DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. BUILDING ______ B. WING ______	C 07/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER	1200 WEST NISHNA ROAD SHENANDOAH, IA 51601

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F 000	INITIAL COMMENTS Correction date 7-6-17. Complaints #68190-C and # 69001-C were substantiated. Complaint #67278-C was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
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. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Laird
TITLE: ADM
(X6) DATE

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.

POC accepted 7/31/17 [illegible]

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F 309	Continued From page 1 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 clinical record review, policy review, and interviews with staff and physician, the facility failed to ensure one (1) of three (3) residents received services to maintain the highest physical wellbeing. Record review and staff interviews revealed the facility failed to complete adequate assessments of Resident #1's decline in condition and edema. Record review revealed Resident #1 normally independent with ambulation (to and from bathroom and for meals); however staff interviews revealed a decline in the resident's urinary needs, decline in mobility and increased pain when standing and needing more assistance with activities of daily living. Record review revealed the resident sent to the emergency room per his/her family request and required hospitalization for his/her care. The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/6/17 listed Alzheimer's disease, depression, weakness, difficulty walking and cognitive communication deficit among Resident #1's diagnoses. The MDS noted Resident #1 scored 5 out of 15 on the BIMS (brief interview for mental status), which indicated severe cognitive	F 309		

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F 309	Continued From page 2 impairment. According to the MDS, PRN (as needed) pain medication had been prescribed for occasional pain Resident #1 rated as 7 on a scale of 1 to 10. The MDS noted that Resident #1 required the limited assistance of one person to transfer between surfaces, including to or from bed, chair, wheelchair or standing position. According to the MDS, Resident #1 also required the limited assistance of 1 person to walk in his/her room with a walker. The assessment noted he/she had not been considered steady, but could stabilize without staff assistance. The resident also required limited assistance of 1 person to get dressed. The MDS revealed Resident #1 required the supervision of one person for personal hygiene and toileting. The 7/14/16 revised care plan noted Resident #1's needs should be anticipated and met. The care plan also noted Resident #1 had an ADL (activities of daily living) self-care deficit related to stroke, dementia, fatigue and COPD (chronic obstructive pulmonary disease). As a result, supervision should be provided PRN for increased confusion and agitation. The 7/28/16 revised care plan instructed staff to administer medication as ordered. The 12/6/16 care plan noted Resident #1's risk of unidentified pain related to arthritis. According to the care plan, the resident's normal activities should not be interrupted by pain. The care plan instructed staff to identify, record and treat the resident's existing conditions which may cause increased pain and/or discomfort. The care plan also instructed staff to monitor and document for probable cause of each pain episode and remove/limit the cause where possible. The care plan further instructed staff to monitor, record and report any non-verbal	F 309		

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F 309	Continued From page 3 sign and/or symptom of pain; like changes in breathing, vocalizations, mood and/or behaviors, facial expressions or body postures. According to the care plan, staff should notify the physician if interventions are unsuccessful or if the current complaint exhibited a significant change from the resident's past experience of pain. The care plan noted that the nurse should be notified of any change in usual activity attendance. The Order Summary Report dated 2/28/17 documented one to two tablets of Tylenol 500 mg (milligram) should be taken by mouth every 6 hours as needed for complaints of pain. The May 2017 MAR (Medication Administration Record) documented that one to two tablets of Tylenol had been administered to Resident #1 on only two occasions between 5/1/17 and his/her discharge date of 5/15/17. The MAR also noted that Lasix 20 mg had been administered daily between 5/11/17 and 5/15/17. A Progress Notes under a Health Status Note dated 5/3/17 identified TED hose (compression socks) had been ordered with directives to apply in the morning and removed at bedtime. A doctor's order/progress note dated 5/10/17 documented that Resident #1 had been seen for swelling [edema in ankles], chronic kidney disease and Alzheimer's dementia. The note also documented labs had been checked and new orders included Lasix (water pill) 20 milligrams at noon every day, increased water consumption and to elevate the resident's legs in bed twice a day. The physician ordered staff to notify him if Resident #1 had not gotten better in 10 to 14 days.	F 309		

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A Progress Notes under Health Status Note dated 5/14/17 by Staff A, LPN (licensed practical nurse) indicated Resident #1 had swelling to his/her right knee and 3+ pitting edema (numerical scale of 1+ to 4+ that describes impressions left on the resident's swollen skin after being pressed on (4+ being the worst)) on both feet. The resident's feet were up in the recliner with an ice pack applied to the knee. The resident exhibited some facial grimacing as the nurse applied lotion to his/her legs.

