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
-	165586	A. BUILDING _____ B. WING _____	C 06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMELY MISSION NURSING HOME	109 MISSION DRIVE BUFFALO CENTER, IA 50424

(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 VKK 7/3/18 Correction date: June 7, 2018 The following deficiencies were identified during the investigation of complaint #74318-C completed May 23 - June 6, 2018. Complaint 74318-C was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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 (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.	F 580	See Attachment	6-7-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janis Coleman	Administrator	07/05/2018

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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F 580	Continued From page 1 (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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interview, the facility failed to immediately consult with the resident's physician when there was 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 for 3 of 5 residents reviewed. The facility failed to notify the physician of Resident #1 and Resident #2 declines and significant weight losses and other changes identified by staff. The facility failed to immediately notify the physician of Resident #5's condition change. The next day the physician received the fax and the resident went to the	F 580		

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F 580	Continued From page 2 hospital. The facility identified a census of (34) thirty-four residents. Findings include: 1. A MDS with assessment reference date of 1/1/18 assessed Resident #2 with a BIMS score of "0" (severe cognitive impairment) The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required total staff assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The resident was always incontinent of bowel and bladder. The resident was 63 inches tall and 114 pounds. The MDS did not identify a significant weight loss. A Do Not Resuscitate Request (DNR) dated 2/6/17 revealed the resident did not want chest compressions, defibrillation or intubation. The form identified the DNR decision would not prevent the resident from other emergency care which would make the resident more comfortable; comfort measures included but were not limited to: pain medication, fluid therapy and respiratory assistance. Resident Weights A December 2017 MAR revealed the resident weighed 114.2 on 12/26/17. A January 2018 MAR identified the resident weighed 112 on 1/17/18. A February 2018 MAR revealed the resident weighed 104.6 on 2/20/18. The resident lost 7.4 pounds in 1 month (from 1/17/18 to 2/20/18) which was a significant weight	F 580		

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F 580	Continued From page 3 loss. On 2/27/18 the hospital weighed the resident at 97 pounds. A Nutritional Assessment sheet dated 1/3/18 revealed the resident usually took fluid better than food. The resident's appetite varied with the resident often eating less than 50%. The resident had no special food likes. The assessment identified that the resident received Resource 2.0 supplement 60 cc three times a day and 4 ounces of strawberry Ensure three times a day and 4 ounces of yogurt at breakfast. (Resource 2.0 is a high calorie, protein rich nutritional drink to help meet increased protein or calorie requirements. Intended for malnutrition, fluid restriction, inadequate oral intake, and unintentional weight loss. Ensure is a nutrition drink to help maintain a healthy weight. It contains calories, protein, vitamins and minerals). Review of the February 2018 Medication Administration Record (MAR) showed staff signed they administered the Resource drink listed on the nutritional assessment. On 5/30/18 at 12:52 p.m. Staff B LPN (licensed practical nurse) stated she initialed she gave the resident Resource because she offered it. She stated the resident would not take the Resource. On 5/30/18 at 9:40 a.m. the DON stated the kitchen delivered the Ensure so those would not be on the MAR. The Resource should be recorded on the MAR. On 5/30/18 at 10 a.m. the food service manager stated dietary supplied strawberry Ensure to the resident. They did not document when it was given. A Clinical Nursing Home Note completed by the physician dated 2/23/18 revealed the physician	F 580		

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F 580	Continued From page 4 saw the resident. The physician ordered Norco (narcotic) for the resident for administration prior to bath for pain control on bath days. The weight listed on the clinic note was 139.2 pounds. Her diagnoses included: adult failure to thrive and dementia. On 5/31/18 at 11:57 a.m. the MDS nurse stated the 139.2 pounds was an error. They just noticed that yesterday. Daily food intakes revealed the following: 2/15/18 Breakfast 0 lunch 15 supper 0 2/16/18 Breakfast 0 lunch 15 supper 15 2/17/18 Breakfast 25 lunch 25 supper 85 2/18/18 Breakfast 25 lunch 25 supper 25 2/19/18 Breakfast 0 lunch 100 supper 50 2/20/18 Breakfast 0 lunch 0 supper 25 2/21/18 Breakfast 15 lunch 50 supper 75 2/22/18 Breakfast 25 lunch bites supper 25 2/23/18 Breakfast 50 lunch 35 supper 80 2/24/18 Breakfast 0 lunch 25 supper 20 2/25/18 Breakfast 0 lunch bites supper bites 2/26/18 Breakfast 0 lunch 0 supper 25 2/27/18 hospital/expired There were no fluid intake records. Nurses Notes: Nurses Notes dated 2/23/18 at 9:30 p.m. documented: staff reported the resident saying "ow" and hollering out with movement of any kind. The resident was very stiff and difficult to do range of motion with. The resident receives scheduled Tylenol (analgesic). 2/24/18 at 5 p.m. revealed the resident showed signs and symptoms of pain/discomfort. At times the resident would holler out "ow" and have a facial grimace. At times the resident would stiffen	F 580		

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F 580	Continued From page 5 her body out. 2/25/18 at 1 a.m. the resident hollered out with with movement and transfers. The resident stated "ow" when moved. The resident was awake for most of the night, talking out loud. Staff repositioned the resident every 2 hours. At 4 p.m. of the same date the resident continued to yell out with any movement and said "ow" and straightened her body out. On the same date at 8 p.m. the resident yelled with any movement. She said "ow" or just screamed and straightened her body. Staff continued to administer scheduled Tylenol (analgesic). On the same date at 10:40 p.m. the resident rested in bed with no hollering at that time. 2/26/18 at 6:30 p.m. and documented by Staff C RN (registered nurse) the resident moaned continuously in the gerichair and pulled her legs up towards her chest. Staff gave Tylenol but the resident spit some of it out. Staff could not determine where the resident's pain was and the intensity due to the resident's nonverbal status. 2/27/18 at 2 a.m. resident's condition appeared worse. The resident's eyes looked sunken and dark and the resident's feet were cold and blue, respirations were 40. The nurse was unable to feel pulses as the pulse was too weak and she could not obtain a blood pressure. Staff notified the DON (director of nursing). On 6/4/18 at 2:10 p.m. the DON stated Staff C, RN did call her saying the resident was not doing well. She said she called the resident's family. The DON told Staff C to find out if the family wanted the resident transferred to the hospital. The DON stated she could not fully recall the details of the call. On the same date at 4:45 a.m. Staff C notified the	F 580		

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F 580	Continued From page 6 resident's family of the resident's condition and they wanted the resident hospitalized for comfort. The resident transported to the hospital. During an interview with Staff C on 5/29/18 at 8:12 a.m. when asked, "Why didn't you get an ambulance sooner than 4:45 a.m. when you charted at 2 a.m. that you were unable to obtain a pulse or blood pressure?" Staff C stated, I didn't think she was that bad yet. And we have other things to do besides just sit there and watch the clock go by. There are other residents and things to get done. An ED (emergency department) physician final report dated 2/27/18 revealed the resident arrived at the ED after staff found her unresponsive at the nursing home. When the emergency services personnel arrived the resident was hypoxic with oxygen in the low 80's. The resident had dryness and chapping of the mucus membranes. The resident's pupils were 2 mm (millimeters) and nonreactive. The resident's blood work on 2/27/18 at 6:23 a.m. revealed the following: Sodium 189 (HI) normal is 133 to 146 Chloride 150 (HI) normal is 97 to 109 Carbon dioxide level 16 mMo/L (LOW) normal is 20 to 34 BUN (blood urea nitrogen) 99 (HI) normal is 10 to 28 Creatinine 3.71 (HI) normal is 0.6 to 1.2 Lactic Acid level 11.2 (HI) normal is 0.5 to 2.0 The resident was diagnosed with lactic acidosis, acute renal failure, dehydration, hypernatremia, significant hypotension and unresponsive. Nurses Notes identified the resident was back at	F 580		

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F 580	Continued From page 7 the facility on 2/27/18. No actual arrival time was documented but an entry dated 2/27/18 at 2 p.m. documented family at her (resident's) bedside. On the same date at 2:20 p.m. revealed the resident admitted to Hospice care. On the same date at 2:50 p.m. staff were unable to obtain an apical pulse. The resident expired. Prior laboratory work dated 1/8/18 revealed the following: Sodium 144 Chloride 113 BUN 31 Creatinine 1.12 When interviewed on 5/30/18 at 1:20 p.m. the ED physician stated with a sodium level of 189 he would guess that the resident had not drank fluids in the previous 4 to 5 days, if not longer. She could have been that way a couple weeks if she had occasional water. Staff should have been able to tell she was dehydrated for 3 to 5 days before the hospital. The resident was comatose when she arrived at the ED and after receiving 1 liter of fluid she was awake and following staff. The hydration made her responsive. Staff Interviews: On 5/30/18 at 1:34 p.m. Staff C, RN stated on the day the resident went to ED, the resident started making sounds like a sheep. The resident never did that before. The day nurse and Staff C thought the resident had pain. The resident got barely anything for pain control. Staff C tried to give the resident crushed Tylenol. On the first round, the resident was dry which was strange because she was usually incontinent of urine. The resident looked gaunt like she could die. On	F 580		

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F 580	Continued From page 8	F 580		

the next round (between 2 a.m. and 4 a.m.) Staff C checked her vital signs and they were low. Staff C didn't think the resident would make it. Staff C called the resident's daughter who wanted her transferred to the hospital. The resident looked like she was dying. Staff C stated the resident was responsive up until 1 a.m.

