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	165161	A. BUILDING _____ B. WING _____	R 03/01/2017

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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{F 000}	INITIAL COMMENTS Correction date 4/4/17 The following deficiencies relate to the first revisit of the facility's annual health survey and investigation of complaints #66009-C & #66190-C. The complaints were substantiated. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	{F 000}		
{F 309} SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is	{F 309}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted 4/29/17 VV

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{F 309}	Continued From page 1 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. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide adequate assessment and timely intervention for 2 of 11 residents reviewed (Resident #8 and #11). Resident #8 had a history of urinary tract infection (UTI) and a diagnosis of urinary retention. Resident #8's family had concerns with his/her condition and requested he/she be seen. Facility staff noted Resident #8 not eating or drinking well, with difficulty swallowing through the week. The resident's clinical record lacked any documentation or assessment of Resident #8's change of condition. On 1/20/17 Resident #8 transferred to the hospital with diagnoses of sepsis related to UTI and acute kidney injury and hypernatremia likely related to dehydration. Resident #11 returned to the facility on 1/5/17 following hospitalization. Staff failed to assess the resident upon return to the facility until the resident developed a condition change that required return to the hospital on 1/6/17. The facility reported a census of 86 residents. Findings include: 1. According to the Minimum Data Set (MDS)	{F 309}		

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{F 309}	Continued From page 2 assessment dated 11/18/16, Resident #8 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive and memory impairment. Resident #8 required the assistance of one staff member in order to eat. Resident #8's diagnoses included Non-Alzheimer's dementia, Parkinson's disease and urinary retention. Resident #8's had a history of UTIs, which included: a. A Department of Pathology and Clinical Lab Services final report with a collected dated of 6/27/16 and report status dated 7/1/16 showed Resident #8 had greater than 100,000 colony forming units (CFU) of aerococcus urinae in the urine. The report documented to continue the current antibiotics. b. A Department of Pathology and Clinical Lab Services report collected on 7/23/16 showed Resident #8 had greater than 100,000 CFU per ml of gram negative bacteria in their urine. The physician ordered administration of Cephalexin (an antibiotic) 500 mg (milligrams) 2 times a day for 10 days. c. A Department of Pathology and Clinical Lab Services report collected on 9/17/16 with a final report date of 9/20/16 showed Resident #8 had greater than 100,000 CFU per ml of escherichia coli in their urine. A Medication Record showed Resident #8 received Macrobid (an antibiotic) 100 mg 2 times a day from 9/20 to 9/28/16. The resident's Care Plan, revised on 12/26/16, identified that Resident #8 required assistance with eating and had the goal to maintain his/her intake of food and fluids. Interventions instructed to assist the resident to eat in the dining hall and to record meal intakes daily. The care plan lacked any identification of Resident #8's history	{F 309}		

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{F 309}	Continued From page 3 of UTIs. Review of the resident's clinical showed no documentation of Resident #8's fluid intake. A Progress Note dated 12/2/16 at 4:27 p.m. documented Resident #8 had excellent support from his/her spouse and family. Resident #8's spouse visited multiple times a week. A Weights and Vitals Summary dated 3/1/17 documented Resident #8 weighed 186 pounds on 1/9/17. The Progress Notes dated 1/20/17 at 12:42 p.m. documented Resident #8 as physically unable to swallow medication. Staff called the resident's physician at 11:20 a.m. and updated on this issue and the family member's concern. Staff told the documenting nurse (Staff A) that Resident #8 had not swallowed well since the previous day and the family stated he/she had declined all week and s/he believed Resident #8 had a UTI. The family member wanted the resident's urine checked. The nurse requested an order for a urine analysis and culture and sensitivity per straight catheter and awaited a call back. At 5:25 p.m. staff called the physician's office again when another family member requested they get the resident seen as soon as possible, telling the nurse this had gone on for at least a week. The family believed Resident #8 had a UTI. Staff received approval to send Resident #8 to the emergency room (ER). Resident #8 left the facility at approximately 1:20 p.m. The Progress Notes dated 1/20/17 at 4:41 p.m. (written by Staff D) documented Resident #8's family member came in and questioned how	{F 309}		

