resident #150 consumed 50-100% of every meal from 6/1/14 through 6/7/14. Meal consumption for 6/8/14-breakfast (25%), lunch	F 327	supervisor, including weekends. The report will also be monitored Monday-Friday by the Director of Nursing in the Risk Management meeting. Nurses and nurse aides were in serviced by the Director of Nursing by 9-10-14 about the 24 hour report of change in condition and how to use it effectively to monitor labs and subsequently residents who might be at risk for dehydration. b. Dietary and speech therapy will also be notified of poor intake by the Clinical Coordinator and ADON as a result of the 24 hour change in condition report. This is reviewed by the midnight Supervisor and turned into the DON who will bring in to risk meeting each morning. The review will include poor intake and dietary, MD, and ST will be notified. c. Weights will be performed each week for four weeks upon admission. Weights will be audited each week by the supervisor and Dietician. d. All diuretics will be care planned to monitor for signs and symptoms of dehydration. e. Fluids offered by the nurses will be added into the EMAR (electronic medication record) to supplement capturing fluid intake offered from the nurse. 3. Midnight supervisors will monitor 24 hour reports each night to verify that weights and any resident with poor intake has been documented. This will be ongoing and indefinite. a. Fluid Intake will be audited by the evening supervisor and midnight	

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F 327	Continued From page 27 (25%), dinner (refused); 6/9/14-breakfast (100%), lunch (75%), dinner (refused); 6/10/14-breakfast (not recorded), lunch (not recorded), dinner (25%); 6/11/14-breakfast (75%), lunch (resident not available), dinner (not recorded); 6/12/14-breakfast (50%), lunch (25%), dinner (255); 6/13/14-breakfast (50%), lunch (25%), dinner (25%); 6/14/14-breakfast (50%), lunch (0%), dinner (25%); 6/15/14-breakfast (0%), lunch (0%). Laboratory results for a renal panel dated 5/27/14 revealed a sodium level of 129 (normal--136--147), BUN (blood urea nitrogen) 64 (normal--7--24) and creatinine 1.70 (normal--0.60--1.30). Laboratory results for a renal panel dated 5/30/14 revealed a sodium level of 122, BUN 82 and creatinine 1.80. Nursing notes dated 5/25/14 through 5/31/14 indicated Resident #150 was alert and oriented to self, place, time and reason for admission to the facility, able to feed herself, was incontinent of bladder and bowel. An Admission Minimum Data Set (MDS) Dated 5/30/14 indicated Resident #150 was cognitively intact. She required supervision with eating and extensive assistance with toilet use. Resident #150 was frequently incontinent of bladder and occasionally incontinent of bowel. A care plan dated 5/28/14 and last revised on 6/2/14 did not address the use of diuretic medication, the low sodium level, elevated BUN and creatinine.	F 327	supervisor on random residents each week for 3 months, then every 2 weeks indefinitely. This will be reviewed by the dietician to determine if resident is meeting the fluid needs. b. Results of audit will be given to the Director of Nursing weekly. 4. Results of audits will be reported to the quarterly QA committee by the Director of Nursing to ensure ongoing compliance for one year.	

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F 327	Continued From page 28 Laboratory results for a renal panel dated 6/4/14 revealed a sodium level of 131, potassium 3.6 (normal), BUN 50 and creatinine 1.00. Laboratory results for a urinalysis dated 6/10/14 indicate white blood cells TNTC (too numerous to count) and red blood cells 5--10 (normal is none) as well as heavy bacteria. The culture and sensitivity was received 6/12/14. A physician's progress note dated 6/12/14 stated Resident #150 was somewhat somnolent (drowsy) and it was felt that this may be due to her pain medication Percocet. Her oral mucosa was somewhat dry. Lab work would be repeated (CBC and renal panel) and her Percocet was discontinued and changed to Tramadol. A physician's order dated 6/13/14 indicated Macrobid (antibiotic) 100 mg twice daily x seven (7) days. A physician's order dated 6/15/14 stated to send resident to (name) emergency room for evaluation. A physical therapy progress note dated 6/12/14 stated Resident #150 did not want to get out of bed. Physical therapy discussed with nursing regarding Resident #150's decline in status Speech therapy was to start working with resident regarding improving po intake. A speech therapy consultation dated 6/12/14 indicated Resident #150 was referred to speech therapy due to the fact nursing staff and therapy staff indicated Resident #150 had difficulty swallowing, was unable to chew food and had poor po intake.	F 327		

