

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

1265

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CTR VANCOUVER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST 33RD STREET VANCOUVER, WA 98663
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(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
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Kindred Transitional Care and Rehabilitation of Vancouver on 03/22/2013 and 03/25/2013. A sample of 9 residents was selected from a census of 59. The sample included 4 current residents and the records of 5 former and/or discharged residents.

**POC DATE CERTAIN
EXTENDED TO 05/28/2013
PER REQUEST OF
SCOTT PERLMAN**

The following complaints were investigated:

- #2774226
- #2765073
- #2775559

The survey was conducted by:

~~XXXXXXXXXXXX~~, RN, MS

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 3, Unit D
5411 East Mill Plain Blvd., Suite 203
Vancouver, WA 98661

Telephone: 360-397-9550
Fax: 360-992-7969

David W. [Signature] 4/15/13
Residential Care Services Date

RECEIVED
APR 23 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X8) DATE 4/15/2013
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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 279 483.20(d), 483.20(k)(1) DEVELOP SS=E COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care related to bowel management for 3 of 3 residents (#4, 1 & 9) with problems related to spinal cord injury or lower extremity paralysis. This failure placed the residents at risk of complications from not having a regular bowel care program.

According to the National Spinal Cord Injury Association, "Autonomic dysreflexia (AD), also

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This Plan of Correction is the result of the resident's allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F279 05/08/13

- Residents #1, 4, and 9 are no longer in the facility.
- Residents with a diagnosis of hemi/paraplegia have had orders for bowel care obtained and care plan updated as warranted. Residents with hemi/paraplegia will be reviewed upon admit for specific bowel program and care plan initiated.
- Staff Development Coordinator/designee in-serviced licensed nurses on obtaining specific bowel protocol for residents with hemi/paraplegia and updating care plans. Nursing staff in-serviced on bowel protocol, documentation of bowel movements and follow up if no bowel movements. The DNS/designee will audit three times per week for compliance with bowel protocol.
- The findings will be discussed at the monthly PI Meeting until compliance is met. The DNS is responsible to validate compliance with this standard.

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known as hyperreflexia, refers to an over-active Autonomic Nervous System, which causes an abrupt onset of excessively high blood pressure. Persons at risk for this problem generally have {spinal cord} injuries. AD can develop suddenly and is potentially life threatening as is considered a medical emergency. If not treated promptly and correctly, it may lead to seizures, stroke, and even death. AD occurs when an irritating stimulus is introduced to the body below the level of the spinal cord injury. Signs and symptoms include pounding headache, sweating, slow pulse, restlessness, high blood pressure, nausea, flushed face, cold, clammy skin." Interventions to avoid AD include maintaining a regular bowel program, preventing overfull bladder and preventing skin breakdown or other injuries below the level of spinal cord injury. A regular bowel program would include considerations of the prior level of function, the age and ability of the patient.

Findings include:

<Resident #4>
Resident #4 was admitted on [REDACTED] 12 with diagnoses to include a [REDACTED] infection, [REDACTED], [REDACTED] and [REDACTED]. On 09/17, the Resident was hospitalized for treatment, then was re-admitted to the facility on [REDACTED] 12. The Resident's [REDACTED] had caused the Resident's level of physical functioning to decline. By the time of re-admission, the Resident had lost the ability to feel pain below the waist level and had no sensation of the need to urinate or defecate. According to the Minimum Data Set (MDS), an assessment tool, the Resident was alert and oriented, but was dependent on staff for most

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activities of daily living (ADLs).

Bowel assessments were completed on 7/31/12 and on 9/29/12. The 7/31 assessment showed the Resident was always continent (able to control) his bowel function with a usual pattern of having a bowel movement (BM) "every day to every 2 days". The 9/29 assessment completed on re-admit showed the Resident was "always incontinent (unable to control) of bowel, was physically reliant on care giver to go to the bathroom, and had no sensation of need to have a BM."

