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WEST BEND HEALTH AND REHABILITATION	**203 FOURTH STREET NW WEST BEND, IA 50597**

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F 000	INITIAL COMMENTS The investigation of complaints # 93992-C and #93161-C conducted January 11-20, 2021 resulted in the following deficiencies. Complaint # 93992-C was substantiated. Complaint # 93161-C was unsubstantiated. See Code of Federal Regulations (42CFR) Part 482, Subpart B-C. Total Residents 38	F 000		
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 staff interviews, chart reviews and policy review the facility failed to provide needed care or services by not notifying the resident's physician of acute decline in health status for one of three residents reviewed, (Resident #1) which resulted in immediate jeopardy to resident health and safety. Resident #1 had an emesis event on 9/30/20 at 7:30 pm and was visibly not feeling well. The resident was diaphoretic, pale, moaning, and breathing heavy. The resident had no bowel sounds at that time and was complaining about pain in her lower abdomen	F 684	Past noncompliance: no plan of correction required.	

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

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which was tender to the touch. Resident #1 was given Tylenol, a suppository, and an injection of Ativan for comfort. The resident became lethargic but able to answer questions per her baseline. At 2:00 am the resident began to decline further, continuing to be restless and moan. Vital signs were abnormal and oxygen levels were low. Resident #1 was placed on oxygen at 5 liters with no improvement. The resident passed away at 3:55 am. The residents physician was notified through a fax sent containing a copy of the nurse's Progress Note. The physician signed the fax on 10/4/20. The facility reported a census of 38 residents.

Findings include:

The Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/29/20 for Resident #1 showed a Staff Assessment for Mental Status was completed and showed the resident to have severely impaired cognition with impaired long term memory and memory recall. The MDS showed the resident required limited assistance with walking in the corridor and Resident #1 used a walker for assistance.

Review of the Nurses Progress Note dated 10/1/20 at 4:37 am by Staff A Registered Nurse (RN), showed Resident #1 had a large emesis event of food and brown liquid at 7:30 pm. Vital signs at this time were, blood pressure 95/68, pulse 110-120, oxygen 95% on room air, and temperature 97.8. The resident was assisted to bed. At 7:45 pm the resident came to the nurse's station and was visibly not feeling well, resident was diaphoretic, pale, moaning, and breathing heavy. The nurse assessed the resident's blood sugar. Blood sugar was 187 at that time. Vitals

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signs were taken and were, blood pressure 100/76, pulse 115-130, oxygen 95% on room air, respiration rate 25, and temperature 97.5. Resident #1 was complaining of pain in the lower abdomen, which was tender to touch. The nurse documented the resident had no bowel sounds auscultated at this time. Staff A RN notified Staff B Director of Nursing (DON) of resident's change in condition at 8:58 pm.. The DON advised Staff A to keep resident as comfortable as possible due to DNR status. The resident was given a suppository and Milk of Magnesia. The resident continued to complain about abdominal pain, at which time the resident was given Tylenol at 9:50 pm. The resident was anxious and agitated due to pain being uncontrolled and a intermuscular (IM) of Ativan was administered at 10:03 pm to assist the resident to relax and slow her breathing. Resident #1 vital signs at 11:26 pm were blood pressure of 120/75, oxygen at 98% on room air, pulse at 130, temperature of 97.6, and respiration rate of 30. Resident #1 was lethargic but able to answer questions per baseline. Staff A notified the residents guardian of resident's change in condition at 10:13 pm, at which time he stated to keep her comfortable and no further measures were to be taken. The resident rested in bed with her eyes closed, but continued to moan at times and was still somewhat restless. Resident #1 continued to rest in bed and at approximately 2:00 am the resident's condition began to deteriorate. During multiple attempts to obtain vital signs residents blood pressure was 151/99, respiration rate of 46, temperature of 97.8, and oxygen was reading 66% on room air. Attempted to warm up the residents fingers and obtain oxygen saturation but was unable to do so. Oxygen at 5 liters was placed on the resident through nasal cannula in the mouth, due to mouth

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breathing. The resident's oxygen saturation continued to remain below 70%. Staff A notified the DON at 3:09 am of resident's rapid deterioration. At 3:55 am the resident ceased to breath and no heartbeat was auscultated for at least one minute. The DON was notified of resident's passing, and the resident's guardian was notified at 4:25 am.