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{F 309}	Continued From page 4 Resident #8 could be so sick. The family member stated the ER doctor told them they would make Resident #8 as comfortable as they could and let him/her die. The family member stated Resident #8 had such a bad UTI and dehydration that his/her body was shutting down. The family member asked how a place supposed to care for people could let this happen and they did not know? The ER recorded dated 1/20/17 documented the resident arrived at 2:26 p.m. Family members voiced that nursing home staff did not give the resident fluids; family members do it. The resident's mucosa (mucous membranes) were very dry. The ER report documented the following abnormal laboratory findings: a white cell count of 17.69 (normal 5 to 10); a sodium level of 158 (elevated); a chloride level of 116 (elevated); a Blood Urea Nitrogen (BUN) level of 78 (very elevated), a Creatinine level of 256 (very elevated). The physician documented the resident had the active diagnosis of sepsis related to a UTI and dehydration. According to LabTests Online, elevation of electrolytes (like sodium and chloride) and kidney function studies (like BUN and Creatinine) are often present with dehydration. A hospital History and Physical dated 1/20/17 documented the resident's chief complaint as altered mental status and weakness per reports from the nursing home facility staff. Family accompanied Resident #8 to the ER and apparently over the previous week, s/he had declined, been more weak, had more confusion and was not eating. Resident #8 looked very dehydrated with significantly dry mucous	{F 309}		

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{F 309}	Continued From page 5 membranes. Hospital staff inserted a catheter with minimal urine output with thick sediment in the catheter tubing. The family stated Resident #8 had been very confused over the past couple days, and had similar episodes in the past with a UTI and similar behaviors. Resident #8 weighed at 156# (30# less than the last weight at the facility on 1/9/17). Resident #8 appeared dehydrated, cachectic (ill health with emaciation/abnormal thinness), and sickly. Resident #8's diagnoses included: a. Sepsis secondary to acute cystitis with a white blood cell count of 17.69. The urine revealed large leukocyte esterase with moderate blood and many bacteria. Resident #8 started on Levaquin in the ER, and received 2 liters of intravenous fluid (IV) and hospital staff planned to continue IV fluid hydration. b. Acute hypernatremia (elevated sodium level) likely due to dehydration as he/she did not eat or drank well over the previous week. c. Acute encephalopathy, secondary likely to sepsis and UTI. d. Acute on chronic kidney injury, likely secondary to dehydration. During an interview on 2/28/17 at 12:10 p.m. Staff I Certified Nursing Assistant (CNA) stated Resident #8 had not been him/herself that whole week that he/she went to the hospital. The resident did not have an appetite and pushed food and fluids away. Resident #8 slept in their chair a lot, not unusual for the resident. During an interview on 2/28/17 at 2:19 p.m. Staff B CNA stated Resident #8 did not eat well and didn't drink, so he/she slept a lot, and it went on the whole week. Staff B stated she reported to a nurse about Resident #8 not eating or drinking,	{F 309}		