The data gathered in the bowel assessments was not incorporated into the plan of care. The plan of care specified the Resident required "Extensive staff assistance", but there was no care plan to address the Resident's bowel issues. The plan of care did not include how potential complications of prolonged incontinence, constipation, AD or other concerns would be identified or avoided. The plan of care did not specify how the facility would assist the Resident to achieve his prior level of continence or to achieve having a bowel movement every 1-2 days.

The facility staff had physician orders for a laxative twice daily and for a suppository daily as needed for bowel care. The facility did not use the suppository order to establish a bowel program for the Resident or to intervene timely in periods of extended constipation.

Bowel records reflect the Resident had no bowel movement on 2/22, 2/23, 2/24, 2/25, & 2/26 (or 5 consecutive days). No suppository was

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administered to the Resident during this period of time. Nursing notes written on 2/26 reflected the Resident was "feeling better but still not eating or drinking well." No information was available to clarify if the extended period of constipation was a contributing factor.

The Resident again had no bowel movement on 3/6, 3/7, 3/8, 3/9, 3/10, & 3/11 (or 6 consecutive days). A suppository was administered on the evening on 3/12 after the Resident complained to staff about feeling bloated and nauseated. Chart notes did not reflect facility intervention in the Resident's extended period of constipation prior to the Resident's complaints on 3/12.

On 3/25 at 09:50 p.m., Nursing Assistant (NAC) K stated "The Resident (#4) would put on his call light and ask us if he had soiled himself. He could sometimes tell he had a bowel movement if he could smell himself, but he couldn't feel anything."

On 03/25 at 10:34 a.m., Licensed Nurse (LN) F stated "We have a written bowel protocol that we can use for residents. Our bowel protocol calls for the evening shift to give milk of magnesia after no BM for 3 days, then if no BM, the night shift gives a suppository, then if no BM, the day shift would give an enema. A resident should never have to go more than 3-4 days without a bowel movement. I guess the protocol got missed for that resident {Resident #4}."

On 3/25 at 12:45 p.m., Resident Care Manager (RCM) C stated "The Resident (#4) was alert and oriented and was able to determine his own bowel care needs. His usual pattern was to go

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every 5-6 days." When asked, RCM C stated she had not discussed risks of extended periods of time with no bowel movements with the Resident. RCM C stated "Any special considerations for paraplegics or quadriplegics would be care planned if it was different from the protocol."

<Resident #1>

Resident #1 was admitted to the facility on 1/13 with diagnoses to include quadriplegia (paralysis from the neck down), with associated incontinence (paralysis) from a spinal cord injury. According to the MDS, the Resident was alert and oriented but was totally dependent on staff for ADL assistance.

The bowel assessment completed on 1/12/13 showed the Resident was always incontinent and was accustomed to having a bowel movement every day. The Resident had no ability to feel the need to urinate or to have a bowel movement.

There was no evidence that the information gathered in the bowel assessment was used to develop a plan of care for bowel management for the resident. There was no plan of care for a bowel management program and there was no indication that risks of not having a regular program had been identified or considered.

Bowel records show the Resident had no bowel movement on 2/12, 2/13, 2/14, 2/15, 2/16 & 2/17 (or 6 consecutive days).

<Resident #9>

Resident #9 was admitted on 12/12 with a re-admit on 1/13 with diagnoses to include

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_____ of _____ and _____ According to the MDS, the Resident was alert and oriented but was totally dependent on staff for ADL care.

The Resident was assessed on 3/13 as being accustomed to having a BM every 2-3 days, but was noted to be incontinent and not able to participate in bowel care.

Bowel records for Resident #9 reflect no bowel movement on 3/13, 3/14, 3/15, 3/16, 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, 3/23 & 3/25 (or 12 consecutive days). MAR records reflected the Resident received a laxative twice a day and could receive a suppository daily as needed. The Resident had received a suppository once on 3/18 with no results recorded.

