STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(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 (complaint) survey was conducted 03/07/17 through 03/08/17. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. There were three complaints investigated during the survey. The census in this 180 certified bed facility was 153 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents 1, 4, and 5) and 2 closed record reviews (Residents 2 and 3).	F 000	Preparation and submission of this plan of correction by **Charlottesville Pointe Rehabilitation and Healthcare, LLC,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157	**F157** 1. Resident #2 was discharged from the facility on 02/17/17. 2. An audit was completed on 3/14/17 by the Unit Managers of the current residents' medical records for the past 30 days to ensure the physician has been notified of changes in condition. 3. The licensed nurses were reeducated on 3/15/17 by the Staff Development Coordinator on the requirements of notification to the physician on changes in condition.	

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

3.23.17

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the physician in a significant change of condition for one of 5 residents in the survey sample (Resident # 2), which resulted in harm. The facility staff failed to notify the physician of a significant physical and mental status change for Resident # 2; the resident was sent to a regularly scheduled infusion appointment, arrived at the appointment essentially unresponsive, where life	F 157	4. The Director of Nursing or the Unit Managers will audit 5 current residents' medical records on each of the 3 units weekly for 4 weeks and monthly for 2 months to ensure the physician continues to be notified of changes in condition. The Director of Nursing will submit a report to the Quality Assurance Committees monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date:	03/24/17

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saving measures were implemented. The resident was then taken to the emergency department and later admitted to the MICU (medical intensive care unit); the resident subsequently expired two days later.

Findings include:

Resident # 2 was admitted to the facility originally on 01/05/17, with the most current readmission on 02/02/17. Diagnoses for Resident # 2 included, but were not limited to: gastritis w/ history of bleeding, chronic kidney disease, anemia, muscle weakness, hypothyroidism, obesity, HTN (high blood pressure), DM (diabetes mellitus) and Von Willebrand disease (a severe bleeding disorder).

The most current full MDS (minimum data set) was an admission assessment dated 02/09/17. This MDS assessed the resident with a cognitive score of "13", indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive to total assistance from at one to two staff members for most ADL's (activities of daily living).

An admission MDS assessment, dated 01/12/17 was reviewed for comparison. This MDS assessed the resident as having a cognitive score of "14", again indicating the resident was cognitively intact. The resident triggered in the CAAS (care area assessment summary) section of this MDS for, but not limited to: ADL's and urinary.

During a complaint investigation on 03/07/17, Resident # 2's closed clinical record was

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reviewed.

Resident was originally admitted to the facility on 01/05/17. The resident was discharged from the facility and admitted to the hospital on 01/25/17 for anemia and relative hypotension.

The resident was readmitted back to the long term care facility on 02/02/17.

A BIMS (brief interview for mental status) form dated 02/02/17, documented that the resident had a cognitive score of "15", indicating the resident was cognitively intact in decision making skills.

Nursing notes were reviewed. A nursing note dated 02/17/17 and timed 8:45 a.m. documented, "Resident noted to have an altered mental status change. Resident slow to respond and lethargic. Resident was able to follow some commands very slowly. This nurse spoke with (name of person) [identified as O (Other) # 2] at (initials of infusion center) in relation to resident condition. O#2 will make infusion center aware. Resident out of facility at 8:40 a.m. via priority in poor condition...signature of LPN [Licensed Practical Nurse] # 3.

No information was found in the nursing notes and/or in the clinical record to indicate that LPN # 3 had notified the physician of Resident # 2's significant change in condition. No vital signs documented, no assessment information for the resident and no evidence of notification were found in the clinical record.

Resident # 2's physician's orders were then reviewed, no physician's orders were found

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during this time frame. One physician's progress note was found, dated 02/06/17.

No other information regarding Resident # 2's significant mental status change on the morning of 02/17/17 could be found.

The hospital discharge summary dated 02/19/17 (the date the resident expired at the hospital), documented, "...per (name of long term care facility) where she lives, she went to bed last night in her normal state of health. This morning on awakening she was found to be lethargic and following commands, but doing so slowly...Septic shock 2/2 [secondary to] GNR [gram-negative rod] bacteremia..."