A Progress Note under Health Status Note dated 5/15/17 by Staff B, RN (Registered Nurse) indicated that Resident #1's bilateral (both) lower extremity edema continued at 3+ with right knee swelling. According to the document, the resident's pedal (foot) pulses were palpable (able to be felt), extremities were warm with capillary refill less than 3 seconds (color returned after the nurse stopped squeezing the toes). The resident continued on Lasix 20 mg. An appointment had been made for Resident #1 to see the doctor on 5/16/17 at the family's request.

A Progress Note under Health Status Note dated 5/15/17 by Staff C, LPN, revealed that with a doctor's order, Resident #1 went to the ER (Emergency Room) for edema at 3:15 p.m. per the family's request. Staff C also noted that he called the ER at 7:15 p.m. and received information that Resident #1 had been admitted to the hospital for edema.

The Patient Care Report dated 5/15/17 authored by the Ambulance Service noted they arrived at the facility on 5/15/17 at about 3:15 p.m. According to the paramedic's assessment, an IV

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F 309	Continued From page 5 had been started and IV pain medication had been administered for severe pain. The assessment revealed the resident had tenderness/pain in his/her pelvis, edema and pain in his/her left hip, ankle and knee and right ankle. The resident also had lower left abdominal pain. The paramedic also noted family members informed him that Resident #1 had CHF (congestive heart failure). According to the paramedic, the resident's lower extremities had substantial pitting edema from the knees down, but no redness. Initially the resident denied pain when asked, but pointed to his/her left mid abdominal area when asked where he/she felt pain. The paramedic noted that family thought he/she might have fallen recently, but did not know for sure. The paramedic documented Resident #1 "yelled out" in severe pain when he moved his/her legs. The paramedic had not noticed any swelling or deformities to his/her legs. The paramedic documented he noticed dried dark urine on the back of the resident's t-shirt. He also said Resident #1's room had a strong urine smell to it. When they rolled the resident, they noticed a strong ammonia/urine smell and urine soaked clothes from the middle of Resident #1's back to the backs of his/her legs. The paramedic noted that Resident #1 yelled in pain when 6 people lifted him/her from the recliner to the cot. According to the paramedic, the resident's vital signs were WNL (within normal limits). He said Resident #1 had not tolerated the ride very well, so he administered another dose of IV pain medication just as they arrived at the ER. The ER note dated 5/15/17 at 4:27 p.m. and authored by the ER RN documented Resident #1 arrived with family accompaniment and complaints of edema and leg pain. The "Objective	F 309		

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Statement" noted the resident had transported by ambulance to the ER from the facility with increased lower leg edema since yesterday. According to the report, nursing home staff stated Resident #1 started Lasix 20 mg on 5/11/17 without improvement. The RN also documented 3+ to 4+ edema to feet and 1+ to 2+ to both lower legs which are painful to touch. The RN also noted Resident #1 smelled of urine and his/her clothes were soiled with wet and dry urine. According to the RN, family members indicated the resident had been in his/her recliner since Saturday. Finally, the doctor instructed the report should be faxed to Resident #1's PCP (primary care physician).