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F 327	Continued From page 29 A speech therapy note dated 6/12/14 stated Resident #150 was seen in her room. She had limited verbalizations and was fatigued. She tolerated a mechanical soft diet without signs/ symptoms of difficulty for less than 50% of presentations, spit out food, prolonged chewing. Meal intake was less than 25%. A speech therapy note dated 6/13/14 stated Resident #150 was seen in her room for the breakfast meal. She was very fatigued. She tolerated a mechanical soft diet without difficulty for 50% of presentations-soft cold cereal, eggs, soft bread. Resident #150 had prolonged chewing, oral residue (food in her mouth) and a slight cough. The speech therapist consulted with the hall nurse regarding poor po intake and fatigue. A social work note dated 6/13/14 stated an interdisciplinary care plan meeting was held with a family member present. Physical therapy and Occupational therapy had reported Resident #150 was making minimal progress. Resident #150 had a lack of motivation, had dizzy spells at times and therapy had noted she was sleeping more, staying in bed and did not engage in conversation. speech therapy had evaluated Resident #150 on 6/12/14 and indicated she had poor intake with a diet downgrade to mechanical soft diet. A nursing note dated 6/13/14 at 7:16PM stated Resident #150 was oriented with some confusion noted. She continued to feed herself and no concerns were noted with speech, swallowing foods/ liquids or medications.	F 327		

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A nursing note dated 6/14/14 at 1:55AM stated Resident #150 had some difficulty swallowing which was noted during medication administration. Resident #150 remained groggy and disoriented that evening.

A nursing note dated 6/15/14 at 1:20PM stated a family member had visited and stated Resident #150 did not look right or open her eyes to look at her or talk to her. The family member requested Resident #150 go to the hospital. The physician was notified and Resident #150 was transferred to (name) hospital. vital sings at that time were temperature 96.2, pulse--77, respirations 18, blood pressure 118/62.

Vital signs were reviewed and revealed the following:
5/23/14 at 4:18PM 121/65; 5/24/14 at 2:25pm--108/51; 5/26/14 at 11:25am--101/56; 5/27/14 at 7:23pm--95/56; 5/28/14 at11:16am--96/48; 5/28/14 at 7:26pm--108/55; 5/29/14 at 11:11AM--99/60; 5/31/14 at 1:49AM--92/55; 6/9/14 at 1:01AM--98/50; 6/13/14 at 1:58AM--93/48; 6/13/14 at 2:20PM--96/52; 6/14/14 at 11:42AM--105/59. Pulse rate remained in the 70-80 ' s except the following days: 6/8/14 at 5:58PM--97, 6/9/14 at 1:52AM--93 and 6/9/14 at 1:46PM--97.

Emergency room records dated 6/15/14 revealed the following diagnoses: altered mental status, urosepsis, acute renal failure, hyperkalemia and anemia. The emergency room records revealed that resident #150 had a urinary tract infection withy 3+leukocytes and greater than 100 white blood cells and heavy bacteria. Her white blood cell count was significantly elevated at 47.5. Anemia was noted with a hemoglobin of 10.4 and

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hematocrit 30.5. Acute renal failure was noted with a BUN (blood urea nitrogen) of 204 and creatinine of 6.71. Impression: 1. altered mental status 2. urosepsis 3. acute renal failure 4. hyperkalemia 5. anemia. The records revealed Resident #150 was admitted to the intensive care unit at the hospital.