No care planned information was located regarding the bowel management program for the Resident.

Refer to F 309

This Plan of Correction is the center's credible allegation of compliance.

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F281

05/08/13

1. Resident # 4 is no longer in the facility
2. An audit of alert documentation by licensed nurses and CNAs with a 7 day look back period was performed to establish a baseline.

3. Staff Development Coordinator/designee in-serviced licensed staff on bowel protocol, diabetes management, change of condition policy and procedure with a focus on recognizing the significance of the change and communicating them clearly and promptly to the attending practitioner. DNS/designee will audit alert documentation of LNs and CNAs three times per week during morning clinical meeting with follow up as warranted.

4. Results of this audit will be discussed in the monthly PI meeting until compliance is met. The DNS is responsible for overall compliance.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for 1 of 9

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residents (#4) when they failed to monitor or recognize changes in the Resident's condition. This failure caused harm for the resident when when the need for acute medical treatment was delayed.

Findings include:

According to the American Nurses Association, Scope and Standards of Practice, 2011, " according to standards of care, a licensed nurse shall, in a complete, accurate and timely manner, report and document nursing assessments or observations, the care provided by the nurse for the client, and the client's response to that care. Nurses assume a liability risk if they fail to monitor a patient or to recognize changes in a patient's condition. Failure to recognize the significance of changes or to communicate them clearly and promptly to the attending practitioner could endanger the patient. "

Resident #4 was admitted to the facility on [redacted]/12 with diagnoses to include [redacted] because of a [redacted] and [redacted]. The Resident went to the hospital on 9/17, then re-admitted on [redacted]/12. The Resident had [redacted] had to use a [redacted] ([redacted]) for [redacted]. According to the Minimum Data Set (MDS), an assessment tool, the Resident was normally alert and oriented but was dependent on staff for activities of daily living. The Resident received routine insulin (a medication to control blood sugars) and a sliding scale type of [redacted] that could be adjusted, depending on the Residents blood sugar readings. Sliding scale [redacted] was to be

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administered for blood sugars over 130 mg/dL. The order was changed to give slightly less sliding scale starting on 3/12 at 4:30 p.m. The Resident was to have blood sugar checks (CBG's) done 5 times per day.

Resident record review reflected the Resident with an elevated blood sugar, poor appetite, decreased fluid intake, decreased urine output and complaints of "not feeling well" beginning with the day shift (6:00 a.m. until 2:30 p.m.) on 3/12/13. Additionally, the Resident was constipated, with no bowel movement recorded on 3/6, 3/7, 3/8, 3/9, 3/10, & 3/11. The Resident was "moaning" on several occasions during the evening shift (2:00 p.m. until 10:30 p.m.) of 3/12 and the night shift (10:00 p.m. until 6:30 a.m.) of 3/13. The Resident was given a suppository on the day shift of 3/12 for no bowel movement, but there was no assessment recorded. The Resident was not assessed on the evening shift of 3/12. The Resident was not assessed on the night shift of 3/13. Vital signs were not recorded. Pain medication was not administered. The physician was not notified of the changes in Resident condition until 8:00 a.m. on 3/13.

Blood sugar checks were elevated despite the Resident not eating. Blood sugars were recorded as follows:

- 3/12 at 7:00 a.m. = 318 mg/dL sliding scale insulin given as ordered, "did not eat breakfast"
- 3/12 at 11:30 a.m. = 317 mg/dL "sliding scale insulin not given", orders were for 12 units of Novolog Insulin, "did not eat lunch",
- 3/12 at 4:30 p.m. = 224 mg/dL "sliding scale insulin not given", orders were for 5 units of Novolog Insulin, "not eating, constipated",

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3/12 at 8:00 p.m. = 186 mg/dL "sliding scale insulin not given", orders were for 3 units of [REDACTED]
3/13 at 3:00 a.m. = 107 mg/dL sliding scale [REDACTED] not required

Urine output was recorded sporadically for the prior week, with no usual pattern established. The Resident had a [REDACTED] ([REDACTED]). On the day shift of 3/12 the Resident's [REDACTED] output was 400 cc (milliliters). On evening shift of 3/12, no urine output was recorded. On the night shift of 3/13, a urinary output of -0- was recorded. No assessment was completed to determine if the [REDACTED] was positioned correctly or was open to drainage.