During interview on 1/11/21 at 3:50 pm Staff A RN stated Resident #1 started not feeling good at 7:30 pm, before the incident the resident was acting her normal self and walking around the facility. Staff A RN stated the resident was having a lot of pain and was very restless. Staff A RN contacted the DON to report the condition of the resident and asked if it was possible to send the resident to the emergency room and the DON informed Staff A RN not to send the resident out that she was a Do Not Resuscitate (DNR). Staff A RN stated the DON stated she would be coming to the facility to assist with situation but the DON did not arrive until after Resident #1 passed away.

During interview with Staff C Licensed Practical Nurse (LPN) on 1/12/21 at 11:45 pm she stated she was informed by other staff members that Resident #1 was in pain and didn't seem right, stating the resident was very sweaty. Staff C stated Staff A was the on duty nurse and that the two of them had a conversation about the resident's condition. Staff C LPN stated Staff A called the DON and the POA twice. Staff C stated the resident only had an order for Tylenol and IM Ativan and there was a discussion about the only pain medication in the Emergency Kit was tramadol. Staff C LPN stated the resident was in a lot of pain, very restless and uncomfortable.

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Staff C stated she was unsure if Staff A contacted the physician. Staff C LPN stated a DNR does not mean not to call the physician.

During interview on 1/12/21 at 12:00 pm Staff D Certified Nurses Aide (CNA) stated Resident #1 was fine throughout the day and ate her supper. Around 7:30 pm the resident vomited, by 8:30 pm the resident needed two staff members to help her ambulate. Staff D stated before this event, the resident would walk around the facility by herself with her walker. Staff D stated the resident had said her stomach hurt and she was rolling side to side moaning in pain. Staff D stated Staff A did give the resident Tylenol and her Ativan but it did not work. Staff D stated Staff A did call the DON and the POA. Staff D stated the phone conversation was overheard and Staff A informed the POA the resident was in pain and that there was nothing at the facility to help her. Staff D stated her shift ended at 10 pm but stayed until around 11:30 pm as Resident #1 was less restless when somebody would sit with her.

During interview with Staff E CNA on 1/12/21 at 3:50 pm she stated she was informed of Resident #1's condition at start of her shift at 10 pm by Staff D. Staff E stated Resident #1 was very pale, clammy and not looking very good. The resident would roll side to side. Staff A went into the resident's room several times and took her vitals. The resident informed Staff E that her stomach hurt and then she would sit up, hold her side and then lay back down.

During interview with Staff A on 1/12/21 at 3:50 pm Staff A stated the physician was not called due to the DON stating to wait and that the DON would call the physician when she came in. Staff

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A stated she felt the residents condition was acute and that she should have been sent to the emergency room but the DON and POA informed her not to transfer her out. Staff A stated she did inform the POA there was no medication at the facility to make the resident comfortable. The DON did not arrive to the facility until after the resident passed away and informed Staff A to fax the nurse's Progress Note documentation to the physician as notification of the event. Staff A stated she was in contact with the DON throughout the event through phone conversations and text messaging.

Review of the text messages between Staff A and the DON showed Staff A informed the DON on 9/30/20 at 8:12 pm the resident was in a lot of pain and requested to transfer the resident to make sure the resident didn't have an obstruction. The DON responded No we cannot. Staff A informed the DON on 9/30/20 at 9:48 pm the resident was given Tylenol and an Ativan injection because the resident was anxious and upset from the pain. Staff A texted she had nothing else to give her to keep her comfortable, she is moaning in pain. The DON responded at 9:49 pm she will be fine. Give it time. Staff A informed the DON at 11:26 pm the resident was still moaning and breathing heavier than normal and still in pain. Staff A informed the DON on 10/1/20 at 2:11 am the resident's oxygen level was 67 percent and her heart rate was 200. The DON responded, She could have aspirated and has pneumonia, relax this has happened before. Staff A responded at 2:13 am that she thinks the resident did aspirate because her right lung sounds like she has some rhonchi. The DON responded to try some oxygen, calm down she still doesn't need to go anywhere, she is a DNR.

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The DON responded on 10/1/20 at 2:17 am just wait and use some oxygen for now. We will need to call the Physician later when I come in. At 2:20 am Staff A texted she isn't responding to me, verbal or sternal rub right now. The DON texted back she doesn't respond when she sleeps often. Staff A texted at 2:23 am she doesn't look like she is sleeping, eyes open and glazed. She has cheynes stroke type breathing. The DON responded at 2:24 am Ok she is a DNR and you put oxygen on her so remain calm, I will be there in 30 minutes or so. The DON texted at 2:25 am She has no quality of life and would have to be isolated if sent out, must think about the bigger picture. The DON texted at 2:50 am her IPOST states comfort measures only, so don't worry Staff A notified DON on 10/1/20 at 2:53 am she is gone, no heartbeat.