LPN # 3 was interviewed on 03/07/17 at 2:40 p.m. regarding Resident # 2 and her condition on 02/17/17. LPN # 3 stated that the resident had appointments with the infusion center every other day and she had an appointment that morning (Friday February 17, 2017). The LPN further stated that she had came in that morning and got report from the night shift nurse (LPN # 5), the night shift nurse told her (LPN # 3) that the resident was slow to respond and lethargic and had asked LPN # 3 to go assess the resident. The LPN stated that she went to the room and checked on the resident and confirmed that the resident had a mental status change from her normal self and was slow to respond and lethargic. The LPN stated that the resident was not able to give any details or anything specific, basically yes no answers to questions, but was very slow. The LPN stated that this was not Resident # 2's usual self, because she could normally converse and let you know what was going on with her, she was able to make her

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needs known. The LPN was asked if she got a set of vital signs on the resident. The LPN stated, "I didn't put them in my note, but I'm sure I did." The LPN was asked, where would those be documented. The LPN stated again that she did not document them in her note. The LPN stated that she probably just had them written down on a piece of paper. The LPN was asked if the vital signs were normal or abnormal. LPN # 3 stated that she could not remember. LPN # 3 was asked if the night nurse assessed the resident. LPN # 3 stated that she did not know if the night shift nurse assessed the resident.

LPN #3 was asked if she notified the physician. The LPN stated that she did not, the night shift nurse had notified the NP and that the NP was there at the facility that day and the NP said it was ok for her (resident) to go to her appointment, it was early in the morning. The LPN stated that the NP was aware before she (LPN # 3) had even got to the facility and didn't know if the nurse had assessed the resident or not. The LPN stated that there is a 24 hours report book and she was not sure what was in the book for that day. The LPN again stated that the night shift nurse spoke with the NP.

LPN #3 was again asked why the resident was sent to the infusion center and not to the emergency room without physician notification. The LPN stated that the resident had an appointment that morning and that she called O (other) #2 at the infusion center and told O#2 to inform the infusion center of the resident's condition, so they would know when the resident arrived. The LPN was asked what O#2's last name was. The LPN did not know. The LPN was asked of O#2's title, was the person a medical

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professional or an operator. LPN # 3 stated that she did not know, she did not get the last name or the person's title.

LPN # 3 was again asked why she sent the resident to the infusion center instead of the emergency room. LPN # 3 stated, "The NP told me it was ok [for resident] to go to the appointment. The LPN was asked if an order was received for that. The LPN stated that she did not know. The LPN was asked if the NP wrote a note. The LPN stated again that she did not know. The LPN was asked who was the NP that told her to send the resident to the infusion center appointment and the LPN identified the NP as NP # 1. The LPN was asked what time did she speak with NP #1. The LPN stated that she didn't remember.

LPN # 3 was asked if the transporters taking Resident # 2 to her appointment seemed concerned in the resident's condition. The LPN stated that they didn't seem concerned and if they did they did not express that to her.

LPN # 3 stated that at approximately 11:00 a.m. that morning she got a call from the infusion center (individual was not identified) and they (infusion center) had asked who the LPN had spoke with that morning and the LPN told them O#2 and further stated that she (woman at infusion center) acted as though she did not know who O#2 was.

The LPN was asked if she obtained a blood sugar reading on Resident # 2. LPN # 3 stated that she did not and stated that the resident was not listed as a diabetic for us (the facility). The LPN was informed that the resident had a diagnosis of

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diabetes.