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{F 309}	Continued From page 6 but did not know what nurse she reported to. Residents #8's family member thought s/he had a UTI prior to the day the resident went to the hospital, and the resident declined. Staff B stated Resident #8 could not swallow the day before s/he went to the hospital; the resident had dry cracked lips and appeared very pale. During an interview on 2/28/17 at 3:13 p.m. Staff F Registered Nurse (RN) (who worked 1/19/17 evening shift) stated she did not usually work D hall, so she did not recall anything because she did not know the residents well enough. She did not recall anyone reporting anything to her about Resident #8. She did not know what she would do since she did not know Resident #8. During an interview on 2/28/17 at 4:20 p.m. Staff C Certified Medication Aid (CMA) stated Resident #8's appetite had decreased and he/she took half of his/her normal fluids. Staff C stated he came in 1/18/17 for the Christmas party, a staff member gave Resident #8 his/her pills and he/she would not swallow them. Resident #8 seemed tired that day. Staff C worried about Resident #8, but the day before hospitalization, s/he seemed OK. During an interview on 2/28/17 at 4:30 p.m. Staff H CNA (who worked 1/19/17 evening shift) stated Resident #8 did not want to eat or drink, was super tired and not talking. They sent him/her a tray and s/he did not eat or drink. Resident #8 was hard to arouse and had been getting that way. The resident had not been eating or drinking well. Staff H stated she checked Resident #8 vital signs and they were normal. Staff H did not recall who the nurse was. Staff H stated Resident #8's spouse expressed concern about the resident's condition.	{F 309}		

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{F 309}	Continued From page 7 During an interview on 3/1/17 at 11:43 a.m. Staff A Licensed Practical Nurse (LPN) stated on 1/20/17, she worked D hall for the first time in 3 to 4 years. She stated Resident #8 could not swallow pills. She asked Staff B about it and Staff B told Staff A that Resident #8 had been like that for a few days. She asked the unit manager and she didn't know the normal for Resident #8. Resident #8's spouse called about 8:00 a.m. concerned about how he/she was doing. Resident #8's spouse then showed up and said it had been (going on) a week. Staff A called the doctor's office and said Resident #8 could not swallow, had lethargy and the spouse said it had been a week. The doctor's office had not returned the call when another family member showed up very upset. Staff A called the doctor's office again and said the family felt Resident #8 was dying. The doctor's office said okay for non-emergent transfer to the ER. Staff A said Resident #8 looked rough and she thought s/he was dehydrated. Staff B told Staff A she had reported (Resident #8's condition) many times to Staff C but no one reported to Staff A, who was the charge nurse (on C hall) covering D hall the day before. She said if staff had reported she would have assessed the resident's vital signs, skin, urine, etc. Staff A thought Resident #8 looked dehydrated but she did not report that to the doctor's office. Staff A felt like she had a mess that should have been taken care of a day or days before. During an interview on 3/1/17 at 10:15 a.m. Staff D LPN stated she had not worked on D hall that week until 1/20/17, after Resident #8 went to the hospital. She moved from the A hall to the D hall after the shift started and did not get report.	{F 309}		

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{F 309}	Continued From page 8 When Resident #8's family came in, she had no idea what had happened. Resident #8's family member was very upset about how he/she could be in that condition. Staff D called the hospital that evening and they told her Resident #8 was very ill. Staff D said if a resident did not drink or eat well she would check urine, check for signs and symptoms of dehydration (like skin and mucous membranes) and notify the physician. If a family member wanted a resident seen she would call the doctor right away. During an interview on 3/1/17 at 7:53 a.m. Staff E LPN stated if a resident's family wanted a resident seen by the physician or in the ER she would call the physician. She would also assess the resident and notify the physician of the resident's condition. During an interview on 3/1/17 at 8:31 a.m. Resident #8's physician stated if a resident did not eat or drink well she would expect staff to assess the resident and report to the physician. If a family member wanted a resident seen, she would expect the facility to call and they would get them in. During an interview on 3/1/17 at 9:12 a.m. Staff G RN stated if a resident did not eat or drink well, she would assess for orientation, check his/her urine, push fluids and report to the physician. During an interview on 3/1/17 at 9:25 a.m. Resident #8's spouse stated on 1/19/17 she told the nurse she thought Resident #8 needed to go to the hospital. The nurse asked why. Resident #8's spouse told the nurse s/he was ill and not eating or drinking well. The nurse told Resident #8's spouse she would leave a message for the	{F 309}		