Review of Iowa Physician Orders for Scope of Treatment (IPOST) shows Resident #1 was a DNR with comfort measures only, use medication by any route, positioning, wound care, and other measures to relive pain and suffering. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life sustaining treatment. Transfer if comfort needs cannot be met in current location.

Review of Progress Note dated 9/27/20 at 5:33 pm showed Resident #1 had a chocking episode after stuffing bread and ground meat into her mouth all at once, the physician was notified of the episode via fax.

Review of Speech Therapy communication dated 7/23/20 noted Resident #1 had a diagnosis of dysphagia and on a mechanical soft, ground

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meat diet.

Review of Pain Level summary for the month of September 2020 showed the resident only had pain documented once and scored at 2, (1-3 is minor pain).

Review of the Order Summary report, showed Resident #1 had an order for DNR with comfort measures only, Tylenol 650 mg by mouth every 4 hours as needed for pain, Ativan 2mg/ml, inject 1 mg IM every 24 hours as needed for yelling, aggression, refusing ADL, wandering related to anxiety and schizophrenia.

During interview with Resident #1's physician on 1/13/21 at 10:50 am he stated he was not notified of the situation until receiving faxed notification on 1/4/20. Physician stated a DNR does not mean not to treat or evaluate the situation, he stated he would have expected at least a phone call to discuss the evaluation and possible treatment of the resident. The physician stated he believes this was an acute event and that the resident possible had aspirated. The physician stated being a DNR can be a judgement call but always needs an evaluation with at least a phone call to determine the next course of action.

Review of the facility Change in Condition policy updated 6/2018, showed When to report to Medical Doctor; Immediate notification of any symptom, sign or apparent discomfort that is acute or sudden in onset, unrelieved by measures already prescribed, abrupt onset of severe abdominal pain, abdominal tenderness, absent bowel sounds with severe abdominal pain, abrupt new onset of wheezing, rales, or rhonchi, nausea with recent change in condition, new

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severe pain.

Review of the facility Residents Rights policy dated 8/2007, showed the nurse will notify the residents attending physician when there is a significant change in the residents physical, mental or psychosocial status.

During interview on 1/12/21 at 2:20 pm the DON stated she was notified about the residents change in condition and she informed Staff A that Resident #1 was an DNR and to make her comfortable. The DON stated the resident had a similar event in the past and she came out of it fine and thought it was like that again. The DON stated the nurse should have called the physician.

During interview on 1/13/21 at 1:35 pm The DON stated she never told Staff A not to call the physician, stated she did tell her to call the physician and the POA. The DON stated she was texting back and forth with Staff A offering help but never thought about asking if the physician had been called.

Interview with Staff F on 1/13/21 at 2:40 pm showed the facility was aware of the incident and conducted their own investigation. During their investigation it was found there was concern with the lack of physician notification. Staff F stated the DON was educated along with all nursing staff on residents DNR status, notifying the physician and obtaining medication for comfort.

Review of the Education to Nurses pertaining to DNR status and documentation in Point Click Care (PCC) dated 11/9/20 states; Residents family wishes them to remain in facility and kept

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as comfortable as possible without being sent to hospital or higher level of care at this time. The resident is DNR status and Emergency Room physician notified and aware of situation, DON notified and aware of resident's condition. If necessary you may attempt to request other medication for comfort and if needed a staff member will pick up or request pharmacy to deliver to facility when necessary due to limited emergency medication kit contents.

Abatement:

The facility was notified of the Immediate Jeopardy and given the IJ template on 1/13/21 at 1:20 pm. The facility abated the immediate jeopardy on 11/9/20 by taking the following actions:

Education to Nurses pertaining to DNR status and documentation in PCC:
a. Residents family wishes them to remain in the facility and kept as comfortable as possible without being sent to the hospital or higher level of care at this time.
b. The Resident is a DNR status and ER physician notified and aware of situation.
c. DON notified and aware of resident's condition.
d. If necessary attempt to request other medication for comfort and if need a staff member will pick up or request pharmacy to deliver to facility when necessary due to limited emergency medication kit contents.
e. Pharmacy may be paged by calling Hospital ER at night.

The facility educated nursing staff on the Change of Condition Policy with a 1 hour inservice on 1/13/21.

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