NP #1 was interviewed on 03/08/17 at 8:20 a.m. The NP stated that he had only seen the resident 2 or 3 times while she was here at the facility and further stated twice in January and once in February that the resident was actually seen by the NP. The NP stated that he last seen this resident on 02/06/17 and wrote a progress note at that time. The NP stated that he did not see the resident on 02/17/17, that the resident was already gone to the appointment when he arrived at the facility and he had not received any calls from the facility with concerns regarding Resident # 2 at anytime. The NP was asked if he was made aware of any concerns regarding Resident # 2, once he arrived at the facility that morning. The NP stated, "No, I did not." The NP stated that I would have had a note if I had seen her and I had a list of 15 patients to see that day and she wasn't on the list, so I didn't see her, as far as I knew she went out to her regular appointment as usual, no concerns. The NP stated there is a communication book if a resident has issues, they should have documented that she was altered. The NP stated that he received no notification that anything was wrong on the 17th or he would have seen her and based on that assessment triaged with the physician if needed. The NP stated that the staff call me first and if needed, he (NP) will call the physician.

The NP was asked if had spoke with LPN # 3 that morning and told her (LPN # 3) to go ahead and send the resident to the infusion appointment. The NP stated, "I have no recollection of that, I would have remembered that." The NP stated that he was unaware that any of this was going on. The NP stated that it would have been

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appropriate for staff to notify me (NP) and further stated, "I can't treat what I don't know."

An attempt to contact the night shift nurse (LPN # 5) for interview was made several times without success.

The infusion center was contacted on 03/08/17 at 9:20 a.m. in an attempt to identify O#2. O#2 was found to be an operator for the infusion center. O#2 stated that all calls come through the call center and if immediate assistance is needed the physician is paged for the person calling. O#2 stated that he recalled LPN # 3 calling that morning an informing him of the resident being lethargic and not her normal state. O#2 stated that LPN # 3 had called approximately 8:30 a.m. and he entered the information into an email, while on the phone with LPN # 3 and sent that information to the infusion center. O#2 gave his title as an access associate, not a medical professional. O#2 stated that he did not know what the turn around was on emails, as far as how long it would take for someone to check that email and that it could essentially still be sitting there. O#2 could not provide an exact time when the email was sent, but estimated it to be at approximately 8:35 a.m.

The 24 hour report book was reviewed on 03/08/17 at 12:50 p.m. The book documented an entry by LPN # 3 on 02/17/17 for 'dayshift', which documented the resident was with AMS, lethargic and slow to respond and that the resident had an appointment at the infusion center at 9:15 a.m. that morning and that O # 2 had been called and given a message on the resident's condition. The 24 hour report book had an area to check if the physician and/or family

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were notified, neither were marked to evidence that the anyone was notified of Resident # 2's change in condition.

The DON (director of nursing) was asked for a policy on physician notification and the SBAR (situation/background/appearance/review and notify) form used by nurses on 03/08/17.

A policy titled, "Change in Condition" was presented and reviewed and documented, "...to maintain the resident's safety, a resident's change in condition will be collected and reported in a timely manner...when a change in condition occurs, the nurse shall collect and document/report the following baseline information as needed: ...vital signs...neurological status...level of consciousness...cognitive and emotional status...onset, duration, severity...all active diagnoses...before contacting a physician about someone with an acute change of condition, the nursing staff will make pertinent observations and collect information to report to the physician...the nurse will contact the physician about a significant change in condition..."

The SBAR form documents, "...Before calling the physician/NP/PA(physician's assistant)/other health care professional: Evaluate the resident: Complete relevant aspects of the SBAR form below Check Vital Signs: BP, pulse and/or apical heart rate, temperature, respiratory rate, O2 saturation, and finger stick glucose for diabetics; Review record: Recent progress notes, labs, medications, other orders;...have relevant information available when reporting..." The remainder of the form had areas for detailed information to be filled in or checked off and