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{F 309}	Continued From page 9 day nurse to call the physician in the a.m. Resident #8's spouse returned to the facility on 1/20/17 about 10 a.m. and could tell s/he had worsened. The spouse asked the nurse if she had contacted the physician and the nurse said there had been nothing in report about notifying the physician. The nurse told the spouse she did not have time right then, she was busy. Another family member arrived around 11:00 a.m. went to the nurse's office and stayed until they called the physician. The staff who called the physician's office said family thought Resident #8 was dying. The spouse stated no one did any assessment of Resident #8's condition. The spouse stated it took 30 to 45 minutes to get someone to take Resident #8 to the ER per van. The physician in the ER told the family Resident #8 had a UTI and was totally dehydrated. During an interview on 3/1/17 at 11:00 a.m. the Nurse Consultant stated she had interviewed staff and they had not indicated to her that Resident #8 been declining for days. She read the history and physical and stated it was not unusual to give a patient two liters of fluid in the emergency room for dehydration. She stated she would expect staff to assess and report if a resident did not eat or drink well and had difficulty swallowing. The facility's Interact Care Path for Dehydration (potential for) documented a change noted in resident at risk for dehydration included decreased oral intake over 48 hours, dependence on others for fluids and swallowing difficulties. The path directed the next step as checking vital signs. If they did not meet criteria for vital signs, to assess mental status, functional status, genitourinary, and skin, etc. Also evaluate symptoms and signs, which could include acute	{F 309}		

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{F 309}	Continued From page 10 mental status change, not eating or drinking at all and low urine output. If noted notify the physician. 2. The Skilled Charting dated 12/22/16 at 1:43 p.m. documented Resident #11 admitted on 12/22/16. Resident #11 presented as alert and oriented to person, place, time and situation. Resident #11 required assistance with transfers and toilet use. The Progress Notes dated 12/27/16 at 4:31 a.m. documented Resident #11 complained of constant sharp lower abdominal pain rating 8 out of 10. The resident's bowel sounds were hypoactive (slow) on the right side and absent on the left, with tenderness on palpation. Resident #11 had been restless all night. Resident #11's lung sounds showed slight crackles and were diminished. Resident #11 requested to return to the hospital. Staff called the paramedics for transfer to the ER. The clinical record lacked any additional documentation until 1/5/17 at 11:47 p.m. when the Progress Notes documented Resident #11 complained of fluid buildup. Resident #11 stated s/he had shortness of breath and complained of not urinating since being there. The nurse called the physician for orders. On 1/6/17 at 1:58 a.m. Resident #11 complained of the inability to urinate, and his/her legs and abdomen were filling with fluid. Resident #11 coughed up blood tinged sputum and the nurse received orders to transfer him/her back to the hospital. At 4:37 a.m. the nurse called the hospital and Resident #11 admitted. A History and Physical dated 1/6/17 documented	{F 309}		

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{F 309}	Continued From page 11 Resident #11 had discharged from the hospital the previous morning (1/5/17) to the facility. Resident #11 presented with hemoptysis (coughing blood), shortness of breath and urinary retention. A bladder scan showed Resident #11 had greater than 850 cubic centimeters of urine in their bladder. The facility failed to perform any assessment of Resident #11 on his/her return from the hospital on 1/5/17. During an interview on 3/1/17 at 11:00 a.m. the Nurse Consultant stated she had to check on Resident #11's transfer information due to the lack of documentation in the clinical record. Resident #11 had returned from the hospital on 1/5/17. She confirmed they had no documentation of his/her return, or assessment of his/her condition, until the resident had complaints on the night shift. The Nurse Consultant expected staff to document a resident's return and status on return from the hospital. Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for 2 of 11 residents reviewed (Resident #8 and #11). Resident #8 had a history of Urinary tract infection (UTI) and a diagnosis of urinary retention. Resident #8's family had concerns with his/her condition and requested he/she be seen. Facility staff noted Resident #8 not eating or drinking well, with difficulty swallowing. Staff indicated this went on through the week. The clinical record lacked any documentation of Resident #8's change of	{F 309}		

