STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495347	A. BUILDING _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 07/08/15 through 07/09/15. One complaint was investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 114 certified bed facility was 107 at the time of the survey. The survey sample consisted of 3 closed record reviews (Residents #1, 2 and 3).	F 000	Preparation and submission of this Plan of Correction does not constitute an admission Or agreement by the provider of the truth or facts alleged or correctness of the conclusions set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of the requirements under State and Federal Law. This Plan of Correction will serve as the Facility's allegation of substantial compliance .	
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	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 7-28-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 staff interviews and clinical record review the facility staff failed to ensure an Admission Record had the correct Responsible Party information for 1 of 3 residents in the survey sample, Resident #1.

The findings included:

Resident #1 was admitted from an acute hospital to the facility on 6/19/15 with diagnoses to include congestive heart failure, bilateral pneumonia, acute renal (kidney) failure, infected swollen gums and history of stroke with PEG (percutaneous endoscopic gastrostomy) feeding tube placement.
The hospital's General Information sheet listed the resident as his/her Guarantor. The primary next of kin was listed as the daughter.
Guarantor, n. a person or entity that agrees to be responsible for another's debt or performance under a contract, if the other fails to pay or perform.
Legal-dictionary.thefreedictionary.com/guarantor
The Admission Record (face sheet) listed the resident as his/her own responsible party, instead of the daughter. The daughter was listed as emergency contact #1.

F 157

1. Resident #1 is no longer a resident at the facility.
2. Residents that reside in the facility have a change in condition has the potential to be affected. Residents who have been identified as their own responsible party current face sheet will be reviewed for current contact information.
3. Licensed staff will be educated by the Director of Clinical Services (DCS) or designee on the facility transfer resident to the hospital policy and assessing resident with a reported or observed change in condition. Audit will be conducted on new admission face sheets that make their own decisions for current contact information. Residents contact information will be reviewed and updated at the Care plan for necessary changes as required as to the residents face sheet. Nursing staff will be in-serviced when to notify Social Services and Admission when to update a face sheet.

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The admission MDS (Minimum Data Set) with an assessment reference date of 6/17/15 Section C Cognitive Patterns assessment was incorrectly conducted and the score was invalid.

The social services (SS) staff responsible for completing this section of the MDS was interviewed on 6/9/15 at 10:50 am. She stated the resident was not able to answer any of the questions in Section C Cognitive Patterns when asked. She stated the resident would just stare at her and not respond.

She continued to state the daughter was actively involved in the resident's care and she understood the daughter was the Responsible Party. The SS stated, "She (the daughter) is listed on the face sheet as the RP." The SS worker was asked if she thought the resident was capable of making her own medical decisions, she responded, "Based on my assessment, no she wasn't able to make her own decisions."

The admission coordinator responsible for inputting the data on the Admission Record was interviewed on 7/9/15 at 4:15 pm. She stated the information on the Admission Record was obtained from the hospital General Information sheet. The admission coordinator was asked, "Do you normally follow the information on the hospital's General Information sheet?" She stated, "No...we ask that information when they get here."

The admission coordinator stated she had gone into the resident's room on at least 2-3 occasions to clarify the information on the Admission Record and each time the resident was asleep. She was asked if she attempted to get this information

F 157

4. ED or designee will audit weekly Care Plan report regarding verification of contact information for RP or follow up due to RP not attending weekly X 3 months. DCS/ designee will audit RP notification daily 5x a week for 1month, weekly x 1 month and monthly x1. The results of the physician notification audit will be reported by Director of Clinical Services (DCS) to the Quality Assurance Performance Improvement Committee (QAPI) for recommendations.
5. Allegation of Compliance: August 13, 2015

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from the resident at a later time of the day instead of the morning, she stated, "No." The admission coordinator indicated the resident signed a form to give the daughter permission to complete all paperwork. When asked why, she stated, "The resident wouldn't have understood all the admission paperwork." When asked if she should have clarified who was the responsible party with the daughter she stated, "Yes." When asked if the resident was capable of being his/her own RP she stated, "No...I understand I am responsible for making changes to the face sheet, I should have changed it."

