STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL TYLER CARE CENTER	930 S BAXTER TYLER, TX 75701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the physician about a significant change of condition for 1 of 6 residents reviewed for a change of condition. (Resident #4) Resident #4 experienced changes in his level of consciousness, had diarrhea, and refused to eat; however, the physician was not consulted until two days later ([DATE]). Resident #4 was sent to the local emergency room and admitted with altered mental status, profound dehydration, urinary tract infection, metabolic acidosis, and [MEDICAL CONDITION] (elevated potassium). Resident #4 died in the hospital [DATE]. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure contributed to a delay in Resident #4 receiving needed medical treatment and could place 86 residents at risk for delay in medical evaluation and treatment or death. Findings included: Physician orders [REDACTED].#4 was [AGE] years old and admitted on [DATE] with the [DIAGNOSES REDACTED]. An admission assessment dated [DATE] indicated Resident #4 was alert and independent with decision making and could answer questions appropriately. He was assessed with [REDACTED]. He had normal bowel sounds and no diarrhea. The most recent MDS dated [DATE] indicated Resident #4 usually was understood by others and he understood others. Resident #4 required extensive assistance with transfers, dressing, bathing, and personal hygiene. He required limited assistance of one person for eating. Resident #4 was frequently incontinent of bowel and bladder. A comprehensive care plan dated [DATE] indicated Resident #4 was at risk for dehydration related to use of [MEDICATION NAME] (diuretic), history of pneumonia, and possible insufficient fluid intake. The goal for Resident #4 was not to show signs and symptoms of dehydration. The approaches included; maintain intake and output when indicated and report signs of dehydration (lethargy, increased confusion, change of LOC, concentrated urine, dry skin, with poor skin turgor and dry oral mucosa). The facility Medication Administration Record [REDACTED]. During an interview on [DATE] at 3:00 p.m., the OT said on Friday [DATE], Resident #4 performed his therapy without a problem. The OT said the resident was smiling and talkative. During an interview on [DATE] at 3:15 p.m., CNA E said she cared for Resident #4 on the 6 a.m.- 2 p.m. shift Saturday [DATE] and Sunday [DATE]. She said on both days Resident #4 was not his usual self and he was weaker than normal. She said Resident #4 was not able to sit up as he normally did and she had to put him to bed early. CNA E said she notified LVN B of Resident #4 ' s decline. During an interview on [DATE] at 5:25 p.m., CNA F said she provided care for Resident #4 on Saturday [DATE] and Sunday [DATE]. CNA F said Resident #4 was in bed on her 2 p.m.-10 p.m. shift both days which was not normal for him. She said Resident #4 ate 25 percent of his evening meal and only drank a few sips of fluids which was not his norm. CNA F said Resident #4 ' s urine had a strong smell and she reported this to her charge nurse. The 24 hour report sheet dated Saturday [DATE] night shift indicated Resident #4 had diarrhea. There was no indication a physician was notified or any medications to help with the diarrhea were administered. A nursing note by RN C dated [DATE] at 12:00 a.m. indicated Resident #4 had loose stools three times and poor skin turgor. The note did not indicate a physician was notified or medication administered. During an interview on [DATE] at 4:10 p.m., LVN B said she provided care for Resident #4 on Sunday [DATE] and Resident #4's sister voiced concern about Resident #4 not eating or drinking well. LVN B said on Sunday Resident #4 stayed in bed, had extremely dry skin, and did not eat well. She said she thought the resident looked the same. LVN B said she did not call the physician. A nursing note by RN A dated Sunday [DATE] at 12:00 a.m. indicated Resident #4 was drooling. The note did not indicate a physician was notified. During an interview on [DATE] at 3:45 p.m., Resident #4's sister said she came to the facility on [DATE] a little after 8:00 a.m. because her sibling called her very upset about Resident #4's condition change on Sunday [DATE]. She said she found Resident #4 unable to talk and he was so very weak. Resident #4's sister said his morning meal was on his bedside table untouched. She said she went to the nurse's station and demanded someone send him to the hospital. During an interview on [DATE] at 2:10 p.m., ADON D said Resident #4's sister was at the nursing station saying something is wrong with him and requested his transfer to the emergency room . ADON D said she assisted RN A with transferring Resident #4. ADON D said the resident looked like he had a stroke. During an interview on [DATE] at 2:50 p.m., RN A said Resident #4's sister was convinced he had a decline in condition on [DATE] and requested he be sent to the ER. RN A said Resident #4 was his usual total care, nothing unusual. RN A said she pushed fluids on Resident #4 because of decreased food and fluid consumption. RN A said when she assessed Resident #4 prior to sending him to the emergency room she saw no change in him, she saw no signs of dehydration and did not see any reason to notify the physician prior to the sister's request. She said she called the physician because the sister said she could see a whole lot of difference in him. A nursing note by RN A dated Monday [DATE] at 9:00 a.m. indicated Resident #4 was lying in bed alert