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F 157	Continued From page 10 included, but was not limited to: symptoms, diagnoses, mental status evaluation, functional status, behavior status, respiratory status, cardiovascular status, abdominal/GI evaluation, urinary, skin, pain, and neurological status. This type of form could not be located for Resident # 2. The DON and administrator were made aware of the serious concerns regarding Resident # 2's change of condition, without physician notification. The DON agreed with concerns regarding the physician not being notified. No evidence could be located or presented to evidence that Resident # 2's physician was notified and/or made aware of the resident's condition, as a result the resident was transported to a routine visit, where the resident was found essentially unresponsive, where life saving measures were initiated, the resident subsequently expired two days later at the MICU (medical intensive care unit) at the hospital. This is a complaint deficiency.	F 157	**F 309** 1. Resident #2 was discharged from the facility on 2/17/17. 2. An audit was completed on 3/15/17 by the Unit Managers of the current residents' medical records to ensure residents with a change of condition within the past 30 days had assessments completed as required. 3. The Licensed Nurses were reeducated on 3/15/17 by the Staff Development Coordinator on the requirements of completing and documenting assessment when there is a change in condition. 4. The Director of Nursing or the Unit Manager will audit 5 current residents' medical records on each of the 3 units weekly for 4 weeks and monthly for 2 months to ensure assessments continue to be completed with changes in conditions as required. The Director of Nursing will submit a report to the Quality assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up. Completion Date:	03/24/17
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 11 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to complete a thorough assessment and provide necessary care and services to maintain the highest practicable well being for one of 5 residents in the survey sample (Resident # 2), which resulted in harm. The facility staff failed complete a thorough and accurate assessment for Resident # 2 for a significant change in condition, resulting in harm. The resident was found to have a significant change in physical and mental status, was sent to a regularly scheduled infusion appointment, the resident arrived essentially unresponsive, was sent to hospital and subsequently expired two days later. Findings include: Resident # 2 was admitted to the facility originally on 01/05/17, with the most current readmission on 02/02/17. Diagnoses for Resident # 2	F 309		

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included, but were not limited to: gastritis w/ history of bleeding, chronic kidney disease, anemia, muscle weakness, hypothyroidism, obesity, HTN (high blood pressure), DM (diabetes mellitus) and Von Willebrand disease (a severe bleeding disorder).

The most current full MDS (minimum data set) was an admission assessment dated 02/09/17. This MDS assessed the resident with a cognitive score of "13", indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive to total assistance from at one to two staff members for most ADL's (activities of daily living).

An admission MDS assessment, dated 01/12/17 was reviewed for comparison. This MDS assessed the resident as having a cognitive score of "14", again indicating the resident was cognitively intact. The resident triggered in the CAAS (care area assessment summary) section of this MDS for, but not limited to: ADL's and urinary.

During a complaint investigation on 03/07/17, Resident # 2's closed clinical record was reviewed.

Resident # 2 was admitted originally on 01/05/17 and discharged to the hospital on 01/25/17 for anemia and relative hypotension.

The resident was readmitted back to the long term care facility on 02/02/17. Admission orders for the resident did not evidence any antihypertensive medications had been reordered on this admission and no medications for the

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treatment of diabetes had been ordered for the resident on this readmission.

A BIMS (brief interview for mental status) form dated 02/02/17, documented that the resident had a cognitive score of "15", indicating the resident was cognitively intact in decision making skills.

Nursing notes were reviewed. A nursing note dated 02/17/17 and timed 8:45 a.m. documented, "Resident noted to have an altered mental status change. Resident slow to respond and lethargic. Resident was able to follow some commands very slowly. This nurse spoke with (name of person) [identified as O (Other) # 2] at (initials of infusion center) in relation to resident condition. O#2 will make infusion center aware. Resident out of facility at 8:40 a.m. via priority in poor condition...signature of LPN [Licensed Practical Nurse] # 3.

No information was found in the nursing notes and/or in the clinical record to indicate that LPN # 3 had notified the physician of Resident # 2's significant change in condition. No vital signs could be located, no assessment information for the resident and no evidence of notification to the physician could be located.

Resident # 2's physician's orders were then reviewed, no physician's orders were found during this time frame. One physician's progress note was found, dated 02/06/17.

No other information regarding Resident # 2's significant mental status change on the morning of 02/17/17 could be found.

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Hospital records were obtained and reviewed at this time.