On 7/9/15 at 4:00 pm, an interview was conducted with the daughter. She alleged she was the RP for the resident for the past 25 years that the resident had resided with her. The daughter stated she was the contact person who was called when there was a procedure/consent for treatment or any change when the resident was at a previous long term facility and while the resident was in the hospital. The daughter indicated she did not know why the facility did not have her listed as the RP.
The daughter identified the resident had a change in condition for three days; 6/25, 6/27 and 6/28/15. The daughter requested Resident #1 be transferred to the emergency room for evaluation each of those three days.

The facility staff did not comply with the daughter's request as the facility's Admission Record was incorrect and did not list her as the resident's RP.

The resident was subsequently sent to the emergency room via 911 on 6/28/15 with diagnoses of altered level of consciousness,

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F 157	Continued From page 4 diabetic hyperosmolar non-ketotic state (diabetic coma), dehydration, acute renal failure and sepsis (a life-threatening complication of infection). The emergency physician documented, " . Patient had reportedly been increasingly lethargic over the last few days--daughter had been trying to get him/her sent to hospital reportedly since that lethargy began." No further information was provided prior to exit. COMPLAINT DEFICIENCY	F 157		
F 278 SS=F	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	F 278		

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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 by:
Based on information obtained during a complaint investigation, clinical record review, staff interviews, and review of the facility's policy the facility staff failed to complete discharge Minimum Data Set (MDS) assessments for all residents who had planned and unplanned discharges over the last 2 years.
The facility staff dash filled (-) all MDS assessment items for discharge residents except the demographic section and active diagnosis sections because that information remains in the computer system. The staff only added the reason for the assessment and the date the discharge occurred.
The findings included:
During a complaint investigation involving unplanned discharged residents, discharge MDS assessments were viewed. The facility staff had coded each discharge assessment with dashes except for sections "A" and "I". The survey team expanded the sample of discharge MDS assessments to include residents who had planned discharges as well as unplanned discharges back to July 2014. The results were the same; all discharge MDS assessments were dash filled in all sections except "A" and "I".
An interview was conducted with MDS coordinator #1 on 7/9/15 at approximately 11:20 a.m. to ascertain a rationale. MDS coordinator #1

1. Resident discharges within in the last 30 days will be audited for accuracy and modified as needed
2. Residents that have a planned or un- planned discharge from this facility will have the potential to be affected.
3. The MDSC's will be re-educated by RCMC (Regional Case Mix Coordinator) on the appropriate uses of dashes during planned and un-planned discharges to comply with RAI manual.
4. The DON designee will audit a random selection of discharged MDS's weekly X's 8 weeks, bi-weekly X 1 month and monthly X 1 month. The RCMC (Regional Case Mix Coordinator) will audit a random sample of discharge MDS assessments X 3 months. The results of these audits will be presented to QAPI for recommendations.
5. Allegation of Compliance: August 13, 2015

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stated she began the MDS position at this facility April 2015 and during the orientation period she was instructed by MDS coordinator #2 to dash fill all sections of all discharge assessments.
An interview was also conducted with corporate Casemix coordinator on 7/9/15 at approximately 2:50 p.m. The Casemix coordinator stated she is the staff member who signs the MDS assessment as complete and periodically audits the MDS assessments for this facility. The surveyor asked the Casemix coordinator if she was aware the facility staff was not completing the discharge MDS assessments. The Casemix coordinator stated she was not aware the facility staff was dash filling discharge MDS assessments. The corporate Casemix coordinator further stated her expectation was for the MDS coordinators in the facility to complete all discharge MDS assessments (planned and unplanned) as they would all other MDS assessments, utilizing all resources (i.e., the medical record, staff interviews, etc.).
An interview was also conducted with MDS coordinator #2 on 7/9/15 at approximately 4:10 p.m. MDS coordinator #2 was asked by the surveyor why were all discharge MDS assessments dash filled instead of coded like other MDS assessments. MDS coordinator #2 stated a MDS coordinator from the previous facility she was employed by instructed her dash filling was the correct manner to complete discharge assessments. The rationale was discharge MDS assessments were solely for tracking purposes and did not affect reimbursement. MDS coordinator #2 stated she has been employed by this facility since May 2013 and dash filling discharge assessments had been her practice since she began working for the facility.