but slow to respond. The resident did not follow directions, had decreased tactile sensation, increased right sided facial drooling, was very weak, and had a very poor appetite. The note indicated the family was present and requested Resident #4 be transferred to the hospital. At 9:30 a.m. the nursing note indicated after the family's insistence, the nurse practitioner was notified and an order was given to send to ER for evaluation. The note indicated at 10:10 a.m. EMS was at the facility to transfer Resident #4 to the ER. The undated nursing home transfer to hospital form completed by RN A indicated Resident #4's vital signs were: blood pressure ,[DATE], heart rate 63, respirations 16, temperature 97.1, and oxygen saturation 90%. The reason for transfer was listed as possible TIA ([MEDICAL CONDITION]- mini stroke). During an interview on [DATE] at 3:10 p.m., the DON said she was not familiar with Resident #4's condition when he left the facility. The DON said there was not an intake and output record for Resident #4. The DON said his disease processes did not warrant use of monitoring using intake and output recordings. She said she was not notified of Resident #4 having diarrhea, decreased appetite, and weakness. The DON said she expected the nurse to assess the resident and to call the physician when resident ' s experienced changes in condition. The hospital admission lab results dated [DATE] at 10:50 a.m. indicated Resident #4 had the following abnormal results: *white blood cell count of 22.7 (Normal range 3XXX,[DATE].6), *sodium 145 (normal range ,[DATE]), *potassium 6.1 (normal range 3XXX,[DATE].1), *chloride 118 (normal range ,[DATE]), *BUN 170 (normal range ,[DATE]) and, *creatinine 6.94 (normal range 0XXX,[DATE].30). *The urine WBCs were loaded (too many to count) and had heavy bacteria. *A chest x-ray indicated atelectasis in the lung basis. A hospital history and physical dated [DATE] at 2:40 p.m. indicated when Resident #4 arrived in the emergency room his mental status was very altered, he was barely awake, and could not respond at all. The laboratory reports indicated the resident had increased potassium and increased BUN and creatinine. Resident #4's general assessment was blood pressure ,[DATE], heart rate 111, temperature 97.7, and respirations 13. The resident ' s tongue was very dry and he was unable to respond to verbal commands. The assessment indicated Resident #4 [MEDICAL CONDITION] secondary to a urinary tract infection with severe dehydration resulting in acute kidney injury. A renal consult report from the urologist on [DATE] at 2:40 p.m. indicated Resident #4 was lethargic and severely dehydrated. Resident #4's oral

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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) mucosa were very dry and his skin turgor was very poor. The note indicated the etiology of Resident #4's acute [MEDICAL CONDITION] was secondary to profound dehydration. Resident #4 also presented with [MEDICAL CONDITION] (increased potassium) and metabolic acidosis. (Life threatening condition that occurs when the kidneys can't eliminate acid buildup) A cardiopulmonary resuscitation note dated [DATE] at 6:25 a.m. indicated Resident #4 expired in the intensive care unit. The policy and procedure dated ,[DATE] indicated .to notify the physician and inform the resident and resident's responsible party of a significant change in the resident's physical, mental psychological status including accidents and when there is a need to alter treatments significantly. Change of Condition related to physician notification is defined as the physician should be notified of any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denoting a new problem, complication or permanent change in status and requiring a medical assessment, coordination and consultation with the physician or physician extender and a change in the treatment plan. 1. It is the responsibility of the person observing the change to report that change to the licensed nurse. 3. The licensed nurse is responsible for making all notifications of changes to the physicians, the resident and the resident's representative. 4. Examples of changes may include but not limited to: abnormal findings, gastrointestinal problems, neurological changes. The administrator and DON were notified on [DATE] at 4:40 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's Plan of Removal was accepted on [DATE] at 5:55 p.m. and included: *All nursing staff will be re-educated on the use of the Interact tools which include changes of condition, stop and watch early warning tool, evaluation, SBAR forms and progress notes, acute change in condition file cards, MD Notification, Acute care transfer and quality improvement program. In-services will begin immediately until all nursing staff were re-educated. *The change in condition tool reflects on vital signs, laboratory test/diagnostic procedures, symptoms and signs, acute mental status changes, behavior changes, dehydration, fever, gastrointestinal symptoms, shortness of breath, [MEDICAL CONDITION] and urinary tract infections. *Stop and watch reflects on the early signs of changes in condition. *SBAR is the communication form and progress note that is started prior to calling the physician to gather all the information necessary for the physician to make a decision as to what actions needs to be taken. *Change in condition file cars are used to identify specific conditions and the signs and symptoms to report to the physician. *All the tools are located at each nursing station for the staff to use. *The administrative staff will review the 24 hour reports daily to identify any potential changes of condition in the morning clinical meeting. On [DATE], the survey team confirmed the POR had been implemented sufficiently to remove the IJ as evidenced by: *12 LVNs were interviewed and were able state how to use the facility tools to help recognize a change of condition and how to respond to that change appropriately. *5 RNs were interviewed and were able to state how to use the facility tools to help recognize a change of condition and how to respond to that change appropriately. On [DATE] at 2:00 p.m., the administrator and DON were informed the IJ was removed: however, the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The CMS 672 dated [DATE] indicated a census of 86.