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{F 309}	Continued From page 12 condition, and the facility failed to assess Resident #8's condition. On 1/20/17 Resident #8 transferred to the hospital where he/she had sepsis related to urinary tract infection (UTI) and acute kidney injury and hypernatremia likely related to dehydration. The facility reported a census of 86 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment, dated 11/18/16, Resident #8 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Resident #8 required extensive assistance with activities of daily living (ADL's) including eating, personal hygiene and toilet use. Resident #8's diagnoses included non-Alzheimer's dementia, Parkinson's disease, and urinary retention. Resident #8's history of urinary tract infection (UTI) included: a. A Department of Pathology and Clinical Lab Services final report with a collected dated of 6/27/17 and report status dated 7/1/16 showed Resident #8 had greater than 100,000 colony forming unit (CFU) aerococcus urinae in the urine. The report documented to continue the current antibiotics. b. A Department of Pathology and Clinical Lab Services collected 7/23/16 with a final report date of 7/27/16 showed Resident #8 had greater than 100,000 CFU per ml of proteus mirabilis in the urine. Resident #8 took Cephalexin (antibiotic) 500 mg 2 times a day for 10 days. c. A Department of Pathology and Clinical Lab Services collected 9/17/16 with a final report date of 9/20/16 showed Resident #8 had greater than 100,000 CFU per ml of escherichia coli in the	{F 309}		

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	165161	A. BUILDING _____ B. WING _____	R 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 309}	Continued From page 13 urine. A Medication Record showed Resident #8 with an order for Macrobid (antibiotic) 100 mg 2 times a day for 10 days. The Care Plan revised 7/5/16 identified Resident #8 required assistance with eating, with a goal to maintain his/her intake of food and fluids. The clinical record lacked any documentation of Resident #8's fluid intake. The care plan lacked any identification of Resident #8's history of UTI's. A Progress Note dated 12/2/16 at 4:27 p.m. documented Resident #8 had excellent support from his/her spouse and family. Resident #8's spouse visited multiple times a week. A Weights and Vitals Summary documented Resident #8 weighed 186# on 1/9/17. The Progress Notes dated 1/20/17 12:42 p.m. documented Resident #8 physically unable to swallow medication. Staff called the physician at 11:20 a.m. and updated on the issue and the family members concern. Staff told the nurse Resident #8 had not swallowed well since the previous day, and the the family stated he/she had declined all week and believed he/she had a UTI. The family wanted the urine checked. The nurse requested an order for a urine analysis and culture and sensitivity per straight catheter. The physician's office would return the call. At 17:25 p.m. staff called the physician's office again when another family member of Resident #8's requested they get him/her seen ASAP, telling the nurse this had gone on for at least a week. The family believed Resident #8 had a UTI. Staff received the okay to send Resident #8 to the emergency room (ER). Resident #8 left the	{F 309}		

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{F 309}	Continued From page 14 facility at approximately 1:20 p.m. The Progress Notes dated 1/20/17 at 4:41 p.m. documented Resident #8's family member came in and questioned how his/her family member could be so sick. The family member stated the ER doctor told them they would make Resident #8 as comfortable as they could and let him/her die. The family member stated Resident #8 had such a bad UTI and dehydration that his/her body was shutting down. The family member asked how a place supposed to care for people could let this happen. He/she questioned how they did not know. A hospital History and Physical dated 1/20/17 documented the chief complaint as altered mental status and weakness per reports from the nursing home facility staff. Family accompanied Resident #8 to the ER and apparently over the previous week he/she had declined, been more weak, had more confusion, and not eating. Resident #8 looked very dehydrated with significantly dry mucous membranes. They inserted a catheter with minimal urine output with thick sediment in the catheter tubing. The family stated Resident #8 had been very confused over the past couple days, and had similar episodes in the past with a UTI and similar behaviors. Resident #8 weighed at 156# (30# less than the last weight at the facility on 1/9/17). Resident #8 appeared dehydrated, cachetic (ill health with emaciation/abnormal thinness), and sickly. Resident #8's diagnoses included: a. Sepsis secondary to acute cystitis with a white blood cell count of 17.69 (normal 5 to 10). The urine revealed large leukocyte esterase with moderate blood and many bacteria. Resident #8 started on Levaquin in the ER, and received 2	{F 309}		