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The surveyor asked MDS coordinator #2 on 7/9/15 at approximately 4:10 p.m. were the MDS assessments completed within the facility audited by any source and if so what were the findings. MDS coordinator #2 stated the MDS assessment are audited for Medicare A/reimbursement purposes. MDS coordinator #2 stated she had spoken with the corporate Casemix coordinator earlier today and the corporate Casemix coordinator told her dash filling the discharge MDS assessments was not correct and was contrary to the instructions given in the Resident Assessment Instrument (RAI) manual. MDS coordinator #2 stated the corporate Casemix coordinator told her from today forward the discharge MDS assessments were to be completed as described in the RAI manual.
The facility policy Minimum Data Set (MDS) document M-1025 dated 11/30/14 did not address the discharge MDS assessment.
The RAI MDS 3.0 manual states at chapter 3 page 4:
"Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System (ASAP).
- A dash value means an item has not been assessed. This most often occurs when a resident is discharged before an item has been assessed.
- Dashed values allow an assessment to be submitted when an assessment is required for payment purposes.
- There are 4 date items (A2400C, O0400A6, O0400B6, O0400C6) that use a dash-filled value to indicate the event has not yet occurred . . .
Assessment Management Requirements and Tips for Discharge Assessments.

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Must be completed when the resident is discharged from the facility (see definition of Discharge on page 2-10)

Must be completed when the resident is admitted to an acute care hospital.

Must be completed when the resident has a hospital observation stay greater than 24 hours.

Must be completed on a respite resident every time the resident is discharged from the facility.

May be combined with another OBRA required assessment when requirements for all assessments are met.

May be combined with a PPS Medicare required assessment when requirements for all assessments are met.

For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a Discharge assessment is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days).

The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the Discharge assessment with another assessment(s) when requirements for all assessments are met.

For unplanned discharges, the facility should complete the Discharge assessment to the best of its abilities (RAI manual, MDS 3.0 chapter 2-36)

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The above findings were shared with the Director of Clinical Services and a peer Director of Clinical Services on 7/9/15 at approximately 4.20 p.m. No addition information was providec prior to the survey team's exit.

F 309 SS=G 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 staff interviews, clinical record review and during the course of a complaint investigation the facility staff failed to identify an existing diagnosis that required treatment, and failed to transfer a resident to an acute hospital for further evaluation to maintain their highest practicable physical well-being for one of three resident's in the survey sample, Resident #1.

1 A. The facility staff failed to identify Resident #1 had a medical history of diabetes. The diabetes was not treated during the course of the Resident's stay from 6/10/15 through 6/28/15.

1 B. The facility staff failed to identify and acknowledge that Resident #1 had a Responsible Party (RP), the daughter. The daughter identified the resident had a change in condition for three days. The daughter requested Resident #1 be

F 278

F 309

1. Resident #1 has been discharged from the Facility.
2. Residents who reside and admitted to the facility who are Diabetic and receiving tube feeding who experience a change in condition has the potential to be affected.
3. Licensed nursing staff will be in-serviced by the Director of Clinical Services (DCS) or designee on Physician discharge orders for specialty formulas And responding to residents change of condition as reported by family members or nursing assessment.
4. Director of Clinical Services (DCS) or Designee will audit new admissions hospital discharge documentation and facility admission orders for discrepancies relating to diets and diagnosis of diabetics for 5 X a week X 4 weeks then weekly X 4 weeks then monthly x 1.
5. Allegation of Compliance: August 13, 2015

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transferred to the emergency room for evaluation each of those three days. The resident was subsequently sent out 911 on 6/28/15 and admitted to the ICU (intensive care unit) with sepsis and in a diabetic coma with a blood sugar greater than 1500 mg/dl (milligrams/deciliter-the hospital laboratory reference range for blood sugar was between 65-99 mg/dL).
Sepsis is a life-threatening complication of infection. It often occurs in people who are elderly or have weak immune systems. www.nih.gov
The findings included:

1 A. Resident #1 was admitted from the hospital to the facility on 6/10/15 with diagnoses to include congestive heart failure, bilateral pneumonia, acute renal failure, infected swollen gums and history of stroke with PEG (percutaneous endoscopic gastrostomy) feeding tube placement.