On 3/13/13 at 8:15 a.m., according to nursing notes, Resident #4 was sent to the hospital emergently for signs and symptoms of [REDACTED] chest (an [REDACTED] with a "Blood pressure of 70/40, pulse 130, temperature of 99.7 and [REDACTED] and [REDACTED] of the [REDACTED]"

On 3/25/13 at 3:25 p.m., the Director of Nursing stated "I am continuing to investigate, but I don't think we did anything wrong."

See F 309 for detailed interviews and explanations of the Resident's deteriorating condition.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

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F282 05/08/13

1. Resident #4 is no longer in the facility
2. All residents have the potential to be affected by this practice.
3. DNS in-serviced Staff Development Coordinator on orientation expectations for agency staff. Staff Development Coordinator/designee will in-service agency staff prior to first shift in this facility. An orientation binder is available at each nurse's station for reference.
4. DNS/designee will monitor for compliance of orientation. The Administrator is responsible for validating compliance with this standard.

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This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure care was provided in accordance with each resident's written plan of care for 1 of 9 residents (#4) when the facility failed to have a method of orienting temporary/agency staff to the facility and did not have a timely way to retrieve information when questions arose regarding the care that had been delivered to the Resident by temporary staff.

Findings include:

Resident #4 was admitted to the facility on [REDACTED] 12 with diagnoses to include [REDACTED] because of a [REDACTED] and [REDACTED]. The Resident went to the hospital on 9/17, then was re-admitted to the facility on [REDACTED] 12. The Resident had [REDACTED] and [REDACTED] and [REDACTED] for [REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, the Resident was normally alert and oriented but was dependent on staff for activities of daily living.

The Resident's plan of care dated 8/8/12, noted the Resident had chronic pain. Interventions were to observe and report changes in usual routine, sleep patterns and decrease in functional abilities and to notify the physician if the interventions were unsuccessful or if the current complaint was a significant change from the residents past experience of pain.

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F 282 Continued From page 11

According to facility records, on 3/11/12, Resident #4 had started to have some problems with blood sugar control and had become sleepy. On 3/12/12, the Resident began experiencing problems with lower than normal urine output. On 3/12, during the day shift, the Resident received a suppository for bowel care.

On the evening shift {2:00 p.m. to 10:30 p.m.} of 3/12, Licensed Nurse (LN) G, a facility employee, was the nurse on duty. On 3/22 at 4:45 p.m., LN G stated "I was on duty on the evening of 3/12. The Resident told me he felt better after having results from the suppository he received earlier on the day shift. He had a large bowel movement at about 9:00 p.m. I checked his blood sugar. He was alert and oriented and his ~~output~~ was draining."

No information was recorded in the Resident's chart regarding what happened with the Resident between the time the facility LN G reported off on the evening shift of 3/12 and when the day shift {6:00 a.m. to 2:30 p.m.} LN F came on duty on the morning of 3/13. Medication administration records indicate Resident #4 received no pain medication during the night shift. A temporary/agency nurse worked on the night shift beginning 3/12 at 10:00 p.m. until the morning of 3/13 at 6:30 a.m.

By the time the facility LN F reported for duty on the morning of 3/13, Resident #4's clinical condition had changed dramatically. LN F wrote a nursing assessment note on 3/13 which stated "Around 7:30 a.m., noticed res {Resident} very confused and looks pale. Res moaning off and on. While positioning noticed lower abd.