The ER Provider Note dated 5/15/17 at 4:22 p.m. and authored by the ER physician noted Resident #1 complained of edema and leg pain. According to the physician the resident's presenting symptoms were abdominal distention, constipation, nausea and urinary incontinence with pain rated 9 out 10. The Objective Statement noted that Resident #1 had been transported to the ER with severe left leg pain, bilateral leg swelling and abdominal distention. According to the report, Resident #1 had been assessed as positive for 3+ edema and joint pain/swelling. The Doctor's Physical Exam noted the resident as "well appearing, well nourished, awake, alert/oriented to person, place, time/situation and not in apparent distress. According to the abdominal exam, his/her abdomen was firm, distended and positive for guarding. The physician noted hypoactive bowel sounds in all four quadrants. The exam also included that Resident #1's skin had been assessed as a normal color, warm, dry, intact and no evidence of trauma. Indications for left hip X-rays were

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F 309	Continued From page 7 documented as hip pain with no known trauma. The results were noted as mild degenerative changes of the left hip and a possible minimally displaced transverse fracture of the upper aspect of the greater trochanter (thigh bone). The report listed diagnoses as anasarca , chronic renal insufficiency (state III) and leukocytosis (increase in white blood count). [Anasarca is defined as extreme generalized edema, is a medical condition characterized by widespread swelling of the skin due to effusion of fluid.] The resident's disposition was stable as being admitted to the medical surgical floor of the hospital. The Hospital Admission Note dated 5/15/17 at 9:29 p.m. and authored by the RN indicated Resident #1 had been admitted from the ER for a UTI (urinary tract infection). According to the document, the last time Resident #1 had been known to be "well" was 5/13/17. The document noted that due to the resident's current level of function he/she required assistive equipment and person for ambulation, bathing, dressing, toileting and transferring. The RN noted that Resident #1 had been walking independently until last weekend when he/she had a change in functional level. The RN documented that the resident complained of acute pain/discomfort. A list of Current/Past Medical History included Alzheimer's, stroke, DVT (deep vein thrombosis), distended colon, arthritis and an occasional episode of urinary incontinence. The report noted that no pressure ulcers had been observed during admission. An interview on 6/28/17 at 9:30 a.m. with Resident #1's Primary Care Physician (PCP) stated he had not received the ER report as the ER physician had instructed. According to the	F 309		

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PCP, his records indicated he visited Resident #1 on 5/10/17 for edema secondary to inactivity among other things. The PCP also said Resident #1 had arthritic knees, swelling in bilateral lower extremities with slight discomfort, but no acute distress when he visited the resident.
The PCP accessed a death certificate on the computer and stated cardio pulmonary failure and chronic kidney disease among the causes of death for Resident #1. Further discussion indicated that he had never observed Resident #1 being unclean during any of his visits.

An interview on 6/28/17 at 10:46 a.m. with the ER doctor revealed she saw Resident #1 on 5/15/17 at 4:22 p.m. for bilateral lower extremity edema, pain and abdominal distention. The doctor stated Resident #1 "reeked" of urine. When asked, the doctor stated "if he/she couldn't have been kept any cleaner, he/she should have been sent sooner". The doctor also stated Resident #1 should have been sent to ER sooner based on his/her physical condition.

An interview on 6/22/17 at 9:50 a.m. with the Interim Administrator/DON revealed they sent Resident #1 to the ER for edema. She said his/her family sent the resident somewhere else so they do not have summary of discharge. According to the DON, Resident #1's family member came to the facility and alleged Resident #1 had been left in "pee pants" for 3 days. According to the DON, the family member's accusations were false; they did not leave him in "pee pants" for 3 days.

An interview on 6/26/17 at 10:30 a.m. with Staff C revealed he had just started his 2:00 p.m. to 10:00 p.m. shift on 5/15/17 when Resident #1's