On 5/30/18 at 12:52 p.m. Staff B, LPN (licensed practical nurse) stated she could tell the resident was in pain. She stated sometimes staff were not able to get the resident to take Tylenol and it was not effective anyway. In the 1 to 2 weeks prior to her death the resident had more pain. When asked why she wrote a "0" by the resident's pain level on the February MAR of she was having pain, she stated because the resident was nonverbal. She stated she approached the former MDS nurse to report the resident had more pain and she more or less told Staff B that she didn't know what she was doing. Staff B had to go through the MDS nurse to get more pain medication for the resident. Staff B stated she did a pain assessment on the resident. Later on 2/23/18 the doctor came to the facility and the MDS nurse took the physician into her office and told her she never saw any of the things that Staff B identified on the pain assessment so the physician did not change the resident's pain medication.

On 5/30/18 at 3 p.m. Staff A, CNA stated the 2 days before the hospital the resident did not eat or drink at all.

On 5/30/18 at 12:25 p.m. Staff D, CNA stated the resident could ask for drinks. She spit food out and she got worse the last week or two. Staff D reported the resident would holler and scream

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F 580	Continued From page 9 with increased movement. Her mouth was dry, but she slept with her mouth open and she normally had deep sunken eyes. On 5/30/18 at 12:14 p.m. Staff E, CNA reported the resident was eating and drinking less and when staff gave her a drink she would plug the hole of the cup. She was not eating or drinking more frequently at the end. She was very stiff and complained a lot when she was touched or moved. Even when she wasn't touched she said "ow". On 5/29/18 at 1:32 p.m. Staff F, CNA reported the resident was in a lot of pain at the end. The resident made noises and acted funny for about a week before she passed away. She didn't want anything to eat or drink for a couple of weeks. On 5/29/18 at 1:17 p.m. Staff I, CNA stated the resident's drinking and appetite had decreased. On 5/29/18 at 12:08 p.m. Staff J, RN stated a few days before the resident expired she was in pain and her eating and drinking decreased. The resident would hold her lips together. She stated on the same date at 3:44 p.m. when she signed for Resource drink on the MAR that meant the resident drank it. On 5/29/18 at 3:07 p.m. Staff G, CNA stated the resident's eating and drinking decreased, she refused to eat and held her mouth closed. On 5/29/18 at 2:54 p.m. Staff H, stated the resident went down hill. The resident barely ate anyway but the week the resident expired she would just have a spoon of food in her mouth and would spit it out. The resident wasn't as	F 580		

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F 580	Continued From page 10 responsive and made sounds. The day before she expired the resident uncrossed her legs which was unusual because they were always crossed. The next day they were crossed. Physician Interview: On 5/31/18 at 12:22 p.m. the resident's regular physician stated she would expect notification, assessment and documentation of changes in intakes and significant weight loss. She stated she saw the resident on 2/23/18 and the resident seemed pretty normal then. The physician did not receive any information about changes at that time. When asked about Staff C's explanation for the 2 hour gap between a condition change and ambulance call, the physician stated, that was not a good excuse. 2. A Minimum Data Set (MDS) with assessment reference date of 12/10/17, assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of "0" (severe cognitive impairment). The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required extensive staff assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The resident was occasionally incontinent of bladder. The resident was 58 inches tall and 104 pounds. The MDS identified a weight loss of 5% or more in the last month or 10% in the last 6 months. The resident was not on a physician prescribed weight loss regimen. A February 2018 Medication Administration	F 580		

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F 580	Continued From page 11 Record (MAR) identified the resident's weigh 95.4 pounds on 2/5/18 and 90 pounds on 2/19/18 (significant weight loss of 5% in 2 weeks). A Nutritional Assessment dated 12/20/17 documented the resident's usual weight on admission 10/08, 152 pounds. The assessment identified the resident had varied fluid intakes, the resident's food intake was less than the desired amounts and had a significant weight loss. The assessment identified that the resident received Resource 2.0 supplement 60 cc twice a day and Breeze supplement with meals and milk shake at bedtime. Staff increased fats all as accepted by resident. The assessment did not identify food likes other than a history of preferring morning servings. Review of the February 2018 MAR showed no Resource drink listed. Review of December 2017 and January 2018 MARS showed the Resource was discontinued on 11/28/17. On 5/30/18 at 9:40 a.m. the DON stated the kitchen delivered the Breeze supplement and milkshakes so those would not be on the MAR. The Resource should be recorded on the MAR. (Breeze nutrition supplement provides additional calories, and protein). A Nurse's Note dated 2/20/18 at 1:30 p.m., documented the physician saw the resident for recertification and wrote orders to decrease the resident's Fentanyl patch to 12 mcg. (micrograms) when out of present supply. A Nurse's Note dated 2/27/18 at 5:00 p.m., documented the resident's mental and physical status were declining. The resident did not eat or	F 580		

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F 580	Continued From page 12 drink anything this shift. The resident is not responding to verbal/tactile stimuli. Daily food intake records identified the following: 2/20/18 breakfast 35%, lunch 0 and supper 0 2/21/18 breakfast 0 lunch 0 and supper 0 2/22/18 breakfast 0 lunch 0 and supper 0 2/23/18 breakfast 0 lunch 0 and supper 0 2/24/18 breakfast 0 lunch 0 and supper 0 2/25/18 breakfast 0 lunch fluid only and supper shake 2/26/18 breakfast shake lunch shake and supper 0 2/27/18 "didn't get anything" for all three meals 2/28/18 expired There were no fluid intake records. Nurses Notes dated 2/20/18 at 1:30 p.m. revealed the physician saw the resident. The next entry was dated 2/27/18 at 5 p.m. and revealed the resident had a mental/physical status decline. The facility notified the resident's responsible party of the change. The entry identified the resident did not eat or drink anything that shift. The resident did not respond to verbal or tactile stimuli. There was no signs or symptoms of pain/discomfort. Staff provided the resident with comfort care and repositioning every 2 hours. The Clinical Nursing Home Note dated 2/20/18, completed by the physician, documented the resident is slowly deteriorating over all. Diagnoses Adult failure to thrive and weight down to 94.4 pounds. The Nurses Notes dated 2/27/18 at 9 p.m. documented the resident's mental/physical status	F 580		

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is declining. The resident did not eat or drink anything this shift. The resident is not responding to verbal or tactile stimuli. No signs or symptoms of pain. Comfort measures given.

The Nurses Notes dated 2/28/18 at 1 a.m. identified the resident resting with eyes closed. No response to interaction. Respirations 16 and shallow. At 11 a.m. the resident rested with eyes closed. Non-responsive. No intake. The resident's skin was pale with mottling. At 1 p.m. the resident rested with agonal (difficult breathing prior to cardiac arrest) breathing. On the same date at 2:10 p.m. staff found the resident expired.

Record review revealed no assessment or physician notification of lack of intakes and decline after 2/20/18.

Physician Interview:

On 5/30/18 at 10:58 a.m. the physician stated he would expect notification of no intakes and a significant weight loss. He stated he would also expect assessment and documentation regarding the resident during that time. He stated the resident was slowly failing over a long period of time. The lack of intakes reflected her end of life condition related to her advanced dementia.

