Department of Inspections and Appeals
Health Facilities Division
Citation

Number **5851**			**Report date** September 14, 2022
Facility name Stratford Specialty Care		**Survey dates** August 22, 2022- August 29, 2022	
Facility address 1200 Highway 175 East			
City Stratford	JB		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.19(2)j	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(2)** *Medication and treatment.* *j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) **DESCRIPTION:** Based on observations, facility policies reviews, clinical record reviews, staff, and physician interviews the facility failed to appropriately provide assessment and interventions for the necessary care and services related to a change in condition for one of five residents reviewed (Resident #11). The facility failed to address Resident #11's weight after a 12 pound weight gain in three weeks with abnormal lab values. Despite the provider visiting Resident #11 multiple times, the increase of weight failed to get assessed. At the time of Resident #11's admission to the hospital on 8/18/22 he did not have a weight for over a month. When the hospital weighed Resident #11, he weighed 391 pounds and had a lab result of NT-Pro	**I**	**$5000**	**Upon Receipt**

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	B Natriuretic Pep (BNP) 3471 high (a test that determines how well the heart is working). The facility reported a census of 38 at the time of the investigation. Findings include: Resident #11's Minimum Data Set (MDS) dated 6.24.22 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition for daily decision making. Resident #11 required extensive assistance of two persons for bed mobility, toilet use, and personal hygiene. The MDS indicated that Resident #11 did not transfer, walk, move around the unit, or move around off the unit. The MDS included diagnoses of coronary artery disease, heart failure, renal insufficiency, diabetes mellitus, depression and sleep apnea. Resident #11 had shortness of breath with exertion. Resident #11 weighed 328 pounds (#) and had no significant changes in weight. The Care Plan Focus initiated 3/3/22 indicated that Resident #11 experienced Sleep Apnea. The Care Plan included the following interventions. Assist Resident #11 with his BIPAP (a device worn to assist with breathing)/CPAP (a machine used as treatment for obstructive sleep apnea. Ensure Resident #11 that he is using his equipment appropriately. Evaluate him each morning for signs of decreased oxygen, (confusion). Resident #11 chose not to use his CPAP as directed by his doctors, even after receiving education. Monitor him for worsening symptoms of sleep apnea and notify the physician as needed. The Order Review History Report reviewed on 8/25/22 included an order dated 6/11/22 for BIPAP with 2 liters (L) of oxygen (O2) bled in as needed.			

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	The Weight Summary reviewed on 8/25/22 documented the following weights completed with a mechanical lift: 2/28/22 at 2:36 PM 350.9 # 3/14/22 at 12:39 PM 329.5 # 3/38/22 at 4:05PM 319.9 # 4/6/22 at 8:46 PM 323.1 # 6/9/22 at 12:12 PM 324.1 # 6/16/22 at 11:34 AM 327.8 # 7/6/22 at 3:27 PM 339.3 # The Task for Vitals-Weight reviewed on 8/25/22 for the previous 14 dates included only one weight charted as not applicable on 8/14/22. The Chemistry Report Results collected on 7.26.22 at 11:45 AM listed the following results flagged as abnormal: Glucose 57 low, range 70-199 mg/dl. BUN 43 high, range 8-21 mg/dl. Creatinine 1.63 high, range 0.44-1.21 mg /dl. Carbon Dioxide 24 normal, range 21-32 mmol/L. The Appointment/Visit Note dated 8/5/22 at 1:35 PM documented that Resident #11 saw the provider during the house rounds. The provider saw Resident #11 to follow-up on his dark sediment urine. The provider gave a new order to check a urinalysis (UA) with a culture and sensitivity (C&S) if indicated and to obtain a basic metabolic panel (BMP) that day. The Progress Note form dated 8.5.22 recorded that the provider saw Resident #11 in his room that day. The nursing staff requested Resident #11 to be seen due to dark urine, sediment, and possible pus present. Resident #11 has an indwelling urinary catheter due to chronic urinary issues and retention. Patient denies any urinary discomfort or urge to void (urinate). Patient states he drinks a lot of juice and his liquid supplements but denies drinking any water because he gets "too full". The			