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and services in accordance with the comprehensive assessment and plan of care for 1 of 6 residents reviewed for a change in condition. (Resident #4) Resident #4 experienced changes in his level of consciousness, had diarrhea, and refused to eat; however, the facility did not assess or provide treatment for [REDACTED]. Resident #4 was sent to the local emergency room and admitted with altered mental status, profound dehydration, urinary tract infection, metabolic acidosis, and [MEDICAL CONDITION] (elevated potassium). Resident #4 died in the hospital on [DATE]. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]. The facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place the census of 86 residents at risk for experiencing an unrecognized change of condition at risk for delay in medical evaluation and treatment. Findings included: Physician orders [REDACTED].#4 was [AGE] years old and admitted on [DATE] with the [DIAGNOSES REDACTED]. An admission assessment dated [DATE] indicated Resident #4 was alert and independent with decision making and could answer questions appropriately. He was assessed with [REDACTED]. He had normal bowel sounds and no diarrhea. The most recent MDS dated [DATE] indicated Resident #4 usually was understood by others and he understood others. Resident #4 required extensive assistance with transfers, dressing, bathing, and personal hygiene. He required limited assistance of one person for eating. Resident #4 was frequently incontinent of bowel and bladder. A comprehensive care plan dated [DATE] indicated Resident #4 was at risk for dehydration related to use of [MEDICATION NAME] (diuretic), history of pneumonia, and possible insufficient fluid intake. The goal for Resident #4 was not to show signs and symptoms of dehydration. The approaches included; maintain intake and output when indicated and report signs of dehydration (lethargy, increased confusion, change of LOC, concentrated urine, dry skin, with poor skin turgor and dry oral mucosa). The facility Medication Administration Record [REDACTED]. During an interview on [DATE] at 3:00 p.m., the OT said on Friday [DATE], Resident #4 performed his therapy without a problem. The OT said the resident was smiling and talkative. During an interview on [DATE] at 3:15 p.m., CNA E said she cared for Resident #4 on the 6 a.m.- 2 p.m. shift Saturday [DATE] and Sunday [DATE]. She said on both days Resident #4 was not his usual self and he was weaker than normal. She said Resident #4 was not able to sit up as he normally did and she had to put him to bed early. CNA E said she notified LVN B of Resident #4's decline. During an interview on [DATE] at 5:25 p.m., CNA F said she provided care for Resident #4 on Saturday [DATE] and Sunday [DATE]. CNA F said Resident #4 was in bed on her 2 p.m.-10 p.m. shift both days which was not his norm. She said Resident #4 ate 25 percent of his evening meal and only drank a few sips of fluids which was not normal for him. CNA F said Resident #4's urine had a strong smell and she reported this to her charge nurse. The 24 hour report sheet dated Saturday [DATE] night shift indicated Resident #4 had diarrhea. There was no indication a physician was notified. A nursing note by RN C dated [DATE] at 12:00 a.m. indicated Resident #4 had loose stools three times and poor skin turgor. The note did not indicate a physician was notified. During an interview on [DATE] at 4:10 p.m., LVN B said she provided care for Resident #4 on Sunday [DATE] and Resident #4's sister voiced concern about Resident #4 not eating or drinking well. LVN B said on Sunday Resident #4 stayed in bed, had extremely dry skin, and did not eat well. She said she thought the resident looked the same. LVN B said she did not call the physician. A nursing note by RN A dated Sunday [DATE] at 12:00 a.m. indicated Resident #4 was drooling. There was no other documentation in the nursing notes from [DATE] - [DATE] of the resident drooling. The note did not indicate a physician was notified of the change. During an interview on [DATE] at 3:45 p.m., Resident #4's sister said she came to the facility on [DATE] a little after 8:00 a.m. because her sibling called her very upset about Resident #4's condition change on Sunday [DATE]. She said she found Resident #4 unable to talk and he was so very weak. Resident #4's sister said his morning meal was on his bedside table untouched. She said she went to the nurse's station and demanded someone send him to the hospital. During an interview on [DATE] at 2:10 p.m., ADON D said Resident #4's sister was at the nursing station saying something is wrong with him and requested his transfer to the emergency room . ADON D said she assisted RN A with transferring Resident #4. ADON D said the resident