Staff Interviews:

On 5/30/18 at 3 p.m. Staff A, CNA (certified nurse aide) stated the resident always tootled around in her wheelchair but the 1 to 2 weeks before she died, she didn't. She also did not eat or drink. She would not even open her eyes, she just laid her head on the table. Staff reported it to nurses and they said to try and give her a milkshake but she

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did not take it. The resident used to resist care at bedtime but the week before she died she did not resist.

On 5/30/18 at 12:52 p.m. Staff B, LPN (licensed practical nurse) stated the resident did not seem to have pain. She just wanted to sleep. She would push her tongue over the cup opening when staff tried to give her a drink . She would pocket food or not let it in her mouth. The day she passed away, a CNA tried to give her a drink but she didn't want anything.

On 5/30/18 at 1:34 p.m. Staff C, RN (registered nurse) stated the week or 2 preceding the resident's death the resident lost a lot of weight. Staff had kept the resident in her room and the resident did not eat or drink.

On 5/30/18 at 12:25 p.m. Staff D, CNA stated the day before the resident expired she was not very responsive and looked like she was dying. In the week or two preceding her death, she refused food and drink more. She refused a little more often until eventually she took nothing.

On 5/30/18 at 12:14 p.m. Staff E, CNA stated the day before the resident expired she was up in her wheelchair. She stated the resident slept all day and did less 'toodling" in the wheelchair. Before she expired the resident just sat there. Staff E, thought the resident was alert the day before she expired. She stated gradually the resident didn't eat or drink anything, more so the last 4 to 5 days. Then it got to where the resident would "fake sleep" through the meal.

On 5/29/18 at 1:32 p.m. Staff F, CNA stated a week before the resident passed away she just

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"shut down", got quiet and wouldn't talk. She declined eating and drinking for a couple weeks. Staff F stated the resident received the milkshake for a long time because of weight loss. And staff had a hard time getting it down the resident.

On 5/29/18 at 3:07 p.m. Staff G, CNA stated before the resident expired she became 'dead' weight, she was sleepier than usual, she refused food and liquid and would hold her mouth closed.

When interviewed on 5/29/18 at 2:54 p.m. Staff H, CNA reported the week before the resident expired she went downhill. She would sleep in her chair instead of watching staff like she usually did. Staff H stated she noticed something was wrong. A couple days before the resident passed she refused food and they tried to give her shakes and liquids. The last week before she expired the resident did not urinate at all. The resident usually urinated heavily on his shift. Staff H reported he told the nurse.

3. A MDS with assessment reference date of 1/1/18 revealed Resident #5 with a BIMS score of "13" (no cognitive impairment). The resident required limited staff assistance with bed mobility, transfers and dressing. The resident had diagnoses that included: diabetes mellitus and heart failure.

Nurses Notes dated 2/5/18 (no time listed) revealed staff received a return fax related to numerous loose stools. Staff received orders to obtain a stool specimen to rule out clostridium difficile. There was no information available that an assessment was completed or any previous entry documented about loose stools. The 2/5/18 fax revealed the resident had loose stools since

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F 580	Continued From page 16 2/3/18 and had a loose stool every time she used the bathroom. The resident had a low grade temperature of 100.6 degrees and the resident was lethargic. There was no abdominal assessment. Nurses Notes dated 2/6/18 at 10 a.m. revealed staff sent a stool sample to the clinic. The entry did not contain any information about an assessment. Nurses Notes dated 2/7/18 at 9:25 a.m. revealed staff notified the resident's responsible party about a status change. The responsible party wanted the resident sent to the hospital. The entry did not contain information regarding an assessment. On 5/31/18 the DON provided a cover page to a fax which contained the date 2/6/18. The fax stated to "see attached nursing assessment due to recent GI (gastrointestinal) changes. The fax contained a nursing assessment dated 2/6/18 at 11:50 p.m. The documented the resident had dim to absent bowel sounds on the left side and had multiple incontinent stools that were yellow mucus with increased odor. The resident had pain rated at "7" on a scale of 0 for no pain to 10 the worst pain. Staff gave Tylenol (analgesic) at 10:30 p.m. for resident moaning. The resident's abdomen distended and tender to touch. The resident hollered out when staff palpated the right lower quadrant. On 6/4/18 at 9:50 a.m. the DON reported staff sent the fax on 2/6/18 at 11:50 p.m. to the Buffalo Center clinic. When the clinic personnel arrived the next morning (2/7/18) they faxed it at 7:43 a.m. to the Forest City Clinic because the	F 580		

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F 580	Continued From page 17 physician was not in Buffalo Center on 2/7/18. The physician saw the fax and returned it with a response on 2/7/18 at 11:35 a.m. The response questioned if the resident wanted the hospital.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 3 of 5 residents reviewed. The facility failed to assess and address Resident #1 and Resident #2 condition declines. Staff noticed symptoms that were not addressed. Resident #2 went to the hospital with severe dehydration and expired that day. On 2/7/18 a hospital history and physical revealed Resident #5 had loose stools for 2 weeks. The first Nurses Note entry regarding this was on 2/5/18 and contained no assessment of the resident. An assessment completed and faxed to the physician on 2/6/18 at 11:50 p.m. was not received by the physician until 2/7/18. On 2/7/18 the resident admitted to the hospital with infectious colitis. Facility census was thirty-four	F 684	See Attachments	6/7/18

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F 684	Continued From page 18 (34) residents. Findings include: 1. A MDS with assessment reference date of 1/1/18 assessed Resident #2 with a BIMS score of "0" (severe cognitive impairment) The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required total staff assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The resident was always incontinent of bowel and bladder. The resident was 63 inches tall and 114 pounds. The MDS did not identify a significant weight loss. A Do Not Resuscitate Request (DNR) dated 2/6/17 revealed the resident did not want chest compressions, defibrillation or intubation. The form identified the DNR decision would not prevent the resident from obtained other emergency care which would make the resident more comfortable which included but not limited to: pain medication, fluid therapy and respiratory assistance. A December 2017 MAR revealed the resident weighed 114.2 on 12/26/17. A January 2018 MAR identified the resident weighed 112 on 1/17/18. A February 2018 MAR revealed the resident weighed 104.6 on 2/20/18. The resident lost 7.4 pounds in 1 month (from 1/17/18 to 2/20/18) which was a significant weight loss. On 2/27/18 the hospital weighed the resident at 97 pounds. A Nutritional Assessment sheet dated 1/3/18	F 684		

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revealed the resident usually took fluid better than food. The resident's appetite varied with the resident often eating less than 50%. The resident had no special food likes. The assessment identified that the resident received Resource 2.0 supplement 60 cc three times a day and 4 ounces of strawberry Ensure three times a day and 4 ounces of yogurt at breakfast.

Review of the February 2018 MAR showed staff signed they administered the Resource drink listed on the nutritional assessment. On 5/30/18 at 12:52 p.m. Staff B LPN (licensed practical nurse) stated she initialed she gave the resident Resource because she offered it. She stated the resident would not take the Resource.

On 5/30/18 at 9:40 a.m. the DON stated the kitchen delivered the Ensure so those would not be on the MAR. The Resource should be recorded on the MAR. On 5/30/18 at 10 a.m. the food service manager stated dietary supplied strawberry Ensure to the resident. They did not document when it was given.

A Clinic Nursing Home note dated 2/23/18 revealed the physician saw the resident. The physician ordered Norco (narcotic) for the resident for administration prior to bath for pain control on bath days. The weight listed on the clinic note was 139.2 pounds. Her diagnoses included: adult failure to thrive and dementia. On 5/31/18 at 11:57 a.m. the MDS nurse stated the 139.2 pounds was an error. They just noticed that yesterday.