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	provider ordered a UA and BMP to check for a urinary tract infection (UTI) and to assess his renal function. The provider noted that Resident #11's had a stable blood urea nitrogen (BUN)/Creatinine when last evaluated. The Physician's Order Form dated 8.5.22 included an order for a UA with C&S if indicated and to obtain a BMP that day. The Progress Note form dated 8.10.22 recorded that the provider evaluated Resident #11 in his room. The nursing staff requested the provider to see Resident #11 the week before due to dark urine, sediment, and possible pus present in his urinary catheter. Resident #11 had an indwelling urinary catheter due to chronic urinary issues and retention. Resident #11 denied any urinary discomfort or urge to void. The provider ordered a UA and BMP to check for a UTI and assess his renal function, as of that day those had not been completed. The nursing staff would obtain a UA that day. The provider reordered his BMP as indicated. The provider noted that Resident #11's had a stable blood urea nitrogen (BUN)/Creatinine when last evaluated. The Chemistry Report Results collected on 8.11.22 at 2:50 PM listed the following results flagged as high: Glucose 143 high, range 70-199mg/dl. BUN 37 high, range 8-21 mg/dl. Creatinine 1.84 high, range 0.44-1.21 mg /dl. Carbon Dioxide 35 high, range 21-32 millimole (mmol)/L. The Progress note form dated 8.12.22 included that the provider evaluated Resident #11 in his room. The Provider ordered a UA and BMP to check for a UTI and assess his renal function. The UA remained pending, but noted the BUN/Creatinine as slightly increased but stable.			

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	The Patient Report documented that Resident #11 had a chest x-ray on 8/17/22. The report included findings from a portable image of the chest demonstrating cardiac silhouette to be within normal limits and no mass seen in the pulmonary hila (supporting structures that connect the lungs to their supporting structures) bilaterally. The lungs noted as clear with no consolidation, no pleural effusion, and no pneumothorax (collapsed lung) visualized. The bilateral Interstitial opacities (scarring in the lungs) may be chronic. The Order Note dated 8/18/22 at 2:03 AM documented Resident #11's vital signs as temperature of 97.0, pulse of 90, respirations of 20, and blood pressure of 107/65, and 92% on 2L of O2 (reference 90-100%). Resident #11 observed to be a little lethargic that shift, but he denied complaints. Vitals obtained and with an oxygen saturation of 44%. He displayed no shortness of breath or increased respirations. Obtained a different device that showed the same reading. O2 applied with nasal cannula and saturation noted in the low 90s. Resident #11's lungs sounded diminished on auscultation (listening). The nurse notified the on call provider who gave orders for a two view chest x-ray. The nurse notified the x-ray provider who reported that they would arrive in the morning. The SPN - Focused Evaluation dated 8/18/22 at 4:24 PM recorded a respiration rate of 12.0 with an O2 rate of 84.0% on room air. Resident #11 noted to have changes in his condition of a headache, ER visit, nausea and vomiting, with decreased urinary output in his catheter. Resident #11 had a low O2 sat and wouldn't keep his O2 on. The nurse noted a bluish color around his mouth. Without O2 he had a saturation level of 55%, after applying O2 his O2 sat came up to 87%. Resident #11 denied having shortness of breath. Upon auscultation his lungs were diminished through all lobes. The nurse			

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	changed his catheter and observed a small amount of bright red blood from his penis. He complained of discomfort when the balloon inflated. The nurse deflated the balloon, readjusted the catheter, and inflated the balloon again. Resident #11 continued to complain of pain and discomfort. After changing the catheter, Resident #11 had no immediate return of urine even though he reported that he had to urinate. Approximately a half hour after, the nurse rechecked on his catheter and observed a small amount of blood tinged, amber urine. The nurse called the on-call provider who gave orders to send Resident #11 to the ER. A telephone order from the Physician dated 8/18/22 indicated the nurse could send Resident #11 to the emergency room for evaluation and treatment. The Emergency Room ED Physician Documentation dated 8/18/22 documented that Resident #11 presented to the ER for low oxygen saturation. The nurse reported that Resident #11 had O2 saturations in the 70s since the previous day that did not respond to application of oxygen. He had a negative COVID test and had an outpatient x-ray that morning which showed normal results. Resident #11 explained that he came for a medical evaluation but he did not really know why. Resident #11 reported that he vomited the day before, but not that day, and stated that he did not have an appetite. He denied any significant chest pain. The section related to Resident #11's vital signs documented the following: Temperature 99.2 Non-labored normal Respiratory rate 22, Oxygen 60% on room air Weight 391 pounds. Resident #11's lab results listed below Carbon dioxide (CO2) 31 normal BUN 77 high Creatinine 3.33 high			