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{F 309}	Continued From page 15 liters of intravenous fluid. b. Acute hypernatremia (elevated sodium level) likely due to dehydration as he/she did not eat or drank well over the previous week. c. Acute encephalopathy, secondary likely to sepsis and UTI. d. Acute on chronic kidney injury, likely secondary to dehydration. During an interview on 2/28/17 at 12:10 p.m. Staff I Certified Nursing Assistant (CNA) stated Resident #8 had not been him/herself that whole week that he/she went to the hospital. He/she did not have an appetite and pushed food and fluids away. Resident #8 slept in his or her chair a lot, not unusual for him/her. During an interview on 2/28/17 at 2:19 p.m. Staff B CNA stated Resident #8 did not eat well and didn't drink, so he/she slept a lot, and it went on the whole week. Staff B stated she reported to a nurse about Resident #8 not eating or drinking, but did not know what nurse she reported to. Residents #8's spouse thought he/she had a UTI prior to the day he/she went to the hospital, and he/she declined. Staff B stated Resident #8 could not swallow the day before he/she went to the hospital. He/she had dry cracked lips and appeared very pale. During an interview on 2/28/17 at 3:13 p.m. Staff F Registered Nurse (RN) (who worked 1/19/17 evening shift) stated she did not usually work D hall, so she did not recall anything because she did not know the residents well enough. She did not recall anyone reporting anything to her about Resident #8. She did not know what she would do since she did not know Resident #8.	{F 309}		

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{F 309}	Continued From page 16 During an interview on 2/28/17 at 4:20 p.m. Staff C Certified Medication Aid (CMA) stated Resident #8's appetite had decreased and he/she took half of his/her normal fluids. Staff C stated he came in 1/18/17 for the Christmas party, a staff member gave Resident #8 his/her pills and he/she would not swallow them. Resident #8 seemed tired that day. Staff C worried about Resident #8, but the day before hospitalized he/she seemed OK. During an interview on 2/28/17 at 4:30 p.m. Staff H CNA (worked 1/19/17 evening shift) stated Resident #8 did not want to eat or drink, was super tired, and not talking. They sent him/her a tray and he did not eat or drink. Resident #8 was super tired and hard to arouse, and had been getting that way. He/she had not been eating or drinking well. Staff H stated she checked Resident #8 vital signs and they were normal. Staff H did not recall who the nurse was. Staff H stated Resident #8's spouse expressed concern about his/her condition. During an interview on 3/1/17 at 11:43 a.m. Staff A Licensed Practical Nurse (LPN) stated on 1/20/17 she worked D hall for the 1st time in 3 to 4 years. She stated Resident #8 could not swallow pills. She asked Staff B about it, and she told her Resident #8 had been like that for a few days. She asked the unit manager and she didn't know the normal for Resident #8. Resident #8's spouse called about 8:00 a.m. concerned about how he/she was doing. Resident #8's spouse then showed up and said it had been (going on) a week. Staff A called the doctor's office and said Resident #8 could not swallow, had lethargy, and the spouse said it had been a week. The doctor's office did not return the call when another family member showed up very upset. She called the	{F 309}		