Daily food intakes revealed the following:

2/15/18 Breakfast 0 lunch 15 supper 0

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F 684	Continued From page 20 2/16/18 Breakfast 0 lunch 15 supper 15 2/17/18 Breakfast 25 lunch 25 supper 85 2/18/18 Breakfast 25 lunch 25 supper 25 2/19/18 Breakfast 0 lunch 100 supper 50 2/20/18 Breakfast 0 lunch 0 supper 25 2/21/18 Breakfast 15 lunch 50 supper 75 2/22/18 Breakfast 25 lunch bites supper 25 2/23/18 Breakfast 50 lunch 35 supper 80 2/24/18 Breakfast 0 lunch 25 supper 20 2/25/18 Breakfast 0 lunch bites supper bites 2/26/18 Breakfast 0 lunch 0 supper 25 2/27/18 hospital/expired There were no fluid intake records. Nurses Notes dated 2/27/18 at 2 a.m. revealed the resident's condition appeared worse. The resident's eyes looked sunken and dark and the resident's feet were cold and blue. Respirations 40. The nurse was unable to feel pulses as the pulse was too weak and she could not obtain a blood pressure. Staff notified the DON (director of nursing). On 6/4/18 at 2:10 p.m. the DON stated Staff C RN did call her saying the resident was not doing well. She said she called the resident's family. The DON told Staff C to find out if the family wanted the resident transferred to the hospital. The DON stated she could not fully recall the details of the call. On the same date at 4:45 a.m. Staff C notified the resident's family of the resident's condition and they wanted the resident hospitalized for comfort. The resident transported to the hospital. During an interview with Staff C on 5/29/18 at 8:12 a.m. when asked, why she didn't get an ambulance sooner than 4:45 a.m. when she charted at 2 a.m. that she was unable to obtain a pulse or blood pressure. Staff C stated, she didn't	F 684		

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think the resident was that bad yet. Staff had other things to do besides just sit there and watch the clock go by, and there are other residents to care for and things to get done.

An ED (emergency department) physician final report dated 2/27/18 revealed the resident arrived at the ED after staff found her unresponsive at the nursing home. When the emergency services personnel arrived the resident was hypoxic with oxygen in the low 80's. The resident had dryness and chapping of the mucus membranes. The resident's pupils were 2 mm (millimeters) and nonreactive. The resident's blood work on 2/27/18 at 6:23 a.m. revealed the following:

Sodium 189 (HI) normal is 133 to 146
Chloride 150 (HI) normal is 97 to 109
Carbon dioxide level 16 mMo/L (LOW) normal is 20 to 34
BUN (blood urea nitrogen) 99 (HI) normal is 10 to 28
Creatinine 3.71 (HI) normal is 0.6 to 1.2
Lactic Acid level 11.2 (HI) normal is 0.5 to 2.0

The resident was diagnosed with lactic acidosis, acute renal failure, dehydration, hypernatremia, significant hypotension and unresponsive.

Nurses Notes identified the resident was back at the facility on 2/27/18. No actual arrival time was documented but an entry dated 2/27/18 at 2 p.m. revealed the resident's family was at her bedside. On the same date at 2;20 p.m. revealed the resident admitted to Hospice care. On the same date at 2:50 p.m. staff was unable to obtain an apical pulse. The resident expired.

Prior laboratory work dated 1/8/18 revealed the

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F 684	Continued From page 22 following: Sodium 144 Chloride 113 BUN 31 Creatinine 1.12 On 5/30/18 at 1:20 p.m. the ED physician stated with a sodium level of 189 he would guess that the resident had not drank fluids in the previous 4 to 5 days, if not longer. She could have been that way a couple weeks if she had occasional water. Staff should have been able to tell she was dehydrated for 3 to 5 days before the hospital. The resident was comatose when she arrived at the ED. He stated after the resident received 1 liter of fluid she as awake and following staff. The hydration made her responsive. Staff Interviews: On 5/30/18 at 1:34 p.m. Staff C, RN stated on the day the resident went to ED, the resident started making sounds like a sheep and she had never done that before. The day nurse and she thought the resident had pain and the resident got barely anything for pain control. Staff C stated she tried to give the resident crushed Tylenol on first rounds, and the resident was dry which was strange because the resident was usually incontinent of urine. Staff C repotted the resident looked gaunt like she could die. On the next round (between 2 a.m. and 4 a.m.) she checked the resident's vital signs and they were low, she didn't think the resident would make it. She called the resident's daughter who wanted her transferred to the hospital. The resident looked like she was dying. Staff C stated the resident was responsive up until 1 a.m.	F 684		

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F 684	Continued From page 23 On 5/30/18 at 3 p.m. Staff A, CNA stated the 2 days before the hospital the resident did not eat or drink at all. On 5/30/18 at 12:25 p.m. Staff D, CNA stated the resident spit food out and got worse in the last week or two (2). The resident would holler and scream. The resident screamed with increased movement. Her mouth was dry but she slept with it open. She normally had deep sunken eyes. The resident could ask for drinks. On 5/30/18 at 12:14 p.m. Staff E, CNA stated the resident resident was eating and drinking less. When staff gave her a drink, she would plug the hole of the cup. She was not eating or drinking more frequently more and more to the end. She complained a lot when she was touched or moved. Even when she wasn't touched, she said "ow". She was very stiff. On 5/29/18 at 1:32 p.m. Staff F, CNA stated the resident was in a lot of pain at the end. She made noises and acted funny for about a week before she passed away. She didn't want anything to eat or drink for a couple of weeks. On 5/29/18 at 1:17 p.m. Staff I, CNA reported the resident's drinking and appetite had decreased. On 5/29/18 at 12:08 p.m. Staff J, RN stated a few days before the resident expired she was in pain, her eating and drinking decreased and she held her lips together. She stated on the same date at 3:44 p.m. when she signed for Resource drink on the MAR that meant the resident drank it. On 5/29/18 at 3:07 p.m. Staff G, CNA stated the resident's eating and drinking decreased and the	F 684		

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F 684	Continued From page 24 resident refused to eat and held her mouth closed. On 5/29/18 at 2:54 p.m. Staff H, stated the resident went down hill. The resident barely ate anyway but the week the resident expired, she would just have a spoon of food in her mouth and would spit it out. The resident wasn't as responsive and made sounds. The day before she expired the resident uncrossed her legs which was unusual because they were always crossed, then the next day they were crossed. Physician Interview: On 5/31/18 at 12:22 p.m. the resident's regular physician stated she would expect assessment and notification of changes in intakes and significant weight loss and documentation of the information. She stated she saw the resident on 2/23/18 and the resident seemed pretty normal then. The physician did not receive any information about changes at that time. When asked about Staff C's explanation for the 2 hour gap between a condition change and ambulance call, the physician stated that was not a good excuse. 2. A Minimum Data Set (MDS) with assessment reference date of 12/10/17, assessed Resident #1 with a brief interview for mental status (BIMS) score of "0" (severe cognitive impairment). The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required extensive staff assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing. The resident did not ambulate and used	F 684		

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a wheelchair for mobility. The resident was occasionally incontinent of bladder. The resident was 58 inches tall and 104 pounds. The MDS identified a weight loss of 5% or more in the last month or 10% in the last 6 months. The resident was not on a physician prescribed weight loss regimen.

A February 2018 Medication Administration Record (MAR) identified the resident weighed 95.4 pounds on 2/5/18 and 90 pounds on 2/19/18 (significant weight loss of 5% in 2 weeks).

A Nutritional Assessment sheet dated 12/20/17 revealed the resident's fluid intakes varied. The resident's food intake was less than the desired amounts and the resident had significant weight loss. The assessment identified that the resident received Resource 2.0 supplement 60 cc twice a day and Breeze supplement with meals and milk shake at bedtime. Staff increased fats all as accepted by resident. The assessment did not identify food likes other than a history of preferring morning servings .

Review of the February 2018 MAR showed no Resource drink listed. Review of December 2017 and January 2018 MARS showed the Resource was discontinued on 11/28/17.

On 5/30/18 at 9:40 a.m. the DON stated the kitchen delivered the Breeze supplement and milkshakes so those would not be on the MAR. The Resource should be recorded on the MAR.

A Clinic Nursing Home Note dated 2/20/18 revealed the physician saw the resident and documented she was slowly deteriorating overall and her weight was 94.4 pounds. Her diagnoses

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F 684	Continued From page 26 included: adult failure to thrive and dementia. Daily food intake records identified the following: 2/20/18 breakfast 35%, lunch 0 and supper 0 2/21/18 breakfast 0 lunch 0 and supper 0 2/22/18 breakfast 0 lunch 0 and supper 0 2/23/18 breakfast 0 lunch 0 and supper 0 2/24/18 breakfast 0 lunch 0 and supper 0 2/25/18 breakfast 0 lunch fluid only and supper shake 2/26/18 breakfast shake lunch shake and supper 0 2/27/18 "didn't get anything" for all three meals 2/28/18 expired There were no fluid intake records. Nurses Notes dated 2/20/18 at 1:30 p.m. revealed the physician saw the resident. The next entry was dated 2/27/18 at 5 p.m. and revealed the resident had a mental/physical status decline. The facility notified the resident's responsible party of the change. The entry identified the resident did not eat or drink anything that shift. The resident did not respond to verbal or tactile stimuli. There was no signs or symptoms of pain/discomfort. Staff provided the resident with comfort care and repositioning every 2 hours. Nurses Notes dated 2/27/18 at 9 p.m. revealed the resident continued non-responsive. Nurses Notes dated 2/28/18 at 1 a.m. identified the resident resting with eyes closed. No response to interaction. Respirations 16 and shallow. At 11 a.m. the resident rested with eyes closed. Non-responsive. No intake. The resident's skin was pale with mottling. At 1 p.m. the resident	F 684		

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rested with agonal (difficult breathing prior to cardiac arrest) breathing. On the same date at 2:10 p.m. staff found the resident expired.