A gastrostomy feeding tube (G-tube) is a tube that is surgically placed into the stomach through the abdominal wall. The G-tube is used to administer medications and feedings. www.nih.gov
The admission MDS (Minimum Data Set) with an assessment reference date of 6/17/15 Section C, Cognitive Patterns assessment was incorrectly conducted, and the score was invalid. The social services staff responsible for completing this section stated the resident was not able to answer any of the questions asked. She stated the resident would just stare at her and not respond.
Review of the admission nursing telephone report received by the facility staff from the hospital staff on 6/10/15 indicated the resident was receiving Glucerna via the tube feeding.

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The Nutrition Evaluation Initial and Annual form dated 6/19/15 filled out by the registered dietician noted the resident's tube feeding previous to admission was Glucerna 1.2 at 50 ml (milliliters) an hour.
Glucerna products are specifically and scientifically designed to meet the needs of people with abnormal glucose metabolism. These products are formulated with reduced carbohydrate, modified fat, and fiber to help manage blood glucose response and lipid levels. Glucerna products have been clinically demonstrated to be efficacious (having the power to produce a desired result or effect) for people with diabetes. www.abbott.co
The admission tube feeding order written by the physician assistant was for Jevity 1.5 at 50 ml an hour.
The laboratory complete metabolic profile (CMP) reported blood glucose (sugar) levels obtained on 6/12/15 and 6/19/15 were high.
1. On 6/12/15 the blood glucose level was 216 mg/dL.
2. On 6/13/15 the blood glucose level was 239 mg/dL.
The facility's laboratory reference range for blood glucose was between 65-100 mg/dL.
Both of these lab reports were initialed as reviewed by the physician assistant.
There were no additional orders from the physician assistant or the physician addressing the high blood sugar levels noted in the clinical record.
On 7/9/15 at 2:30 pm, the attending physician was interviewed. The resident's previous use of Glucerna via the G-tube prior to admission and elevated blood sugars were discussed. When asked if he was aware of Resident #1's history of diabetes he reviewed his notes and then stated, "I

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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don't see it on my notes." He then looked at the 6/10/15 hospital discharge medications and stated "No diabetic medications were listed why did (gender) come here without any treatment?" He stated he always obtains blood work for new admissions. After reviewing the blood work (CMP blood glucose levels), he was asked if the physician assistant should have initiated a treatment plan for the resident. He stated, "Yes, we should have at least collected a hemoglobin A1C level and monitored the resident's blood sugar every 6 hours and probably change the Jevity to Glucerna." The physician stated the report from the hospital to the nursing staff of the resident receiving Glucerna should have been a red flag for the staff. He further stated, "This issue needs to be addressed, definitely."

Hemoglobin A1C provides an average of your blood sugar control over the past 2 to 3 months and is used along with blood sugar monitoring to make adjustments in medicines. www.nih.gov

The resident was sent to the emergency room via 911 on 6/28/15 with diagnoses of altered level of consciousness, diabetic hyperosmolar non-ketotic state (diabetic coma), dehydration, acute renal failure and sepsis.

A diabetic coma could happen when your blood sugar gets too high -- 600 milligrams per deciliter (mg/dL) or more -- causing you to become very dehydrated. It usually affects people with type 2 diabetes that isn't well-controlled. It's common among those who are elderly, chronically ill, and disabled. This is a serious condition, and if it isn't spotted soon and treated quickly, it could be fatal. www.nih.gov

Further review of hospital records evidenced a consult that read, in part ".. resident is known to me from prior evaluation in 2014.. past medical history: diabetes."