The ED (emergency department) records were reviewed. The ED records dated 02/17/17 and timed 10:04 a.m. (approximately 1 hour and 25 minutes after the resident left the facility) documented, "...Altered mental status Hypoglycemia [low blood sugar]...history of GI bleed...DM who presents to the ED via tx [treatment] from cancer center (medic 5) with complaints of altered mental status and hypoglycemia. Per EMS [emergency medical services], (name of resident) arrived at the cancer center today for an infusion and was found lethargic, altered, and semi-unresponsive, with a blood sugar of 16. After receiving 1 amp of D50 [dextrose] EMS reports that her blood sugar is now 97 and she is more responsive but still lethargic. The patient's last blood pressure was 98/70...unable to perform ROS [review of systems] mental status change...urinalysis...color red...leukocyte esterase large...bacteria many...CT of head...no acute intracranial abnormalities...CT of abdomen...No evidence of hemorrhage...XR [xray] chest...bibasilar atelectasis and small bilateral pleural effusion...could represent pneumonia...ED course: ...presenting from infusion center for hypoglycemia, hypotension, AMS [altered mental status]. Tachycardic [high heart rate]...respiratory distress...possible contributing septic shock...The patients treatment in critical care status was because the patient had acute altered mental status, was hypotensive, was hypoxic, was in acute respiratory failure and was septic. The care provided during this time included providing blood product administration, fluid administration, oxygen therapy and pressor medication..."

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The hospital discharge summary dated 02/19/17 (the date the resident expired at the hospital), documented, "...per (name of long term care facility) where she lives, she went to bed last night [02/16/17] in her normal state of health. This morning [02/17/17] on awakening she was found to be lethargic and following commands, but doing so slowly...Septic shock 2/2 [secondary to] GNR [gram-negative rod] bacteremia..."

LPN # 3 was interviewed on 03/07/17 at 2:40 p.m. regarding Resident # 2 and her condition on 02/17/17. LPN # 3 stated that the resident had appointments with the infusion center every other day and she had an appointment that morning (Friday February 17, 2017). The LPN further stated that she had came in that morning and got report from the night shift nurse (LPN # 5), the night shift nurse told her (LPN # 3) that the resident was slow to respond and lethargic and had asked LPN # 3 to go assess the resident. The LPN stated that she went to the room and checked on the resident and confirmed that the resident had a mental status change from her normal self and was slow to respond and lethargic. The LPN stated that the resident was not able to give any details or anything specific, basically yes no answers to questions, but was very slow. The LPN stated that this was not Resident # 2's usual self, because she could normally converse and let you know what was going on with her, she was able to make her needs known. The LPN was asked if she got a set of vital signs on the resident. The LPN stated, "I didn't put them in my note, but I'm sure I did." The LPN was asked, where would those be documented. The LPN stated again that she did not document them in her note. The LPN stated

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that she probably just had them written down on a piece of paper. The LPN was asked if she remembered whether the vital signs were normal or abnormal. LPN # 3 stated that she could not remember. LPN # 3 was asked if the night nurse(LPN # 5) assessed the resident. LPN # 3 did not know if the night shift nurse assessed or not.

The LPN was asked if she notified the physician. The LPN stated that she did not, the night shift nurse had notified the NP and that the NP was there at the facility that day and the NP said it was ok for her (resident) to go to her appointment, it was early in the morning. The LPN stated that the NP was aware before she (LPN # 3) had even got to the facility and did not know if the nurse had assessed the resident or not. The LPN stated that there is a 24 hour report book and she was not sure what was in the book for that day. The LPN again stated that the night shift nurse spoke with the NP.

The LPN was again asked why the resident was sent to the infusion center and not to the emergency room without physician notification. The LPN stated that the resident had an appointment that morning and that she called O#2 at the infusion center and told O#2 to inform the infusion center of the resident's condition, so they would know when the resident arrived. The LPN was asked what O#2's last name was. The LPN did not know. The LPN was asked what was O#2's title, was he a medical professional or an operator. LPN # 3 stated that she did not know.