History and Physical from (name) hospital dated 6/15/14 stated Resident's vital signs on admission were as follows: blood pressure of 97/36, pulse of 77, respiratory rate of 12 and temperature of 96.4. Renal (kidney) function panel revealed, in part, a sodium of 126, potassium 6.1, chloride 92, bicarbonate of 16, BUN (blood urea nitrogen) of 204 and creatinine of 6.71. Assessment and Plan: 1. acute/ subacute encephalopathy/ altered mental status, multifactorial secondary to severe dehydration with acute kidney injury and urinary tract infection. 2. acute kidney injury, likely pre-renal with hyperkalemia with some metabolic acidosis. 3. Hyperkalemia likely secondary to acute kidney injury and metabolic acidosis. 5. hyponatremia probably due to decreased oral intake and dehydration.

A consultation note dated 6/16/14 from (name) hospital stated the physician was concerned that Resident #150 might require dialysis if her renal function did not continue to improve. A catheter was placed for access and also for the possibility of dialysis.

On 8/12/14 at 3:51PM, Nurse #5 stated resident #150 she would feed herself sometimes but needed encouragement and assistance to continue with a meal or complete a meal. She stated nursing staff encouraged resident to eat

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and drink. She stated she had not noticed a change in Resident #150 ' s medical condition. Nurse #5 stated Resident #150 ' s vital signs were " good ' but the family member with the resident insisted that Resident #150 go to the hospital.

On 8/12/14 at 5:48PM, Nurse #6 stated Resident #150 was alert and oriented when she was admitted to the rehabilitation unit (150 hall) on 5/23/14. She stated Resident #150 fed herself but required assistance with turning, repositioning and transfers. Resident #150 was not participating in therapy and was transferred to the 200 hall because she required more assistance with activities of daily living.

On 8/13/14 at 8:46AM, NA#1 stated she provided care for Resident #150 on 200 hall. She said Resident #150 would feed herself when she first arrived on 200 hall. Around 6/12/14, she noted that Resident #150 was not eating or drinking much and just left the food and fluids on her tray. She stated she offered and provided alternate food and fluids but Resident #150 refused them. NA#1 stated the last time she provided care for Resident #150 was on 6/12/14. At that time, Resident #150 just kept her eyes closed and would not say anything to her which was different because Resident #150 had talked with her when she first came to the 200 hall.

On 8/13/14 at 9:22AM, NA#2 stated she had provided care for Resident #150 a few times. NA#1 said she noticed that Resident #150 was feeding herself when she first came to the 200 hall, then stopped feeding herself. She said they would encourage her to eat and drink and try and feed Resident #150 but she would not open her

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mouth or just turn her head away when food and fluids were offered. NA#1 said a family member was present on 7/13/14 and asked what was going on with the resident because she was not eating. NA #1 said she spoke with the nurse that day and told the nurse that Resident #150 was not eating and only drinking small sips of fluid.

On 8/13/14 at 11:24AM, NA#3 stated Resident #150 fed herself meals and was not assisted with meals. She said, at first, Resident #150 consumed her food and fluids, then began refusing her meals and refused substitutes. She stated she thought it was a couple of days before Resident #150 went to the hospital, she informed the nurse on the hall that Resident #150 was eating and drinking only small amounts of food and fluids.

On 8/14/14 at 12:30PM, Nurse #4 stated she provided care to Resident #150 on 6/12/14. She stated a family member was with the resident that day and informed her that Resident #150 had not eaten much the day before and was not feeling well. Nurse #4 did not recall if the nursing assistants had informed her that Resident #150 was not eating or drinking

On 8/14/14 at 2:17PM, Resident #150's physician was interviewed. He stated he visited Resident #150 on admission and also on 6/12/14. The physician said he did not recall if he saw a change in her medical condition that day but did document that Resident #150 was somewhat somnolent and her oral mucosa was somewhat dry. He did not recall being notified that she was not eating and drinking much.