There was no assessment or physician notification of lack of intakes and declines after 2/20/18.

Physician Interview:

On 5/30/18 at 10:58 a.m. the physician stated he would expect notification of no intakes and a significant weight loss. He stated he would also expect assessment and documentation regarding the resident during that time. He stated the resident was slowly failing over a long period of time. The lack of intakes reflected her end of life condition related to her advanced dementia.

Staff Interviews:

On 5/30/18 at 3 p.m. Staff A, CNA (certified nurse aide) stated the resident always tootled around in her wheelchair but the 1 to 2 weeks before she died she didn't. She also did not eat or drink. She would not even open her eyes, she just laid her head on the table. Staff reported it to nurses and they said to try and give her a milkshake but she did not take it. The resident used to resist care at bedtime but the week before she died she did not resist.

On 5/30/18 at 12:52 p.m. Staff B, LPN (licensed practical nurse) stated the resident did not seem to have pain. She just wanted to sleep. She would push her tongue over the cup opening when staff tried to give her a drink . She would pocket food or not let it in her mouth. The day she passed away a CNA tried to give her a drink but she didn't

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F 684	Continued From page 28 want anything. On 5/30/18 at 1:34 p.m. Staff C, RN (registered nurse) stated the week or 2 preceding the resident's death the resident lost a lot of weight. Staff had kept the resident in her room and the resident did not eat or drink. On 5/30/18 at 12:25 p.m. Staff D, CNA stated the day before the resident expired she was not very responsive and looked like she was dying. In the week or 2 preceding the death, the resident refused food and drink more. She refused a little more, more often until eventually she took nothing. On 5/30/18 at 1214 p.m. Staff E, CNA stated the day before the resident expired she was up in her wheelchair. She stated the resident slept all day and did less 'tooting" in the wheelchair. Before she expired the resident just sat there. Staff E thought the resident was alert the day before she expired. She stated gradually the resident didn't eat or drink anything. More so the last 4 to 5 days. Then it got to where the resident would "fake sleep" through the meal. On 5/29/18 at 1:32 p.m. Staff F, CNA stated a week before the resident passed away she just "shut down", got quiet and wouldn't talk. She declined eating and drinking for a couple weeks. Staff F stated the resident received the milkshake for a long time because of weight loss. That was hard for staff to "get down" the resident too. On 5/29/18 at 3:07 p.m. Staff G, CNA stated before the resident expired she became dead weight. The resident was sleepier than usual. She would refuse food and liquid and hold her mouth	F 684		

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F 684	Continued From page 29 closed. The resident loved Mexican food and tacos and would always eat that. On 5/29/18 at 2:54 p.m. Staff H, CNA stated the week before the resident expired she went downhill. She would sleep in her chair instead of watching staff like she usually did. Staff H noticed something was wrong. A couple days before she passed, she refused food and they tried to give her shakes and liquids. The last week before she expired the resident did not urinate at all. The resident usually urinated heavily on his shift. Staff H told the nurse. 3. A MDS with assessment reference date of 1/1/18 revealed Resident #5 with a BIMS score of "13" (no cognitive impairment). The resident required limited staff assistance with bed mobility, transfers and dressing. The resident had diagnoses that included: diabetes mellitus and heart failure. Nurses Notes dated 2/5/18 (no time listed) revealed staff received a return fax related to numerous loose stools. Staff received orders to obtain a stool specimen to rule out clostridium difficile. There was no information available that an assessment was completed or any previous entry documented about loose stools. The 2/5/18 fax revealed the resident had loose stools since 2/3/18 and had a loose stool every time she used the bathroom. The resident had a low grade temperature of 100.6 degrees and the resident was lethargic. There was no abdominal assessment. Nurses Notes dated 2/6/18 at 10 a.m. revealed staff sent a stool sample to the clinic. The entry did not contain any information about an	F 684		

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F 684	Continued From page 30 assessment. Nurses Notes dated 2/7/18 at 9:25 a.m. revealed staff notified the resident's responsible party about a status change. the responsible party wanted the resident sent to the hospital. The entry did not contain information regarding an assessment. On 5/31/18 the DON provided a cover page to a fax which contained the date 2/6/18. The fax stated to "see attached nursing assessment due to recent GI (gastrointestinal) changes. The fax contained a nursing assessment dated 2/6/18 at 11:50 p.m. The assessment revealed the resident had dim to absent bowel sounds on the left side and the resident had multiple incontinent stools that were yellow mucus with increased odor. The resident had pain rated at "7" on a scale of 0 for no pain to 10 the worst pain. Staff gave Tylenol (analgesic) at 10:30 p.m. for resident moaning. The resident's abdomen was distended and tender to touch. The resident hollered out when staff palpated the right lower quadrant. A PRN Medication Administration Record (MAR) identified staff administered Tylenol on 2/5/18 at "23". The entry did not say why or if it was effective On 6/4/18 at 9:50 a.m. the DON stated staff sent the fax on 2/6/18 at 11:50 p.m. to the Buffalo Center clinic. When the clinic personnel arrived the next morning (2/7/18) they faxed it at 7:43 a.m. to the Forest City Clinic because the physician was not in Buffalo Center on 2/7/18. The physician saw the fax and returned it with a response on 2/7/18 at 11:35 a.m. The response questioned if the resident wanted the hospital.	F 684		

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Nurses Notes revealed on 2/7/18 at 10:05 a.m. the resident left the facility for the hospital per ambulance.

A hospital History and Physical (H & P) dated 2/7/18 revealed the resident presented to the ED with abdominal pain. She had the pain for 2 weeks but it was worse lately. The H & P revealed the resident had colitis most likely infectious. A CT of the abdomen included ischemic and infectious etiologies. The H & P also identified an inguinal rash with satellite lesions present. There was no documentation available from the facility to identify they assessed the inguinal rash. On 5/29/18 at 12:25 p.m. the DON confirmed she could not find anything about the facility assessing the inguinal rash.

Nurses Notes dated 2/9/18 at 3 p.m. revealed the resident returned to the facility.

Observation on 5/29/18 at 9:45 a.m. show the resident seated in a wheelchair in her room. The resident stated she had diarrhea that was going on all the time before the hospital. The resident stated it wasn't that bad and she just thought it was from the food she was eating. The resident stated she can't have tomato and that the facility makes a lot of food with tomato.

On 5/30/18 at 11:51 a.m. the DON reported the resident's groins were clear.

On 6/1/2018, the facility abated the Immediate Jeopardy by providing education to the professional nursing staff which included nursing assessment, communication to family and

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F 684	Continued From page 32 providers, change of condition detection and signs and symptoms of dehydration. The scope and severity of the deficiency was lowered from a "J" to a "D" with the need for ongoing monitoring to ensure nursing assesses residents with change of condition.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to 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 for 1 of 5 residents reviewed. Resident #2 had evidence of pain that was not controlled by scheduled Tylenol (analgesic). Facility census was thirty-four residents. Findings include: 1. A MDS with assessment reference date of 1/1/18 assessed Resident #2 with a BIMS score of "0" (severe cognitive impairment) The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required total staff assistance with bed mobility, transfers,	F 697	See Attachments	6/7/18

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dressing, eating, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The MDS did not identify the resident with pain indicators.

A Do Not Resuscitate Request (DNR) dated 2/6/17 revealed the resident did not want chest compressions, defibrillation or intubation. The form identified the DNR decision would not prevent the resident from obtained other emergency care which would make the resident more comfortable which included but was not limited to: pain medication, fluid therapy and respiratory assistance.

A February 2018 Medication Administration Record (MAR) identified the resident received Tylenol 650 milligrams (mg.) at 8 a.m., 6 p.m., and 12 p.m. and every 4 hours as needed for pain. The February 2018 MAR documented the resident received one PRN dose of Tylenol the entire month, on 2/4/18.