looked like he had a stroke. During an interview on [DATE] at 2:50 p.m., RN A said Resident #4's sister was convinced he had a decline in condition on [DATE] and requested he be sent to the ER. RN A said Resident #4 was his usual total care, nothing unusual. RN A said she pushed fluids on Resident #4 because of decreased food and fluid consumption. RN A said when she assessed Resident #4 prior to sending him to the emergency room she saw no change in him, she saw no signs of dehydration and did not see any reason to notify the physician prior to the sister's request. She said she called the physician because the sister said she could see a whole lot of difference in him. A nursing note by RN A dated Monday [DATE] at 9:00 a.m. indicated Resident #4 was lying in bed alert but slow to respond. The resident did not follow directions, had decreased tactile sensation, increased right sided facial drooling, was very weak, and had a very poor appetite. The note indicated the family was present and requested Resident #4 be transferred to the hospital. At 9:30 a.m. the nursing note indicated after the family's insistence, the nurse practitioner was notified and an order was given to send to ER for evaluation. The note indicated at 10:10 a.m. EMS was at the facility to transfer Resident #4 to the ER. The undated nursing home transfer to hospital form completed by RN A indicated Resident #4's vital signs were: blood pressure ,[DATE], heart rate 63, respirations 16, temperature 97.1, and oxygen saturation 90%. The reason for transfer was listed as possible TIA ([MEDICAL CONDITION]- mini stroke). During an interview on [DATE] at 3:10 p.m., the DON said she was not familiar with Resident #4's condition when he left the facility.

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) The DON said there was not an intake and output record for Resident #4. The DON said his disease processes did not warrant use of monitoring using intake and output recordings. She said she was not notified of Resident #4 having diarrhea, decreased appetite, and weakness. The DON said she expected the nurse to assess the resident and to call the physician when residents experienced changes in condition. The hospital admission lab results dated [DATE] at 10:50 a.m. indicated Resident #4 had the following abnormal results: *white blood cell count of 22.7 (Normal range 3XXX,[DATE].6), *sodium 145 (normal range ,[DATE]), *potassium 6.1 (normal range 3XXX,[DATE].1), *chloride 118 (normal range ,[DATE]), *BUN 170 (normal range ,[DATE]) and, *creatinine 6.94 (normal range 0XXX,[DATE].30). *The urine WBCs were loaded (too many to count) and had heavy bacteria. *A chest x-ray indicated atelectasis in the lung basis. A hospital history and physical dated [DATE] at 2:40 p.m. indicated when Resident #4 arrived in the emergency room his mental status was very altered, he was barely awake and could not respond at all. The laboratory reports indicated the resident had increased potassium and increased BUN and creatinine. Resident #4's general assessment was blood pressure ,[DATE], heart rate 111, temperature 97.7, and respirations 13. The resident's tongue was very dry and he was unable to respond to verbal commands. The assessment indicated Resident #4 [MEDICAL CONDITION] secondary to a urinary tract infection with severe dehydration resulting in acute kidney injury. A renal consult report from the urologist on [DATE] at 2:40 p.m. indicated Resident #4 was lethargic and severely dehydrated. Resident #4's oral mucosa were very dry and his skin turgor was very poor. The note indicated the etiology of Resident #4's acute [MEDICAL CONDITION] was secondary to profound dehydration. Resident #4 also presented with [MEDICAL CONDITION] (increased potassium) and metabolic acidosis. (Life threatening condition that occurs when the kidneys can't eliminate acid buildup) A cardiopulmonary resuscitation note dated [DATE] at 6:25 a.m. indicated Resident #4 expired in the intensive care unit. The policy and procedure dated ,[DATE] indicated .to notify the physician and inform the resident and resident's responsible party of a significant change in the resident's physical, mental psychological status including accidents and when there is a need to alter treatments significantly. Change of Condition related to physician notification is defined as the physician should be notified of any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denoting a new problem, complication or permanent change in status and requiring a medical assessment, coordination and consultation with the physician or physician extender and a change in the treatment plan. 1. It is the responsibility of the person observing the change to report that change to the licensed nurse. 3. The licensed nurse is responsible for making all notifications of changes to the physicians, the resident and the resident's representative. 4. 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On [DATE], the survey team confirmed the POR had been implemented sufficiently to remove the IJ as evidenced by: *12 LVNs were interviewed and were able state how to use the facility tools to help recognize a change of condition and how to respond to that change appropriately. *5 RNs were interviewed and were able to state how to use the facility tools to help recognize a change of condition and how to respond to that change appropriately. On [DATE] at 2:00 p.m., the administrator and DON were informed the IJ was removed: however, the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The CMS 672 dated [DATE] indicated a census of 86.