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F 309	Continued From page 9 family approached him and said they wanted something done about the resident's swollen legs. Staff C said he had been off work over the weekend. According to Staff C, Resident #1 had a doctor's appointment in the next day or two. The LPN said evidently other nurses weren't doing much because it was just edema and the resident had an appointment". According to the LPN, the DON said Resident #1 should not be sent out because he/she had an appointment to be seen for edema. Staff C said the facility had a new corporate protocol in which staff should contact the DON and talk about exhausting everything they could do for residents within the facility before sending them out. The LPN said he told the family about the appointment and if they wanted to contact the doctor to have Resident #1 sent to ER she could, which she did. The LPN said he spoke to the doctor's nurse who gave him the telephone order. According to Staff C, he and a couple other staff assisted 3 EMS workers to lift Resident #1 from the recliner to the gurney once they arrived. When asked what his assessment of Resident #1 revealed, Staff C said Staff B had been an extra nurse that day and she completed the assessment and entered it into the computer. Staff C said he could smell urine, but nothing that would have indicated he had been sitting in it for too long. Staff C said once they lifted the resident the stench was awful. The family complained of the resident sitting in the recliner for days and being soaked in urine. Staff C said the resident had expressed so much pain when they lifted him/her he did not say the resident should be cleaned up before being transported. Staff C said he questioned Staff G after the fact who said she knew the resident had edema. According to Staff C, Staff G reported the resident would not have been able to walk without assistance that day.	F 309		

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F 309	Continued From page 10 On 6/26/17 at 11:00 a.m. with Staff G, RN revealed she worked 5/15/17. Staff G said another nurse had assessed Resident #1. She recalled family members were adamant about Resident #1 being sent to the ER. According to Staff G, she agreed because the resident was not in good shape. Staff G said if she remembered right, the resident's abdomen had been slightly distended (bloated), their vital signs were not WNL (within normal limits), he/she had an elevated temp and complained of not feeling good. The RN recalled Resident #1's family saying he/she had not been acting like him/herself. Staff G said she had been in charge of the hall where Resident #1 resided that day, but the extra nurse dealt with it because the situation required so much attention. Staff thought the family had been there since about 10:00 a.m. or 11:00 a.m. An interview on 6/26/17 at 11:30 a.m. with Staff B, revealed that she remembered 5/15/17 when Resident #1's family member wanted the resident to been seen by the doctor for swelling of an arthritic knee and edema in both of his/her lower legs, despite just having been seen by the doctor the week before. According to Staff B, the family member seemed a little upset, she contacted the clinic at the family member's request and informed them as she left the building. The RN did not have a scheduled time and date of appointment yet, but she contacted the family member again and relayed that information when she received it. The RN said she had not heard from the resident's family until Resident #1's son/daughter and another family member arrived at the facility at some time about shift change. Staff B said she heard some commotion and	F 309		

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F 309	Continued From page 11 overheard the family telling another nurse they were going to call the ambulance themselves. Staff B said she assessed Resident #1 at 1:06 p.m. According to the RN, the family had not been there during the assessment and she did not smell urine or notice Resident #1 being wet at that time. Staff B also said there had been no discussion about Resident #1 being wet or smelling like urine earlier. Staff B said she had been Resident #1's nurse over the weekend and realized he/she had edema. The RN said he/she had developed edema the week before and had Lasix prescribed. According to Staff B Resident #1 remained independent over the weekend before being sent to ER, but she had not asked him/her to get up. The RN said the resident had not reported any pain until Sunday. According to Staff B, a family member informed her Resident #1 had swelling and pain, at which time an ice pack and bio freeze (topical pain reliever) had been applied by her and the on-coming nurse. Staff B said she did not recall Resident #1 having a foul odor or wet clothes on either Sunday or Monday. According to Staff B, she could not recall if the resident wore different clothes over the weekend, but did recall he/she never appeared to be extremely unkempt or disheveled. An interview on 6/26/17 at 12:45 p.m. with Staff D, CNA, revealed that she worked 2:00 p.m. to 10:00 p.m. on Saturday 5/13/17, Sunday 5/14/17 and Monday 5/15/17. According to the CNA, Resident #1 had been feeling "icky" for a few days prior to being sent to ER on 5/15/17. Staff D said she told the nurse (Staff A) on Saturday 5/13/17. Staff D also said the day shift told her Resident #1 had not gotten up for breakfast or lunch and had not gotten up much during the day. Staff D told them she would check on Resident	F 309		