A Clinic Nursing Home Note completed by the physician on 2/23/18 revealed an order for Norco (narcotic) for pain control to be administered prior to bath for pain control on bath days.

Nurses Notes:

Nurses Notes dated 2/23/18 at 9:30 p.m. revealed staff reported the resident saying "ow" and hollering out with movement of any kind. The resident was very stiff and difficult to do range of motion with. The resident receives scheduled Tylenol (analgesic).

Nurse's Notes dated 2/24/18 at 5 p.m. revealed the resident showed signs and symptoms of

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F 697	Continued From page 34 pain/discomfort. At times the resident would holler out "ow" and have a facial grimace. At times the resident would stiffen her body out. Nurse's Notes dated 2/25/18 at 1 a.m. the resident hollered out with with movement and transfers. The resident stated "ow" when moved. The resident was awake for most of the night, talking out loud. Staff repositioned the resident every 2 hours. At 4 p.m. of the same date the resident continued to yell out with any movement and said "ow" and straightened her body out. On the same date at 8 p.m. the resident yelled with any movement. She said "ow" or just screamed and straightened her body. Staff continued to administer scheduled Tylenol (analgesic). On the same date at 10:40 p.m. the resident rested in bed with no hollering at that time. Nurse's Notes dated 2/26/18 at 6:30 p.m. and documented by Staff C, RN (registered nurse) the resident moaned continuously in the gerichair and pulled her legs up towards her chest. Staff gave Tylenol but the resident spit some of it out. Staff could not determine where the resident's pain was and the intensity due to the resident's nonverbal status. Nurse's Notes dated 2/27/18 at 2 a.m. The resident's condition appeared worse. The resident's eyes looked sunken and dark and the resident's feet were cold and blue. Respirations 40. The nurse was unable to feel pulses as the pulse was too weak and she could not obtain a blood pressure. Staff notified the DON (director of nursing). On 6/4/18 at 2:10 p.m. the DON stated Staff C, RN did call her saying the resident was not doing well. She said she called the resident's family. The DON told Staff C to find out if the	F 697		

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family wanted the resident transferred to the hospital. The DON stated she could not fully recall the details of the call. On the same date at 4:45 a.m. Staff C notified the resident's family of the resident's condition and they wanted the resident hospitalized for comfort. The resident transported to the hospital.

The resident was diagnosed with lactic acidosis, acute renal failure, dehydration, hypernatremia, significant hypotension and unresponsive.

Nurses Notes Notes dated 2/27/18 identified the resident back at the facility, no actual arrival time was documented. An entry dated 2/27/18 at 2 p.m. revealed the resident's family at her bedside. On the same date at 2;20 p.m. revealed the resident admitted to Hospice care. On the same date at 2:50 p.m. staff documented unable to obtain an apical pulse, resident expired.

Staff Interviews:

On 5/30/18 at 1:34 p.m. Staff C, RN stated on the day the resident went to ED (emergency department), the resident started making sounds like a sheep. The resident never did that before. The day nurse and Staff C thought the resident had pain. The resident got barely anything for pain control. Staff C tried to give the resident crushed Tylenol.

On 5/30/18 at 3 p.m. Staff A, CNA stated the 2 days before the hospital she had pain. Even if staff just touched the resident she would say "ahh" loudly as if in pain. The resident always had her legs crossed and when staff placed her legs on the pillow she would scream.

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F 697	Continued From page 36 On 5/30/18 at 12:52 p.m. Staff B, LPN (licensed practical nurse) stated she could tell the resident was in pain. She stated sometimes staff was not able to get the resident to take Tylenol and it was not effective anyway. In the 1 to 2 weeks prior to her death, the resident had more pain. When asked why she wrote a "0" by the resident's pain level on the February MAR of she was having pain, she stated that was because the resident was nonverbal. She stated she approached the former MDS nurse to report the resident had more pain and she more or less told Staff B that she didn't know what she was doing. Staff B had to go through the MDS nurse to get more pain medication for the resident. Staff B stated she did a pain assessment on the resident. Later on 2/23/18 the doctor came to the facility and the MDS nurse took the physician into her office and told her she never saw any of the things that Staff B identified on the pain assessment so the physician did not change the resident's pain medication. A pain assessment dated 2/23/18 revealed the resident had the following indicators of pain: noisy labored breathing, long periods of hyperventilation, cheyne stokes respirations, repeated troubled calling out with loud moaning and groaning, crying, facial grimacing, rigid, fists clenched, pulling or pushing away, striking out, unable to distract or reassure. The total of the assessment was "10". An increased score suggested an increase in pain. The MDS nurses documented on the form that the physician reviewed the pain assessment on 2/23/18. On 5/30/18 at 12:25 p.m. Staff D, CNA stated in the last week or 2, the resident would holler and scream. The resident screamed with increased	F 697		

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F 697	Continued From page 37 movement. On 5/30/18 at 12:14 p.m. Staff E, CNA stated the resident was feisty with any type of care. She complained a lot when she was touched or moved. Even when she wasn't touched, she said "ow". She was very stiff. On 5/29/18 at 1:32 p.m. Staff F, CNA stated the resident was in a lot of pain at the end. The resident made noises and acted funny for about a week before she passed away. She didn't want anything to eat or drink for a couple of weeks. On 5/29/18 at 1:17 p.m. Staff I, CNA stated the resident seemed to have more pain. She would holler out. On 5/29/18 at 12:08 p.m. Staff J, RN stated a few days before the resident expired she was in pain. She had pain when she was rolled up or gotten up. She only had pain with movement On 5/29/18 at 3:07 p.m. Staff G, CNA stated the resident was more resistive and seemed to have pain. Staff G could just tell she was in discomfort. On 5/29/18 at 2:54 p.m. Staff H, stated the resident went down hill. The day before she expired the resident uncrossed her legs which was unusual because they were always crossed. The next day they were crossed. When interviewed on 5/29/18 at 3:58 p.m. Staff K, CNA stated a couple weeks before the resident expired she seemed to have more pain. She reported the former MDS nurse was told but "blew it off". The resident would just sit there and scream in pain . When Staff asked if she hurt the	F 697		

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F 697	Continued From page 38 resident said "yeah". Staff K, stated she didn't think everyone believed the resident. The resident also grimaced when she was rolled and make noises indicating discomfort.	F 697		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842	See Attachments	6/7/18

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F 842	Continued From page 39 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure medical records were maintained in accordance with accepted professional standards and practices, that were complete and accurately documented for 3 of 5	F 842		

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F 842	Continued From page 40 residents reviewed. Facility reported a census of thirty-four (34) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 12/10/17, assessed Resident #1 with a brief interview for mental status (BIMS) score of "0" (severe cognitive impairment). The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required extensive staff assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The resident was occasionally incontinent of bladder. The resident was 58 inches tall and 104 pounds. The MDS identified a weight loss of 5% or more in the last month or 10% in the last 6 months. The resident was not on a physician prescribed weight loss regimen. Nurses Notes dated 2/20/18 at 1:30 p.m. documented the physician here for the resident's recertification. The next entry dated 2/27/18 at 5 p.m. revealed the resident had a mental/physical status decline. The facility notified the resident's responsible party of the change. The entry identified the resident did not eat or drink anything that shift. The resident did not respond to verbal or tactile stimuli. There was no signs or symptoms of pain/discomfort. Staff provided the resident with comfort care and repositioning every 2 hours. Nurses Notes dated 2/27/18 at 9 p.m. revealed the resident continued non-responsive.	F 842		

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F 842	Continued From page 41 Nurses Notes dated 2/28/18 at 1 a.m. identified the resident resting with eyes closed. No response to interaction. Respirations 16 and shallow. At 11 a.m. the resident rested with eyes closed, non-responsive, no intake, the resident's skin is pale with mottling. At 1 p.m. the resident rested with agonal (difficult breathing prior to cardiac arrest) breathing. On the same date at 2:10 p.m. staff found the resident expired. There was no assessment or physician notification of lack of intakes and declines after 2/20/18. Physician Interview: When interviewed on 5/30/18 at 10:58 a.m. the physician stated he would expect notification of no intakes and a significant weight loss. He stated he would also expect assessment and documentation regarding the resident during that time. He stated the resident was slowly failing over a long period of time. The lack of intakes reflected her end of life condition related to her advanced dementia. Staff Interviews: On 5/30/18 at 3 p.m. Staff A, CNA (certified nurse aide) stated the resident always tootled around in her wheelchair but the 1 to 2 weeks before she died she didn't. She also did not eat or drink. She would not even open her eyes, she just laid her head on the table. Staff reported it to nurses and they said to try and give her a milkshake but she did not take it. The resident used to resist care at bedtime but the week before she died she did not resist.	F 842		