LPN # 3 was again asked why she sent the resident to the infusion center instead of the emergency room. LPN # 3 stated, "The NP told

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me it was ok [for resident] to go to the appointment. The LPN was asked if an order was received for that. The LPN stated that she did not know. The LPN was asked if the NP wrote a note. The LPN stated again that she did not know. The LPN was asked who was the NP that told her to send the resident to the infusion center appointment and the LPN identified the NP as NP # 1. The LPN asked what time did she speak with NP #1. The LPN stated that she didn't remember.

LPN # 3 was asked if the transporters taking Resident # 2 to her appointment seemed concerned. The LPN stated that they didn't seem concerned and if they did they did not express that to her.

LPN # 3 stated that at approximately 11:00 a.m. that morning she got a call from the infusion center and they (infusion center) had asked who the LPN had spoke with that morning and the LPN told them O#2 and further stated that she (woman at infusion center) acted as though she didn't know who O#2 was.

The LPN was asked if she obtained a blood sugar reading on Resident # 2. LPN # 3 stated that she did not and stated that the resident was not listed as a diabetic for us.

NP #1 was interviewed on 03/08/17 at 8:20 a.m. The NP stated that he had only seen the resident 2 or 3 times while she was here at the facility and further stated twice in January and once in February. The NP stated that he last seen this resident on 02/06/17 and wrote a progress note at that time. The NP stated that he did not see the resident on 02/17/17, that the resident was

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already gone to the appointment when he arrived at the facility and had not received any calls from the facility with concerns regarding Resident # 2 at anytime. The NP was asked if he was made aware of any concerns once he arrived at the facility that morning. The NP stated, "No, I did not." The NP stated that, I'd had a note if I had seen her and I had a list of 15 patients to see that day and she wasn't on the list, so I didn't see her. The NP stated there is a communication book if a resident has issues, they should have documented that she was altered. The NP stated that he received no notification that anything was wrong on the 17th or he would have seen her and based on that assessment triaged with the physician if needed. The NP stated that the staff call me first and if needed, he (NP) will call the physician.

The NP was made aware that there was little documentation and no assessment information on the resident such as vital signs. The NP stated, "...if she'd had vital signs that would have been good." The NP further stated that an initial set of vital signs determines what you do, they didn't have any. The NP stated that the resident's blood sugars had been running normal and stated that the facility was checking them periodically. No evidence of blood sugar checks could be located for Resident # 2 for this admission (02/02/17) to the facility.

The NP stated that the resident's condition would have qualified for an assessment. The NP was asked if had spoke with LPN # 3 that morning and told her to go ahead and send the resident to the infusion appointment. The NP stated, "I have no recollection of that, I would have remembered that." The NP stated that he was unaware that

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any of this was going on. The NP stated that it would have been appropriate for staff to notify me (NP) and further stated, "I can't treat what I don't know."

The infusion center was contacted on 03/08/17 at 9:20 a.m. in an attempt to identify O#2. O#2 was found to be call center operator for the infusion center. O#2 stated that all calls come through the call center and if immediate assistance is needed the physician is paged for the person calling. O#2 stated that he recalled LPN # 3 calling that morning an informing him of the resident being lethargic and not her normal state. O#2 stated that LPN # 3 had called approximately 8:30 a.m. and he entered the information into an email, while on the phone with LPN # 3 and sent that information to the infusion center. O#2 gave his title as an access associate, not a medical professional. O#2 stated that he did not know what the turn around was on emails, as far as how long it would take for someone to check that email and that it could essentially still be sitting there. O#2 could not provide an exact time when the email was sent, but estimated it to be at approximately 8:35 a.m.

The 24 hour report book was reviewed on 03/08/17 at 12:50 p.m. The book documented an entry by LPN # 3 on 02/17/17 for 'dayshift', which documented the resident was with AMS (Altered Mental Status), lethargic and slow to respond and that the resident had an appointment at the infusion center at 9:15 a.m. that morning and that O # 2 had been called and given a message on the resident's condition. The 24 hour report book had an area to check if the physician and/or family were notified, neither were marked to evidence that the anyone was notified of Resident

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2's change in condition.

An attempt to contact the night shift nurse (LPN # 5) for interview was made several times without success.