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	Glucose 110 high BNP 3471 high The document included that while awake, Resident #11's had O2 sats in the high 90s, but while lying flat on his back and if no one talked to him, he fell asleep. When asleep his O2 sats go down to the low 80s. According to his chart, Resident #11 had a history of obstructive sleep apnea and a CPAP machine. His wife reported that since he got moved to a different room at the care center, he did not have plug-ins for his CPAP machine and oxygen concentrator so he could not use those. The note dated 8/18/22 at 6:24 PM included in the document indicated that he had an end tidal (a simple graphic measurement of how much CO2 a person is exhaling) CO2 of 59-60. The ER physician recorded that he seemed to be retaining CO2 due to untreated sleep apnea and would definitely benefit from a CPAP or a BIPAP. His BUN/creatinine level elevated most likely due to dehydration. BNP at baseline, will gently hydrate. At 6:50 PM per a discussion with another physician, Resident #11 received an order to be admitted to the hospital. The undated B-Type Natriuretic Peptide Plasma document retrieved from mayocliniclabs.com indicated a BNP aided in the diagnosis of congestive heart failure (CHF). The interpretation of the lab result indicated the following - Normal to less than 200: likely compensated CHF - Equal to 200 or less than 400: likely moderate CHF - Greater than 400: likely to moderate-to-severe CHF The document labeled Heart Failure retrieved from mayoclinic.org listed symptoms as a. Shortness of breath with activity or when lying down b. Very rapid weight gain from fluid buildup c. Nausea and a lack of appetite. The section when to see a doctor indicated that if a person had a diagnosis of heart failure and if any of			

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	the symptoms suddenly become worse or they develop a new sign or symptom, it could mean that the existing heart failure is getting worse or not responding to treatment. This may also be the case if they gain five pounds or more within a few days. The document included the following risk factors: a. Coronary Artery Disease b. Diabetes c. Sleep Apnea d. Obesity e. hypertension The EMR reviewed from lacked documentation to show if Resident #11 had edema. On 8/24/22 at 10:00 AM observed Resident #11's room with two wall plugs with one empty space on each. On 8/23/22 at 8:37 the Emergency Room physician reported that the facility did not take care of their residents. He acknowledged concerns about the residents from the nursing home that came in last Friday. Resident #11 had a high CO2 (carbon dioxide), BUN, and creatinine levels. Resident #11 reported that he could not plug his CPAP in. The Communication with Family note dated 8/25/22 at 9:05 PM documented that Resident #11's wife called and voiced that he passed away that morning. On 8/25/22 at 9:28 AM Staff A, Licensed Practical Nurse (LPN), explained that ever since Resident #11 admitted to the facility, she only knew that he wore his BIPAP only a few times and then the order changed to as needed (PRN). Staff A added that Resident #11 had a low oxygen saturation with diminished lungs (difficult to hear air moving in the lungs) and applied oxygen. Staff A called the physician and received an order for a chest x-ray. Staff A reported that Resident #11 got his chest x-			

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	ray the next day and then they sent him to the hospital. On 8/25/22 at 3:03 PM the Director of Nursing (DON) acknowledged that she could not find the order to change the BIPAP from nightly to PRN. During an interview on 8/29/22 at 10:10 AM the Administrator acknowledged that she would expect physician orders to be followed. She added that if the provider ordered a lab for a specific date she would expect the lab to be done on the date indicated. The Weight Assessment and Intervention policy revised September 2008 directed that the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. The section Policy Interpretation and Implementation instructed the following: 1. The nursing staff will measure resident weights on admission and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter, unless otherwise ordered by a physician or determined by the Interdisciplinary Team (IDT). 2. Weights will be recorded in each resident's electronic medical record (EMR). 3. Any weight change of 5% or more since the last weight assessment will be retaken as soon as possible for confirmation. If the weight is verified, nursing will notify the Dietitian. 4. The Dietitian will respond and make recommendations as necessary. 5. The Dietitian will review the resident's weight monthly to follow individual weight trends over time. Negative trends will be evaluated by the dietician whether or not the criteria for significant weight change has been met. The section labeled Analysis indicated the following:			

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	1. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: a. Resident's target weight range (including rationale if different from ideal body weight); b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake; c. The relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. Whether and to what extent weight stabilization or improvement can be anticipated. 2. The policy included a section labeled Interventions that directed the following: a. The Dietitian/Designee will discuss undesired weight gain with the resident and/or family. b. Interventions for undesired weight gain should consider resident preferences and rights. c. A weight loss regimen should not be initiated for a cognitively capable resident without his/her approval and involvement. d. If a resident declines to participate in a weight loss goal, the Dietitian will document the resident's wishes, and those wishes will be respected. The Medication Orders policy updated November 2014 indicated the purpose of the procedure is to establish uniform guidelines in the receiving and recording of medication orders.			

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	FACILITY RESPONSE:			

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