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	165531	A. BUILDING ______ B. WING ______	C 07/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW CARE CENTER	1200 WEST NISHNA ROAD SHENANDOAH, IA 51601

(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 309	Continued From page 12 #1. According to Staff D, when she and a coworker physically attempted to get the resident up, he/she would not stand. The CNA said Resident #1 had not complained of pain, so they had a room tray sent. Staff D said the resident historically had been independent with toileting, and the daytime CNAs had not said anything had changed. The CNA said she asked Resident #1 and he/she seemed confused. She said she checked the resident, but he had been dry. Staff D said she told the nurse she thought Resident #1 had been getting up independently because of being dry. According to Staff D, they went to get Resident #1 up for dinner, but he/she could not get up. Staff D said she thought that was weird because the resident had always been independent. She picked up his/her dinner tray and said Resident #1 declined when asked if he/she wanted to go to the bathroom. Staff D said she checked him/her again about a half an hour later and the resident had still been dry. She said he/she had not eaten or drank much from the dinner tray, so she thought that could account for why he/she remained dry. According to Staff D, she passed that onto the oncoming shift. When the CNA reported to work on Sunday, she noticed Resident #1 had on the same clothes he/she wore the day before, as he/she often did. Staff D said the resident had been independent and had always been good about picking out his/her own clothes and getting dressed by him/herself. The CNA also said the resident typically remained continent. She said the daytime staff told her at shift change that he/she had not been getting up much and they assumed he/she had been toileting independently. Staff D said she checked him/her shortly after 2:00 p.m. on her first rounds and discovered Resident #1 had been incontinent of urine. She said she got a new pad, brief and	F 309		

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F 309	Continued From page 13 pants and cleaned him/her up by herself. According to Staff D, the resident complained of leg pain the whole time she helped him/her. The CNA said Resident #1 would not let her change his/her shirt. She said the shirt remained dry. The CNA said once she sat him/her back down, she pulled up his/her pant leg and went and got Staff A. Staff D said they put an ice pack and a blanket on the resident. Staff D said the resident had not eaten anything for dinner. She said Resident #1 remained dry and had not gotten up from the recliner for the remainder of the shift. Staff D said she passed that information onto the overnight shift during report. When the CNA reported to work on Monday 5/15/17, she went into Resident #1's room with the off-going CNA, Staff E. At that time they realized Resident #1 had been incontinent of urine again, which Staff E denied knowing. According to Staff D, Resident #1 seemed very confused, so she went and got the nurse, Staff C, who said "let's try to get him/her cleaned up". Staff D said she, Staff E and Staff C started to put the recliner down and Resident #1 immediately screamed in pain. Staff D said the resident had the same pants on that she changed him/her into the day before. According to Staff D, Resident #1's family member came into the room about that time. Staff D said she excused herself so the family member could talk to the nurse According to Staff D, she told the family member Resident #1 smelled of urine and his/her clothes were wet. Staff D said the family member said not to move Resident #1 because of being in so much pain. The CNA said she, Staff C and another staff member they recruited helped the ambulance crew lift Resident #1 onto the gurney once they got there about 20 minutes later. Staff D said the ambulance crew started an IV and gave the resident some pain medication before	F 309		

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F 309	Continued From page 14 being moved. According to Staff D, Resident #1's family member was very angry that his/her medical issues had not been addressed sooner. Staff D said Resident #1 had a history of knee problems, but she had never seen it get as bad. Staff D said she reported to the nurse how she found the resident wet and it did not seem like the day shift had been helping the resident toilet. Staff D mentioned that once they laid the recliner back she noticed how it had been completely soaked; like a puddle. A subsequent interview on 6/26/17 at 1:45 p.m. with the DON revealed they had noted the change in Resident #1's status on the 24 hour report. She said Resident #1 had a history of arthritic knees and edema. An interview on 6/26/17 at 2:00 p.m. with Staff H, CNA revealed that she arrived at the facility about 1:45 p.m. on 5/15/17 and stated Resident #1 sat in the recliner and had been complaining of pain. Staff H said she heard the resident get mad because they were "messing" with him/her. According to the CNA, she had been off that weekend. She said she remembered the resident being fine the last time she worked. Staff H said she had been standing outside the resident's room when they transferred him/her onto the gurney.. According to her, when they loaded him onto the gurney she saw the resident had been wet. She said he/she had been wet enough that she thought he/she should have been changed before she got there. Staff H said she could only recall one time that she had to help Resident #1 into the bathroom since the end of February when she started at the facility. An interview on 6/26/17 at 2:30 p.m. with Staff A	F 309		