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F 842	Continued From page 42 On 5/30/18 at 12:52 p.m. Staff B, LPN (licensed practical nurse) stated the resident did not seem to have pain. She just wanted to sleep. She would push her tongue over the cup opening when staff tried to give her a drink . She would pocket food or not let it in her mouth. The day she passed away a CNA tried to give her a drink but she didn't want anything. On 5/30/18 at 1:34 p.m. Staff C, RN (registered nurse) stated the week or 2 preceding the resident's death the resident lost a lot of weight. Staff had kept the resident in her room and the resident did not eat or drink. On 5/30/18 at 12:25 p.m. Staff D, CNA stated the day before the resident expired she was not very responsive and looked like she was dying. In the week or 2 preceding the death, the resident refused food and drink more. She refused a little more often until eventually she took nothing. On 5/30/18 at 1214 p.m. Staff E, CNA stated the day before the resident expired she was up in her wheelchair. She stated the resident slept all day and did less 'toodling" in the wheelchair. Before she expired the resident just sat there. Staff E thought the resident was alert the day before she expired. She stated gradually the resident didn't eat or drink anything. More so the last 4 to 5 days. Then it got to where the resident would "fake sleep" through the meal. On 5/29/18 at 1:32 p.m. Staff F, CNA stated a week before the resident passed away she just "shut down", got quiet and wouldn't talk. She declined eating and drinking for a couple weeks. Staff F stated the resident received the milkshake	F 842		

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F 842	Continued From page 43 for a long time because of weight loss. That was hard for staff to "get down" the resident too. On 5/29/18 at 3:07 p.m. Staff G, CNA stated before the resident expired she became 'dead' weight. The resident was sleepier than usual. She would refuse food and liquid and hold her mouth closed. The resident loved Mexican food and tacos and would always eat that. On 5/29/18 at 2:54 p.m. Staff H, CNA stated the week before the resident expired she went downhill. She would sleep in her chair instead of watching staff like she usually did. Staff H noticed something was wrong. A couple days before she passed, she refused food and they tried to give her shakes and liquids. The last week before she expired the resident did not urinate at all. The resident usually urinated heavily on his shift. Staff H told the nurse. Record review revealed none of the above information identified by staff was documented in the Nurses Notes. 2. A MDS with assessment reference date of 1/1/18 assessed Resident #2 with a BIMS score of "0" (severe cognitive impairment) The MDS did not identify behaviors including rejection of care. The resident had the following signs and symptoms of delirium: inattention and disorganized thinking. The resident required total staff assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing. The resident did not ambulate and used a wheelchair for mobility. The resident was always incontinent of bowel and bladder. The resident was 63 inches tall and 114 pounds. The MDS did not identify a significant weight loss.	F 842		

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F 842	Continued From page 44 A Do Not Resuscitate Request (DNR) dated 2/6/17 revealed the resident did not want chest compressions, defibrillation or intubation. The form identified the DNR decision would not prevent the resident from obtained other emergency care which would make the resident more comfortable which included but was not limited to: pain medication, fluid therapy and respiratory assistance. Nurses notes: Nurses Notes dated 2/27/18 at 2 a.m. revealed the resident's condition appeared worse. The resident's eyes looked sunken and dark and the resident's feet were cold and blue. Respirations 40. The nurse was unable to feel pulses as the pulse was too weak and she could not obtain a blood pressure. Staff notified the DON (director of nursing). On 6/4/18 at 2:10 p.m. the DON stated Staff C RN did call her saying the resident was not doing well. She said she called the resident's family. The DON told Staff C to find out if the family wanted the resident transferred to the hospital. The DON stated she could not fully recall the details of the call. On the same date at 4:45 a.m. Staff C notified the resident's family of the resident's condition and they wanted the resident hospitalized for comfort. The resident transported to the hospital. An ED (emergency department) physician final report dated 2/27/18 revealed the resident arrived at the ED after staff found her unresponsive at the nursing home. When the emergency services personnel arrived the resident was hypoxic with oxygen in the low 80's. The resident had dryness	F 842		

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F 842	Continued From page 45	F 842		

and chapping of the mucus membranes. The resident's pupils were 2 mm (millimeters) and nonreactive. The resident's blood work on 2/27/18 at 6:23 a.m. revealed the following:

The resident was diagnosed with lactic acidosis, acute renal failure, dehydration, hypernatremia, significant hypotension and unresponsive.

On 5/30/18 at 1:20 p.m. the ED physician stated with a sodium level of 189 he would guess that the resident had not drank fluids in the previous 4 to 5 days, if not longer. She could have been that way a couple weeks if she had occasional water. Staff should have been able to tell she was dehydrated for 3 to 5 days before the hospital. The resident was comatose when she arrived at the ED. He stated after the resident received 1 liter of fluid she as awake and following staff. The hydration made her responsive.

Staff Interviews:

On 5/30/18 at 1:34 p.m. Staff C, RN stated on the day the resident went to ED, the resident started making sounds like a sheep. The resident never did that before. The day nurse and Staff C thought the resident had pain. The resident got barely anything for pain control. Staff C tried to give the resident crushed Tylenol the first round, the resident was dry which was strange because she was usually incontinent of urine. The resident looked gaunt like she could die. On the next round (between 2 a.m. and 4 a.m.) Staff C checked her vital signs and they were low. Staff C didn't think the resident would make it. Staff C called the resident's daughter who wanted her transferred to the hospital. The resident looked like she was dying. Staff C stated the resident

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F 842	Continued From page 46 was responsive up until 1 a.m. On 5/30/18 at 3 p.m. Staff A, CNA stated the 2 days before the hospital the resident did not eat or drink at all. On 5/30/18 at 12:25 p.m. Staff D, CNA stated the resident spit food out and got worse in the last week or 2. The resident would holler and scream. The resident screamed with increased movement. Her mouth was dry but she slept with it open. She normally had deep sunken eyes. The resident could ask for drinks. On 5/30/18 at 12:14 p.m. Staff E, CNA stated the resident resident was eating and drinking less. When staff gave her a drink, she would plug the hole of the cup. She was not eating or drinking more frequently more and more to the end. She complained a lot when she was touched or moved. Even when she wasn't touched, she said "ow". She was very stiff. On 5/29/18 at 1:32 p.m. Staff F, CNA stated the resident was in a lot of pain at the end. the resident made noises and acted funny for about a week before she passed away. She didn't want anything to eat or drink for a couple of weeks. On 5/29/18 at 1:17 p.m. Staff I, CNA stated the resident drinking and appetite had decreased. On 5/29/18 at 12:08 p.m. Staff J, RN stated a few days before the resident expired she was in pain and her eating and drinking decreased. The resident help her lips together. She stated on the same date at 3:44 p.m. when she signed for resource drink on the MAR that meant the resident drank it.	F 842		

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F 842	Continued From page 47 On 5/29/18 at 3:07 p.m. Staff G, CNA stated the resident's eating and drinking decreased. The resident refused to eat and held her mouth closed. On 5/29/18 at 2:54 p.m. Staff H, stated the resident went down hill. The resident barely ate anyway but the week the resident expired, she would just have a spoon of food in her mouth and would spit it out. The resident wasn't as responsive and made sounds. The day before she expired the resident uncrossed her legs which was unusual because they were always crossed. The next day they were crossed. Physician Interview: When interviewed on 5/31/18 at 12:22 p.m. the resident's regular physician stated she would expect assessment and notification of changes in intakes and significant weight loss and documentation of the information. She stated she saw the resident on 2/23/18 and the resident seemed pretty normal then. The physician did not receive any information about changes at that time. When asked about Staff C's explanation for the 2 hour gap between a condition change and ambulance call, the physician stated that was not a good excuse. Staff interviews identified a decline in the resident and other symptoms; record review revealed no assessments documented in the Nurses Notes. 3. A MDS with assessment reference date of 1/1/18 revealed Resident #5 with a BIMS score of "13" (no cognitive impairment). The resident required limited staff assistance with bed mobility,	F 842		