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{abdomen}, { } and { } area swollen and red. { } in {place} but no output in { } irrigated with NS (mild salt solution) but no return flow. BP (blood pressure) 70/40, pulse 130, Temp (temperature) 99.7. MD (Doctor) notified and received order to transfer res to hospital."

On 3/22, at 4:20 p.m., during interview, the Director of Nursing stated: "We had an agency nurse working on the night of the 12th to the morning of the 13th. I have put calls out to her agency to get a statement from her. I am completing an on-going investigation to determine what happened with the Resident that night."

On 3/25 at 9:50 a.m., Nursing Assistant (NAC) K stated "My shift starts at 6:00 a.m. I went into check on {Resident #4} right away on the morning of 3/13 because the off-going aide told me he was moaning all night and seemed to be in pain. I remember his condition on the morning of 3/13 because he was very different from usual. When I first saw the Resident right after I got here, he was gray in color. I took the vital signs and the blood pressure was very low, the pulse was high, he had a temperature. When I went to pull the resident up in bed, I saw his { } area was very swollen. I immediately went and got the day nurse, then he got sent out to the hospital."

On 3/25 at 02:55 p.m., when asked how agency or temporary staff would be trained on the facility practices and residents, the Staff Development Coordinator stated "I don't have anything to do with training or orientation of agency personnel. I would think if they are agency, they are competent. I know we had one nurse here, but I

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F 282 Continued From page 13
don't know how many shifts she has worked. If any training or orientation gets done for agency it would be done by the administrator. I don't do anything with agency staff."

On 3/25 at 3:15 p.m., the Administrator stated "There is a mini orientation that agency staff go through related to our facility. Our Staff Development Coordinator does that orientation. I would assume that anyone who works for us through tempory staffing would have their credentials checked by the agency."

Refer to F 309

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=G
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, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide necessary care and services to attain or maintain the highest practicable level of physical, mental and psychosocial well-being when they failed to complete a timely assessment and respond to reported concerns for 1 of 9 residents (#4) whose overall condition was in decline. This failure resulted in unnecessary pain

F 282
This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F309 05/08/13

- F 309
1. Resident #4 is no longer in the facility.
 2. An audit of alert documentation by licensed nurses and CNAs with a 7 day look back period was performed to establish a baseline.
 3. The facility has implemented a plan for orientation of agency staff prior to their first shift. Staff Development Coordinator/designee in-serviced nursing staff on identifying, reporting, and follow up on change of condition. The DNS/designee will audit alert documentation of LN and CNAs three times per week during morning clinical meeting with follow up as warranted.
 4. The findings of the audit will be discussed in the monthly PI meeting until compliance is met. The DNS/designee is responsible to validate compliance with this standard.

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and delayed treatment for the resident.

All staff interviews were completed on 03/22/13 and 03/25/13.

Findings include:

Resident #4 was admitted to the facility on 03/12/12 with diagnoses to include [REDACTED] because of a [REDACTED] and [REDACTED]. The Resident went to the hospital on 9/17, then re-admitted on 03/12/13. The Resident had [REDACTED] had to use a [REDACTED] (a [REDACTED]) for [REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, the Resident was normally alert and oriented but was dependent on staff for activities of daily living. The Resident received routine [REDACTED] (a medication to control blood sugars) and a sliding scale type of [REDACTED] that could be adjusted, depending on the Residents blood sugar readings. The Resident was to have blood sugar checks (CBG's) done 5 times per day.

According to facility records, Resident #4 saw his physician on 3/11/13 for possible [REDACTED] adjustment. The Resident was planning to discharge to the community and the physician had wanted to ensure the Resident's diabetes was in the best possible control. While the Resident was at the office, the Resident was found to be sluggish and was found to have a low blood sugar. Paramedics were summoned to the doctor's office and administered treatment to the Resident. Paramedics recommended hospitalization, but the Resident declined because he wanted to proceed with discharge

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plans. The physician decided to order a more extended monitoring of the Resident's [redacted] later in the month. The Resident returned to the facility with orders to reduce the amount of [redacted] to be given and to continue to check CBG's 5 times a day.