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F 309	Continued From page 15 revealed that she worked with Resident #1 on the 2:00 p.m. to 10:00 p.m. shift over the weekend before he/she had been sent to the ER on 5/15/17. Staff A remembered getting report from Staff B on Sunday 5/14/17 at shift change. According to Staff A, Resident #1's family member wanted to talk to her. According to Staff A, they went into Resident #1's room and the family member asked her what she thought about her parent's knee. Staff A said she told her she had not finished getting report and had not worked with Resident #1 much before then. Staff A said she involved Staff B because she worked with Resident #1 that day. According to Staff A, Staff B told the resident's family member the doctor had recently prescribed Lasix. Staff A said she and Staff B put ice on Resident #1's knee right then and there in the family member's presence. Staff A said she asked the resident's daughter what she wanted to do. According to Staff A, the resident's son/daughter indicated s/he agreed it would be sufficient to continue monitoring his/her parent's condition. When asked about Resident #1 staying in his/her room that night, Staff A stated Resident #1 frequently stayed in his/her room and sometimes did not go to the dining room for meals. According to Staff A, the CNAs were all aware that Resident #1 had been staying in his/her room and that his/her knee was being treated with ice packs. The LPN said Resident #1 historically had occasional episodes of incontinence and they would help him/her. Staff A said changes in a resident's status gets documented on the 24 hour report. An interview on 6/26/17 at 12:10 p.m. with Staff E, CNA (certified nursing assistant), revealed that she denied working the 6:00 a.m. to 2:00 p.m. shift on 5/15/17 prior to Resident #1 being	F 309		

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F 309	Continued From page 16 sent to the ER. As the interview continued, Staff E recalled she did work that day, and said she knew Resident #1 had been having knee problems that day because someone told her. Though Staff E had been assigned to Resident #1's hall that day, she said about the only time they have to help him/her is when he/she has problems with his/her knee. Staff D said she did not help Resident #1 that day. An interview on 6/27/17 at 7:15 a.m. with the DON revealed that daily head to toe assessments are only done for skilled residents. According to the DON, weekly skin assessments are done on all other residents. The DON said Nurses are not expected to do a head to toe assessments on their shifts. The DON said they only chart by exception (only chart things that are not WNL (within normal limits)). When asked if the care plan should be changed to reflect changes in a resident's status, the DON said "yes, when the need arose, even on weekends". The DON denied knowing that Resident #1 had occasional episodes of urinary incontinence. According to the DON, if Resident #1's condition changed, his/her care plan should have been revised to reflect those changes and address his/her needs. According to the DON, she did not believe staff communicated the changes that occurred that weekend very well. The DON said Resident #1 had been admitted to their facility with arthritic knee pain and that was normal for him/her. The DON agreed it was possible the resident's condition had gotten worse than they had ever seen before due to the progression of the disease. A subsequent interview on 6/27/17 at 8:40 a.m. with Staff E revealed that historically, Resident #1	F 309		