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{F 309}	Continued From page 17 doctor's office again and said the family felt Resident #8 was dying. The doctor's office said okay for non emergent transfer to the ER. Staff A said Resident #8 looked tough and she thought dehydrated. Staff B told her that she had reported (Resident #8's condition) many times to Staff C but no one reported to Staff A, who was the charge nurse (on C hall) covering D hall the day before. She said if Staff had reported she would have assessed the resident's vital signs, skin, urine, etc...On 1/20/17 Staff C said Resident #8 had been like that for a week. Staff A thought Resident #8 looked dehydrated but did not report that to the doctor's office. Staff A felt like she had a mess that should have been taken care of a day or days before. During an interview on 3/1/17 at 10:15 a.m. Staff D LPN stated she had not worked on D hall that week until 1/20/17, after Resident #8 went to the hospital. She moved from the A hall to the D hall after the shift started and did not get report. When Resident #8's family came in, she had no idea what had happened. Resident #8's family member was very upset about how he/she could be in that condition. Staff D called the hospital that evening and they told her Resident #8 was very ill. Staff D said if a resident did not drink or eat well she would check urine, check for signs and symptoms of dehydration (like skin and mucous membranes), and notify the physician. If a family member wanted a resident seen she would call the doctor right away. During an interview on 3/1/17 at 7:53 a.m. Staff E LPN stated if a resident's family wanted a resident seen by the physician or in the ER she would call the physician. She would assess the resident and notify the physician of the resident's	{F 309}		

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{F 309}	Continued From page 18 condition. During an interview on 3/1/17 at 8:31 a.m. Resident #8's physician stated if a resident did not eat or drink well she would expect staff to assess the resident and report. If a family member wanted a resident seen, she would expect the facility to call and they would get them in. During an interview on 3/1/17 at 9:12 a.m. Staff G RN stated if a resident did not eat or drink well, she would assess for orientation, check urine, push fluids and report to the physician. During an interview on 3/1/17 at 9:25 a.m. Resident #8's spouse stated on 1/19/17 she told the nurse she thought Resident #8 needed to go to the hospital. The nurse asked why. Resident #8's spouse told the nurse he/she was ill, not eating or drinking well. The nurse told Resident #8's spouse she would leave a message for the day nurse to call the physician in the a.m. Resident #8's spouse went the following morning and could tell he/she had worsened. The spouse asked the nurse if she had contacted the physician and the nurse said there had been nothing in report about notifying the physician. The nurse told the spouse she did not have time right then, she was busy. Another family member arrived around 11:00 a.m. went to the nurses office and stayed until they called the physician. The staff who called the physician's office said family thought Resident #8 was dying. The spouse stated no one did any assessment of Resident #8's condition. The spouse stated it took 30 to 45 minutes to get someone to take Resident #8 to the ER per van. The physician in the ER told the family Resident #8 had a UTI and	{F 309}		

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{F 309}	Continued From page 19 was totally dehydrated. During an interview on 3/1/17 at 11:00 a.m. the nurse consultant stated she had interviewed staff and they had not indicated to her that Resident #8 been declining for days. She had read the history and physical and stated it was not unusual to give a patient two liters of fluid in the emergency room for dehydration. She stated she would expect staff to assess and report if a resident did not eat or drink well and had difficulty swallowing. The Interact Care Path for Dehydration (potential for) documented a change noted in resident at risk for dehydration included decreased oral intake over 48 hours, dependence on others for fluids, and swallowing difficulties. The next step was checking vital signs. If they did not meet criteria for vital signs, to assess mental status, functional status, genitourinary, and skin, etc... Evaluate symptoms and signs: acute mental status change, not eating or drinking at all, low urine output. If noted notify the physician. 2) The Skilled Charting dated 12/22/16 at 1:43 p.m. documented Resident #11 admitted 12/22/16. Resident #11 presented alert and oriented to person, place, time and situation. Resident #11 required assistance with transfers and toilet use. The Progress Notes dated 12/27/16 at 4:31 a.m. documented Resident #11 complained of constant sharp lower abdominal pain at 8 out of 10. The bowel sounds were hypoactive on the right side, and absent on the left, with tenderness on palpation. Resident #11 had been restless all	{F 309}		