During interview, Licensed Nurse (LN) F stated "I worked the day shift on 3/11, 3/12 and 3/13. My shift is from 6:00 a.m. to 2:30 p.m. On Monday, 3/11, he (Resident #4) went to the doctor with blood sugars out of control. The Resident (#4) would sometimes have blood sugars as low as 30 (mg/dL) and as high as 200-300 (mg/dL). The Doctor wanted to keep the Resident's blood sugars under 130 (mg/dL) and had changed the sliding scale insulin coverage to a lower level. The next day, 3/12, the resident didn't feel well and was staying in bed. At about 1:30 p.m. (on 3/12), the Nursing Assistant (NAC M) reported to me that the Resident was still not feeling well. I checked in the computer and I saw the Resident had not had a bowel movement for 5 or 6 days. I listened to his abdomen and I noticed his bowel tones were sluggish. This had happened a couple of times in the past. He was getting medications that cause constipation, plus he has [redacted] from a [redacted]. He couldn't feel anything from the waist down. I gave him a suppository and told the evening shift nurse. He did not have a bowel movement on my shift."

CBG (blood sugar checks) records for the date of 3/12 show the blood sugar at 7:00 a.m. was 318 mg/dL and at 11:30 a.m. was 317mg/dL. Medication administration records (MARs) show sliding scale [redacted] was administered as ordered

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at 7:00, but was not given in response to the 11:30 a.m. blood sugar. "Resident refused to eat lunch {on 3/12}. ~~not given.~~" Nursing notes written on 3/12 speak to communication with the physician's office about upcoming appointments. The notes do not provide any information as to the Resident's over all well being or why he might not be feeling well. There was no information available regarding whether the Resident's abdomen had been assessed. There was no information available regarding whether the Resident's vital signs had been checked. There was no information available regarding if any consideration had been given to why the Resident's blood sugars were high when he was not eating.

During interview, Nursing Assistant (NAC) J who had worked the evening shift on 3/12 stated "I started my shift about 3:30 p.m. on 3/12. The day shift NAC told me that he {Resident #4} had received a suppository because of no BM in quite a few days and to check him because the resident wouldn't be able to tell if he had a BM or not. I checked on him 3-4 times that shift, but it was about 9:00 p.m. before his bowels moved. When I changed his linen, I leaned him on one side, then when I turned him the other way, I noticed there was not much in the ~~catheter bag~~, the mattress was wet {indicating leakage} and I noticed that his ~~genitals~~ were red and swollen. I told the nurse {LN G} about my observations. She told me she would check on him. Also, the resident seemed like he might be in pain because he was restless and moaning which I also told the nurse about. He also seemed really, really tired."

Nursing notes written by LN G at the end of the

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evening shift on 3/12 reflected "Res (Resident) not hungry this shift due to constipation and had large BM following suppository for same. Low output {urine} at end of shift due to poor fluid intake but feeling better after BM. Continue bowel meds and monitor. Push fluids."

F 309

MAR (Medication Administration Records) records indicated the Resident's blood sugar at 16:30 {4:30 p.m.} was 224mg/dL and the blood sugar at 20:00 {8:00 p.m.} was 186mg/dL. According to the MAR, the Resident's "sliding scale insulin held {not given} - not eating-constipated". No vital signs were recorded in the chart for the evening shift. Nursing notes did not reflect why the Resident was not eating, whether an assessment of the low urine output had been completed or why the Resident's blood sugar remained high despite poor food intake.

During interview, LN G, the evening shift nurse on duty on 3/12, stated "I work the evening shift from 2:00 p.m. until 10:30 p.m. I was told in report on 3/12 that he {Resident #4} had received a suppository on day shift. As far as I know, the Foley catheter was patent {functioning}. He had no appetite that evening he said he felt full and was waiting to have a BM." When asked what assessment she had completed for Resident #4 on the evening of 3/12, LN G replied "I checked his blood sugar and gave his medications. I was aware of the low urine output. I did not assess the resident on the evening of 3/12. I didn't think it was necessary."