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	495347	A. BUILDING _____ B. WING _____	C 07/09/2015

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1 B. On 7/9/15 at 4:00 pm an interview was conducted with the daughter. She alleged she was the RP for the resident for the past 25 years that the resident had resided with her. The daughter stated she was the contact person who was called when there was a procedure/consent for treatment or any change when the resident was at a previous long term facility and while the resident was in the hospital. The daughter indicated she did not know why the facility did not have her listed as the RP.
The daughter stated she had noted there was a change in the resident first identified on Thursday 6/24/15. She stated the resident appeared to be drugged, sleepy, lethargic/ disoriented. The daughter indicated the resident had been receiving pain medications for complaints of tooth pain due to infected gums and this could have attributed to the resident's change
The RP indicated she had visited with the Resident on 6/25/15, 6/27/15 and 6/28/15. Each of those days the RP noted the resident was not responding to her as he/she normally would and grew more concerned. The RP stated she had asked staff each of those days to send the resident out to the emergency room for evaluation. On 6/28/15 the RP stated she was very upset at the nursing staff's lack of acknowledging that the resident had a change in condition (not responding to her). The RP stated the staff had told her that the resident was acting that way (unresponsive) because she was there. The RP indicated she threatened to get a court order to have the resident sent to the emergency room and then left to do so. Several hours later, the facility had called her to tell her that the resident was being sent out 911 for a change in condition.
Interviews were conducted with the nursing staff

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involved with Resident #1's care on 6/25/15, 6/27/15 and 6/28/15

The licensed practical nurse (LPN) #1 was interviewed on 7/9/15 at 10:15 am. She indicated she was assigned to care for the resident on 6/25/15 during the day shift. LPN #1 stated the resident's daughter was in an "Uproar about the tooth infection..." LPN #1 stated an oral surgeon was to have followed up with the resident's tooth concern but the facility had not received any information for a follow up oral surgeon appt. The daughter wanted to take the resident to the emergency room to be evaluated. The nurse stated she told the daughter that she was unsure if she could take the resident to the emergency room and referred her to the nurse at the front desk. Several minutes later the daughter came back down the hall and stated to the nurse, "Everything was taken care of."

Review of the clinical record evidenced a physician order dated 6/15/15 that read, in part: Orajel applied (sic) to gums bid (twice a day) PRN (as needed) sore gums, work (with) family to get oral surgeon appt (appointment) scheduled.

On 7/8/15 at approximately 5:30 pm, LPN #2 was interviewed. She was assigned to care for Resident #1 on 6/27/15 during the day shift. The nurse stated, " The daughter told me she was the RP for the resident. she was belligerent, she said that we were doping the resident and making (him/her) sick with narcotics and we didn't care...she was yelling she wanted the resident to be sent out to a hospital in (name of town approximately 47 miles from facility)...I told her if you feel he/she is in that bad of shape you can call EMS...I went back to the desk and started getting the paperwork ready, I called the on call physician...I called (non-emergent) transport,

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they came and stated they could not transport the resident to the specific hospital the daughter had requested the resident be sent to (name of town approximately 47 miles from facility). then I realized the daughter was not the RP (after reviewing the face sheet)...so I went to the resident's room and asked the resident if he/she was their own responsible party and he/she nodded "yes", I then asked the resident if he/she wanted to go the hospital and he/she nodded, "no." So then I went down and spoke with transport and they left." The nurse indicated the resident's daughter had already left the building. LPN #2 stated she called the daughter's phone number and left a message informing her that the resident was still in the building. LPN #2 stated, "The doctor never called back...I had my hands full."

LPN #2 indicated she had never taken care of the resident before. She was not aware of the resident's baseline. She stated the resident had received a pain medication at 8 am for tooth pain that morning. She stated the resident was responsive, non-verbal, awake and oriented to self and place. The resident's vital signs were documented on the nurses notes as 96 temp, 20 respirations, blood pressure 120/74, the resident was on oxygen at 2 liters per minute with a pulse oxygen saturation of 98%.

LPN #3 assigned to care for the resident on 6/28/15 for the first part of the evening shift was interviewed on 7/9/15 at 3:00 pm. She stated the day shift nurse had reported to her that the resident's family member (daughter/RP) had requested the resident be sent out to the hospital that morning. The day shift reported the daughter was loud, belligerent and threatening stating she wanted the resident sent out to the emergency room. The day shift nurse reported to the

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daughter that the resident was stable and there was no medical justification to send the resident out.