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F 309	Continued From page 17 had only been incontinent a couple of times to her knowledge. The CNA said she never had to help Resident #1 clean him/herself up after an episode of incontinence or assist him/her to the toilet. Staff E said the resident usually did all that by him/herself. Staff E denied being told anything about Resident #1's change in status or needing assistance. Staff E said she "peeks in" on residents that are independent. The CNA said Resident #1 ate meals in his/her room a lot. When asked how she would be able to tell if Resident #1 was having problems when she "peeked in" on him/her. Staff E said she usually checked on residents if she noticed they were not in the dining room at meal time, even those that did not usually eat in the dining room. Staff E said she asked Resident #1 if he wanted breakfast the morning of 5/15/17. According to Staff E, the resident wanted to eat in his/her room. The CNA said she did not remember what or how much the resident ate that day. When asked about Staff D's account of how she and Staff D found Resident #1 soaked in urine during shift change on 5/15/17, Staff E said she could not recall the incident. Staff E also said she could not recall Staff D's account of how Resident #1 screamed in pain as she, Staff D and Staff C began the attempt to clean the resident up about the time Resident #1's family member came to see him/her. An interview on 6/27/17 at 9:00 a.m. with Staff F, CNA, revealed that she worked with Resident #1 a lot because she always had good luck with him/her. Staff F said if she noticed Resident #1 had not been getting ready for meals, she made a point to prompt him/her. The CNA said the resident typically went to the dining room for meals as long as she made the effort to	F 309		

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encourage him/her and walk with him/her instead of just saying he/she refused to go, like other staff do. Though she had not been assigned to Resident #1's hall that weekend.

An interview on 6/27/17 at 9:15 a.m. with Staff K, CNA, revealed that although she worked 5/13/17 through 5/15/17, she did not recall working with Resident #1 during that time. Staff K said towards the end of his/her stay, he/she required a little more help getting dressed, going to the bathroom, getting up out of the recliner to stand and putting on his/her socks and shoes. Staff K said she knew she had not worked with him/her at all on the Monday he/she got sent out. She remembered coaxing him/her to go to the dining room, but he/she did not. According to Staff K, staying in his/her room to eat would not have been considered unusual. Staff K also remembered having to help Resident #1 get up to go to the bathroom. According to the CNA, she very well could have done that on both Saturday and Sunday. Staff K said she did not remember if the resident had been incontinent, but she could say with certainty that he/she had gotten up to go the bathroom on both Saturday and Sunday. The CNA said she did not remember Resident #1's family visiting over the weekend. Staff K said the resident had been more independent, but over the last couple weeks she noticed he/she needed more help. According to the CNA, he/she had not been one to use his/her call light, but would summon a staff person walking by if he/she needed something. Staff K said she had not really heard that Resident #1 had been having more trouble than usual in report for those couple weeks preceding the resident's discharge.

An interview on 6/27/17 at 10:00 a.m. with Staff I,

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F 309	Continued From page 19 CNA revealed she knew Resident #1 had been sleeping a lot and had also been hard to arouse to for him/her to eat. Staff I thought she had been told the resident had a UTI, but could not remember for sure. The CNA said Resident #1 had been relatively independent, but thought therapy had been working with him/her because of having more pain in his/her legs. Staff I said she had been noticing that Resident #1 needed more help with everything. According to the CNA, Resident #1 had not been taking him/herself to the bathroom and needed more help the weekend before being sent out to the ER. The CNA said as she recalled, they just stood him/her up and changed him/her after having been incontinent. Staff I said she could not remember if she told the charge nurse or not. She also said she did not think she had been hearing anything about Resident #1's change in condition during report. According to Staff I, she did not remember hearing that he/she required more attention for toileting or checking and changing him/her. An interview on 6/26/17 at 12:25 p.m. with Staff J, CNA revealed that although she worked the day shift on 5/15/17, she did not remember helping Resident #1 with anything in particular. A subsequent interview on 6/27/17 at 2:40 p.m. with Staff D revealed that she could not account for why she documented Resident #1 had been continent the weekend before he/she had been sent to the ER. Staff D wondered if she had gotten so accustomed to charting that Resident #1 remained "continent" that she inadvertently documented that when in fact he/she had definitely been incontinent as she previously told this surveyor. Staff D said while she assisted Resident #1, she had not noticed any bruising or	F 309		

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did not have any knowledge if he/she had fallen. The CNA stated that she got him/her to stand up for about 5 minutes on Sunday 5/14/17 while she got his/her pants and brief changed. She recalled the resident being confused and she could tell it hurt him/her to stand. Staff D said he/she moaned and groaned and said his/her leg hurt. She said the resident did not indicate which leg hurt. The CNA said favored (put more weight on it) his/her left leg with use of a walker. Staff D said the resident did bear some of his/her weight on the right leg too.