CNA # 1 (certified nursing assistant), the CNA that worked the night before the 17th was interviewed and stated that she could not remember clearly, but did not recall the resident being sick or different.

The day shift CNA # 2 from the day before (02/16/17) was interviewed and stated that she did not notice anything unusual that the resident was acting normal to her.

OS (other staff) # 3, also known as the COTA (certified occupational assistant) was interviewed on 03/08/17 at 2:20 p.m. The COTA stated that he remembered that day, 02/17/17 and he had came to work with Resident # 2 around '7:30 ish' and noticed immediately that the resident was not her normal self, closing her eyes, not as coherent, and even when the resident is tired she would normally be conversing and she wasn't that morning. The COTA stated that he went into the hall and looked for Resident # 2's nurse (LPN # 5/night nurse) and could not find her, but did find the night shift nurse for the other hall (identified as LPN # 4). The COTA stated that they both went into the resident's room and did an O2 (oxygen) saturation on the resident and that it was not registering and her heart rate was up between 99-110 on the pulse ox. The COTA then stated that he left to go treat another resident and was giving the nurse time to do what she needed to do with the resident and then he returned about 8:00 or 8:15 to attempt to work (therapy) with the

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resident again. The COTA stated that at about that same time transport was coming to pick the resident up for her infusion appointment and he helped the transporters get the patient onto the stretcher, at that time LPN # 3 and LPN # 4 were in the room at the same time and they were conversing back and forth about whether the resident should go to the emergency room or on to the appointment. The COTA stated that he did not know and did not hear discussion of an assessment being done, of the physician being notified or anything about any other vital signs being obtained, he knew for sure about the pulse ox at approximately 7:35 because he was there with LPN # 4, shortly after 7:30 a.m.

Resident # 2's CCP (comprehensive care plan) was reviewed and documented the following, "...Full code...my family and staff are made aware of my FULL CODE status....the resident will remain free from UTI (urinary tract infection) related to incontinence...assist with bed pan as needed...assist with peri care personal hygiene as needed...Monitor/document for s/sx (signs and symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns...."

The DON (director of nursing) was asked for a policy on physician notification and the SBAR (situation/background/appearance/review and notify) form that nurse's use on 03/08/17.

A policy titled, "Change in Condition" was presented and reviewed and documented, "...to maintain the resident's safety, a resident's

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change in condition will be collected and reported in a timely manner...when a change in condition occurs, the nurse shall collect and document/report the following baseline information as needed: ...vital signs...neurological status...level of consciousness...cognitive and emotional status...onset, duration, severity...all active diagnoses...before contacting a physician about someone with an acute change of condition, the nursing staff will make pertinent observations and collect information to report to the physician...the nurse will contact the physician about a significant change in condition..."

The SBAR form documents, "...Before calling the physician/NP/PA(physician's assistant)/other health care professional: Evaluate the resident: Complete relevant aspects of the SBAR form below Check Vital Signs: BP, pulse and/or apical heart rate, temperature, respiratory rate, O2 saturation, and finger stick glucose for diabetics; Review record: Recent progress notes, labs, medications, other orders;...have relevant information available when reporting..." The remainder of the form had areas for detailed information to be filled in or checked off and included, but was not limited to: symptoms, diagnoses, mental status evaluation, functional status, behavior status, respiratory status, cardiovascular status, abdominal/GI evaluation, urinary, skin, pain, and neurological status. This type of form could not be located for Resident # 2.

A meeting was conducted with the survey team, the DON and administrator on 03/08/17 at approximately 3:00 p.m. The DON and administrator were made aware of the serious

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F 309	Continued From page 23 concerns regarding Resident # 2's change of condition and that there was not assessment information for the resident, and the resident's physician was not notified. No evidence could be located or presented to evidence that Resident # 2's physician was notified and/or made aware of the resident's condition, no evidence could be located to evidence any type of assessment was completed on this resident, as a result the resident was transported to a routine visit, where the resident was found essentially unresponsive and several life saving measures were initiated, the resident subsequently expired two days later in the MICU (medical intensive care unit) at the hospital. This is a complaint deficiency.	F 309		