The day shift nurse documented at 10:00 am, the resident's vital signs as: blood pressure 136/60, pulse 62, respirations 18 and temperature 97.5. At 1:00 pm, the nurse documented, "Family member verbalizing (resident) has changed." LPN #3 stated at approximately 8:00 pm, the oncoming nurse made rounds and noted the resident was unresponsive except to sternal stimuli and had approximately 60 cc of bright red blood return when the resident's PEG tube residual was checked. 911 was called and the resident was transported to the local hospital emergency room. LPN #3 stated she called and notified the daughter of this change. The daughters response was, "I am glad you sent (resident) out..." The daughter stated she knew there was something going on with the resident.

The resident was sent to the emergency room via 911 on 6/28/15 and diagnosed with altered level of consciousness, diabetic hyperosmolar non-ketotic state (diabetic coma), dehydration, acute renal failure and sepsis. The resident's blood sugar was elevated at greater than 1500 mg/dl. The resident was placed on a IV (intravenous) fluids, insulin drip and antibiotics and placed in the ICU for further care.

The emergency physician documented, "...Patient had reportedly been increasingly lethargic over the last few days--daughter had been trying to get him/her sent to hospital reportedly since that lethargy began. Patient has had a steady decline then was found unresponsive by staff on day of admission--upon arrival WBC (white blood count) >22 (normal lab reference is 4.0-11), glucose 1500, lactic acidosis present, along with hypotension (low blood pressure)."

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Lactic acidosis is a physiological condition characterized by low pH in body tissues and blood accompanied by the buildup of lactate. Lactic acidosis is commonly found in people who are unwell for one of various reasons such as severe heart and/or lung disease, a severe infection with "Sepsis", or severe "Hypovolemia" depletion of body fluid. www.nih.gov
The above findings was shared with the director of clinical services on 7/9/15 during a pre-exit meeting. She indicated resident's should be sent out to the hospital whenever an RP requests. She stated, " If the daughter requested the resident go to the emergency room then we should have called and notified the doctor and moved forward."
COMPLAINT DEFICIENCY

F 354 SS=E 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK. FULL-TIME DON — F 354

Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

This REQUIREMENT is not met as evidenced by:
Based on information obtained during a

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complaint investigation, review of staffing schedules, "as worked schedules" and a staff interview the facility staff failed to assure a registered nurse (RN) was on duty for at least 8 consecutive hours every day for the last 19 months.

The findings included:

During the nursing staff review for the survey days, 4 days prior to the survey and on days the surveyors deemed RN assessments would have been detrimental for the care of acutely ill residents the surveyors were unable to verify RN presence in the facility for at least 8 consecutive hours therefore further review was indicated.

An interview was conducted with the Director of Clinical Services (DCS) on 7/9/15 at approximately 1:15 p.m. The surveyor asked the DCS to show who the RN staff member was on the 6/28/15 - 6/29/15 and the 7/4/15 - 7/5/15 "as worked schedules". The DCS stated there were only 2 RN's other than herself currently employed by the facility. One worked the dementia care unit and was on every other weekend. The weekend she was off there was no RN coverage in the facility to meet the 8 consecutive hours every day requirement. The other RN is the Assistant Director of Clinical Services (ADCS) who works Monday - Friday on the a.m. - p.m. shift.

Also during the interview with the DCS on 7/9/15 at approximately 1:15 p.m., the DCS stated she was not aware regulations required a registered nurse to work 8 consecutive hours per day 7 days per week.

The DCS further stated how difficult it is to recruit RNs to the rural area because of the salary range she has to offer.

The above findings were shared with the Director of Clinical Services and a peer Director of Clinical Services on 7/9/15 at approximately 4:20 p.m. No

F 354

1. Resident #1 has been discharged from the facility.
2. Residents who reside and admitted to the facility have the potential to be affected.
3. ED and DCS will be in-serviced on RN required RN coverage of a minimum of 8 hours per day, seven days a week.
4. DCS and or ED will review schedule on a weekly basis prior to actual week. DSC/ED will audit RN schedule every 2 weeks X8 weeks, bi-weekly X 1 month and monthly X 1 month.
5. Allegation of Compliance: August 13, 2015.

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