Additional interview on 6/27/17 at 4:00 p.m. with the DON revealed they do not have a written policy/protocol about sending people to ER. According to the DON, they had to obtain a doctor's order.

A subsequent interview on 6/28/17 at 12:20 p.m. with Staff B, revealed that she asks residents if they are in pain when she administers medication. According to Staff B, she did a basic assessment of Resident #1 over the weekend related to the new prescription of Lasix. Staff B said she asked Resident #1 about dizziness, checked his/her capillary refill, pulses and edema. Staff B also said Resident #1 denied being in pain. The RN said they chart by exception, and since the assessments on 5/13/17 and 5/14/17 revealed the same abnormal results which she charted on 5/15/17, she probably should have charted them too. According to the RN, she knew the facility expected that. Staff B said she probably would have passed that on to the on-coming nurse, Staff A. She said they were in the middle of report on Sunday when Resident #1's family interrupted them to report Resident #1 had been in pain and she wanted them to look at

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F 309	Continued From page 21 his/her knee. A subsequent interview on 5/28/17 at 2:05 p.m. with the DON revealed her expectations of staff. The DON said she absolutely expected staff to identify changes in residents' status, do a timely and thorough assessment and intervene appropriately. She also expected staff to record their assessments in progress notes, the 24 hour report and relay the information at shift reports and amongst coworkers to keep everyone informed. According to the Notification of Resident Change in Condition policy dated September 2014, staff will notify the doctor and family/responsible party immediately about a change in the resident's clinical condition unless the change had been deemed insignificant. Then notification will be at the earliest convenient time during regular business hours. According to the procedure, current medical orders to treat the change of condition should be verified. Interventions should be implemented as appropriate. The resident's response to the intervention should be evaluated and documented. A physical evaluation should be completed, the results should be documented in the medical record and the care plan should be updated as indicated. The Completion Directions for the 24 Hour Nursing Report Form dated September 2014 identified the purpose as: -To document on-going nursing observation, physician communication, unusual occurrences, change in resident conditions from shift to shift within the nursing department. -To communicate with nursing administration and facilitate follow up.	F 309		

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F 309	Continued From page 22 Instructions include: -The 24 hour report does not replace medical record documentation, but facilitates shift to shift communication and follow up. -Once a resident has been entered on the day shift, there should be follow up with the remaining shifts. -Anything noted on the 24 hour report should have a corresponding entry at the end of their shift. -The nursing administration team with review the 24 hour reports daily at the standup meeting and provide direction for additional follow up.	F 309		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

Date of compliance: 07/06/2017

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It is the practice of Garden View Care center to ensure that residents receive the care and services for the highest well-being.

#1- Resident #1 no longer resides at the facility so no further action is necessary.

#2- For similar residents, the Director of Nursing and Care Plan Coordinator did an audit of residents to identify significant change in condition, assessment or intervention needs on 6-27-2017. Any concerns identified were addressed.

#3- Education was provided on 7-06-2017 to staff regarding identification of significant changes, assessment and intervention practices and expectations. The Director of Nursing or designee will hold huddle meetings 3 times per week for a minimum of 6 weeks to discuss any condition changes or concerns for residents. The Director of Nursing or designee will review nursing documentation for residents a minimum of 3 times per week for the next 6 weeks and randomly thereafter to ensure appropriate assessments and interventions are in place. Any concerns identified will be addressed.

#4- The Director of Nursing will report on the progress of this plan of correction at the monthly QAPI Committee meeting for a minimum of 3 months to ensure ongoing compliance.

Heather Faire ADM/DON 7-21-17