An agency/temporary staff nurse worked during the night shift between 10:00 p.m. and 6:30 a.m.

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	<p>F 309 Continued From page 18</p> <p>The chart did not contain information to explain what was happening with the Resident from the end of the evening shift on 3/12/13 until the beginning of the day shift on 3/13/13. No vital signs were recorded. No pain medication was administered. A CBG was recorded as being 107 mg/dL at 03:00 a.m. During telephone interview, the agency nurse stated "I noticed the Resident (#4) was arousable and responding to verbal stimuli on 3/12 when I came on duty for the night shift. I was not aware of any changes through the night. I checked his blood sugar at 3:00 a.m. I heard him moaning, but he didn't seem to be in pain."</p> <p>Nursing notes in Resident #4's record written on 3/13 showed "Around 7:30 a.m., noticed res {Resident} very confused and looks pale. Res moaning off and on. While positioning noticed lower abd. (abdomen), [redacted] and [redacted] area swollen and red. [redacted] {redacted} in (place) but no output in [redacted].g. [redacted] irrigated with NS {mild salt solution} but no return flow. BP {blood pressure} 70/40, pulse 130, Temp {temperature} 99.7. MD {Doctor} notified and received order to transfer res to hospital."</p> <p>During interview, Nursing Assistant (NAC) K stated "My shift starts at 6:00 a.m. I went into check on {Resident #4} right away on the morning of 3/13 because the off-going aide told me he was moaning all night and seemed to be in pain. I remember his condition on the morning of 3/13 because he was very different from usual. When I first saw the Resident right after I got here, his color was gray. I took the vital signs and the blood pressure was very low, the pulse was high, he had a temperature. When I went to pull the</p>	<p>F 309:</p>	

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resident up in bed, I saw his [redacted] area was very swollen. I immediately went and got the day nurse, then he got sent out to the hospital "

During interview, LN F stated "The agency nurse reported in morning report on 3/13 that he {Resident #4} had been moaning and groaning all night and had a low blood sugar. When I went into his room about 7:30 that morning, he didn't look right. He looked confused and more pale. When we went to move him up in bed, I saw his [redacted]. His [redacted] and [redacted] were very swollen, maybe about 6-8 inches across. And he had no urine output. We sent him to the hospital about 8:15 a.m."

According to staff interview and resident record review, the facility day nurse LN F did not assess the Resident on the day shift on 3/12, despite the Resident not feeling well and having elevated blood sugars and extreme constipation. LN G did not assess Resident #4 on the evening shift of 3/12 despite receiving information from the day shift regarding blood sugar problems, bowel problems and resident complaints of not feeling well, and despite receiving NAC reports of swollen [redacted], apparent pain and low urine output.

During the night shift of 3/12 to 3/13, an agency nurse unfamiliar with the resident was on duty. There was no indication the night nurse assessed the resident or evaluated the resident's vital signs. On the morning on 3/13, the agency nurse reported the resident had been moaning during the night shift, but no interventions were recorded. The night shift nursing assistant reported on the morning of 3/13 that the resident

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had been moaning during the night shift. By the time the day shift Licensed Nurse assessed the resident on the morning of 3/13, the resident was experiencing signs and symptoms of acute infection and required emergency transfer to the hospital. The Resident experienced unnecessary pain and a delay in treatment because of lack of assessment for at least 3 shifts.

On 3/25 at 3:25 p.m., the Director of Nursing stated, "We heard from the Physician that Resident (#4) was found to have a type of [REDACTED]. I am continuing to investigate, but I don't think we did anything wrong. The Resident was found to have [REDACTED] and had to have radical surgery. He was transferred to the burn unit for extensive skin grafting. He will be there for several months."

Refer to F 279, F 281 & F 282