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{F 309}	Continued From page 20 night, Resident #11's lung sounds had slight crackles and were diminished. Resident #11 requested to return to the hospital. Staff called the paramedics for transfer to the emergency room. The clinical record lacked any additional documentation until 1/5/17 at 11:47 p.m. when the Progress Notes documented Resident #11 complained of fluid build up. Resident #11 stated he/she had shortness of breath, and complained of not urinating since being there. The nurse called the physician for orders. At 1:58 a.m. Resident #11 complained of the inability to urinate, and his/her legs and abdomen were filling with fluid... Resident #11 coughed up blood tinged sputum and the nurse received orders to transfer him/her back to the hospital. At 4:37 a.m. the nurse called the hospital and Resident #11 admitted. A History an Physical dated 1/6/17 documented Resident #11 had discharged from the hospital the previous a.m. 1/5/17 to the facility. Resident #11 presented with hemoptysis, shortness of breath and urinary retention. They did a bladder scan and Resident #11 had greater than 850 cc in the bladder. The facility failed to perform any assessment of Resident #11 on his/her return from the hospital. During an interview on 3/1/17 at 11:00 a.m. the Nurse Consultant stated she had to check on Resident #11's transfer information due to the lack of documentation in the clinical record. Resident #11 had returned from the hospital on 1/5/17. She confirmed they had no documentation of his/her return, or assessment	{F 309}		

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{F 309}	Continued From page 21 of his/her condition, until he/she had complaints on the night shift. The Nurse Consultant expected staff to document a residents return, and status on return from the hospital.	{F 309}		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, dietary menu review, group and staff interview, the facility failed to serve the residents food at safe and appetizing temperature. The facility census was 86 residents Findings include: 1. During group interview conducted on 2/28/17 at 1:00 p.m. four of seven residents stated the food did not always get served hot. 2. During observation on 3/1/17 at 8:45 a.m., Staff C, Certified Medication Aide (CMA) passed trays on G hall. At 8:50 a.m., Staff K, Dietary Aide checked the temperature of the resident food items on the cart. The eggs measured 103 degrees Fahrenheit (F), the sausage measured 89 degrees F and the milk measured 47 degrees F.	F 364		

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F 364	Continued From page 22 During interview on 3/1/17 at 8:45 a.m., Staff C stated the hot food should have measured around 140 degrees and the milk should not be that warm, but unsure what it should be.	F 364		

Touchstone Healthcare Community Plan of Correction

Date: 03/27/2017

F309 Provide Care/Services for Highest Well Being

Immediate corrective action:

R#8 and R#11 no longer reside at the facility

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to nurse aides on reporting change in condition including decrease in appetite, intake of fluids.

Education has been provided with licensed nurses on completion of assessment and documentation of assessment when resident experiences a change in condition. Licensed nurses were also educated on completion of assessment and documentation of assessment for all new admissions/readmissions.

Date of completion: 04/04/2017

Recurrence will be prevented by:

Daily monitoring of progress notes will be completed seven days a week to monitor for assessment/documentation completion. Report will be given to nurse managers by licensed nurses and nurse aides seven days a week, reporting any changes in condition, decreased intakes, etc.

The correction will be monitored by: Administrator/designee will complete audits three days a week for four weeks. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/designee

Touchstone Healthcare Community Plan of Correction

Date: 03/28/2017

F364 Nutritive Value/Appear, Palatable/Prefer Temp

Immediate corrective action:

Steam tables were utilized to set up room trays on units when staff available to pass trays immediately to residents.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Dietary staff were educated on appropriate temperature ranges of hot and cold foods.

Date of completion: 04/04/2017

Recurrence will be prevented by:

Dietary Manager will utilize temperature log daily to log food temperatures prior to meal service/tray service.

The correction will be monitored by: Administrator/designee will complete audits three times weekly for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/designee