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F 842	Continued From page 48 transfers and dressing. The resident had diagnoses that included: diabetes mellitus and heart failure. Nurses Notes dated 2/5/18 (no time listed) revealed staff received a return fax related to numerous loose stools. Staff received orders to obtain a stool specimen to rule out clostridium difficile. There was no information available that an assessment was completed or any previous entry documented about loose stools. The 2/5/18 fax revealed the resident had loose stools since 2/3/18 and had a loose stool every time she used the bathroom. The resident had a low grade temperature of 100.6 degrees and the resident was lethargic. There was no abdominal assessment documented. Nurses notes dated 2/6/18 at 10 a.m. revealed staff sent a stool sample to the clinic. The entry did not contain any information about an assessment. Nurses notes dated 2/7/18 at 9:25 a.m. revealed staff notified the resident's responsible party about a status change. the responsible party wanted the resident sent to the hospital. The entry did not contain information regarding an assessment. On 5/31/18 the DON provided a cover page to a fax which contained the date 2/6/18. The fax stated to "see attached nursing assessment due to recent GI (gastrointestinal) changes". The fax contained a nursing assessment dated 2/6/18 at 11:50 p.m. The assessment revealed the resident had dim to absent bowel sounds on the left side and the resident had multiple incontinent stools that were yellow mucus with increased odor. The	F 842		

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
	165586	A. BUILDING _____ B. WING _____	C 06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMELY MISSION NURSING HOME	109 MISSION DRIVE BUFFALO CENTER, IA 50424

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F 842	Continued From page 49 resident had pain rated at "7" on a scale of 0 for no pain to 10 the worst pain. Staff gave Tylenol (analgesic) at 10:30 p.m. for resident moaning. The resident's abdomen was distended and tender to touch. The resident hollered out when staff palpated the right lower quadrant. None of the information was documented in the nurses notes. A PRN Medication Administration Record identified staff administered Tylenol on 2/5/18 at "23". The entry did not say why or if it was effective A hospital History and Physical (H&P) dated 2/7/18 revealed the resident presented to the ED with abdominal pain. She had the pain for 2 weeks but it was worse lately. The H&P revealed the resident had colitis most likely infectious. A CT of the abdomen included ischemic and infectious etiologies. The H&P also identified an inguinal rash with satellite lesions present. There was no documentation available from the facility to identify they assessed the inguinal rash. On 5/29/18 at 12:25 p.m. the DON confirmed she could not find anything about the facility assessing the inguinal rash.	F 842		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F 868		6-7-18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 868	Continued From page 50 administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role and meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. The facility failed to have a quarterly QA meeting in December 2017. Facility identified a census of thirty-four (34) residents. Findings include: 1. On 6/4/18 facility staff provided documentation of their QA meeting attendance sheets. The facility held a meeting 6/27/17, 9/26/17 and the next one being 2/20/18. During interview on 6/4/18 at 12:01 p.m. the Administrator said the facility did not have an administrator in December 2017 so no QA meeting were carried out for that quarter.	F 868		

Plan of Correction, Timely Mission Nursing Home, Provider # 165586

Preparation and/or execution of this Plan of correction does not constitute admission or agreement by this provider #165586 of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because provisions of federal and state law require it. Timely Mission Nursing Home will continue to operate and provide service in compliance with all federal, state and local regulations and codes, and with professional standards and principles to provide services within this facility. This is Timely Mission Nursing Home credible allegation of compliance.

(F 580) All professional nurse's will notify physician and family/responsible party of ALL condition changes or unusual events. The notification will be documented in the nurse's notes, including date, time, who you spoke to and WHAT YOU TOLD THEM. Examples are: significant weight changes, falls and incidents, skin changes, increased pain and when pain medication is implemented, abnormal labs, new medication or treatment orders and any other changes, emesis, cough, refusing to eat and shortness of breath. Resident assessment and condition changes will be identified with a new flagging system which will notify nurses of charts in need of assessment. The DON will flag charts based on new orders, communication book/24-hour nursing sheet, family observation, physician notes, etc. The DON will place charting guidelines which instruct the nurse regarding what should be charted in a complete and accurate manner. All condition changes shall be documented on the first and second shift and third shift if the resident is awake and experiences a change on that shift. All assessments will be documented in the nurse's notes using guidelines on the outside of the chart and every assessment MUST include a complete set of vital signs. Dietary intake forms have been updated to include fluid documentation Residents who have compromised fluid intake will be evaluated by the FSS/Consultant Dietician and Nursing for appropriate interventions. All professional nurses were educated on the signs and symptoms of dehydration, such as skin tugor, mucus membranes, confusion, decreased urine output, constipation, dark urine, decreased BP, etc. All professional nurses were educated on both June 1, 2018 and June 5, 2018. The June 5, 2018 was presented by a Nurse Consultant RN. Education will continue an ongoing time frame. Compliance will be monitored by the Director of Nursing, Administrator and/or designee on an ongoing time frame, special attention to this issue will be addressed at the monthly QA meetings. See attachments.

Note, Staff Member C and MDS Coordinator are no longer employed by Timely Mission Nursing Home

JC

(F 684) All professional nurses were educated on 2 separate occasions, June 1, 2018 and June 5, 2018 on aspects of providing quality care. **Resident assessment was presented,** a flagging system was implemented that will notify nurse of charts that require assessments. The DON will flag charts based on new orders, communication/24- hour nursing sheet, family observation, physician notes, etc. The DON will place charting guidelines on the chart which instructs the nurse regarding what should be charted. All condition changes require charting on the first and second shift and the third shift if the resident is awake or experiences a change on that shift. All assessments will be documented in the nurse's notes using the guidelines on the outside of the chart. Every assessment MUST include a complete set of vital signs. **Physician/Family Notification:** Physicians and families will be notified of ALL condition changes, the notification will be documented completely, accurately in the nurse's notes, including date and time, who you spoke to and what you told them. Examples are, significant weight changes, falls and incidents, skin changes, increased pain, any changes in condition, abnormal labs, new medications and change of dosage, treatment orders. **Hydration:** Dietary intake forms have been updated to include fluid – food/fluid percentage. Residents who have compromised fluid intake will be evaluated by the FSS/Consultant Dietician and DON for appropriate interventions and physician family notification. Assessment for dehydration was covered including skin tugor, mucus membranes, confusion, decreased fluid output, constipation, dark urine, decrease BP, etc. Water will be passed on each shift and water pitchers are within reach of residents who can independently drink. A water station was started in the front lobby for resident convenience and prompting to drink. All professional nurses were educated on both June 1, 2018 and June 5, 2018; the June 5, 2018 education was conducted by a Nurse Consultant RN. Education will continue an ongoing time frame. Compliance will be monitored by the Director of Nursing, Administrator and/or designee on an ongoing time frame, special attention to this issue will be addressed at the monthly QA meetings. See attachments.

Note: staff member C and the MDS Coordinator at the time of the deficient practice are no longer employed by Timely Mission Nursing Home.

JC

(F 697) All professional nurses were educated on June 1, 2018 and June 5, 2018 and on an ongoing time frame on pain management by the Director of Nursing and a RN Nurse Consultant with a special emphasis on recognizing pain with residents who are non-verbal and unable to express the location of pain. Also, giving pain medication and/or offering as directed by the physician orders was covered. Accurate documentation of the MDS and following the Care Plan were also covered. Additionally, the MDS Coordinator at the time of this deficient practice has terminated employment as well as Staff C, RN. Compliance will be monitored by the Administrator and Director of Nursing on an ongoing basis and special attention to this deficient practice will be addressed at the monthly QA meetings.

(F 842) All professional nurses were educated on 2 separate occasions, June 1, 2018 and June 5, 2018 on aspects of complete and accurate documentation and education will be ongoing. Additionally, records need to be organized and accessible for review. Other areas of concern which were presented were Resident Assessment to be complete and accurate, Physician and Family notification to include complete and accurate documentation and to be timely, and Hydration protocol. Upon the new Administrator starting on March 12, 2018, the MDS Coordinator was replaced as was staff member C, RN. Compliance will be monitored by the Director of Nursing and Administrator and/or designee on an ongoing time frame and at the monthly QA meetings.

(F 868) Upon the arrival of the new Administrator on March 12, 2018, the facility has conducted QA meetings every month and will continue to have the QA meetings on a monthly time frame. Those in attendance are the Administrator, DON, MDS Coordinator and representatives from Dietary, HK/Laundry, Maintenance, Activities and the Business Office. Additionally, the Medical Director attends the QA meetings on a quarter time frame. Compliance will be monitored by the Administrator on an ongoing time frame and at the monthly QA meetings.