| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525074 | A. Building<br>B. Wing | 02/24/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Madison Health and Rehabilitation Center | 110 Belmont Rd<br>Madison, WI 53714 |

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|---|---|
| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992<br><br>Based on interview and record review, the facility did not ensure that it provided each resident with sufficient fluid intake to maintain proper hydration and health for 1 of 4 records reviewed (R1) unless the resident's clinical condition demonstrates this is not possible.<br><br>The facility identified that R1 was experiencing a change in condition (COVID-19 positive) and care planned the change in condition. However, there is no evidence that the facility assessed R1's fluid intake to determine if interventions were needed to prevent dehydration.<br><br>The facility did not push fluids, assist R1 to meet her fluid needs, monitoring her fluid intake, and holding furosemide when R1 did not meet her fluid needs. On 1/30/22 R1 was treated in the emergency room (ER) for diagnoses including dehydration, shock (sepsis + hypovolemia), COVID-19 pneumonia, aspiration pneumonia, and multiple cardiac arrthymias. R1 was given nearly 6 liters of fluids (a high amount of fluid particularly in an elderly patient).<br><br>Following R1's return to the facility on [DATE], there is no evidence the facility is currently offering sufficient fluid intake to maintain hydration, monitoring her fluid intake, holding furosemide when R1 is not meeting her fluid needs, and notifying the Physician when R1 is not meeting her fluid needs. In the past 30 days, R1 has not met her fluid intakes requirements for 13 of the last 30 days. There has been no further consultation with R1's Physician regarding her lack of fluid intake.<br><br>This is evidenced by:<br><br>(continued on next page) |

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.

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

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility policy entitled Hydration - Clinical Protocol, dated 9/2017, states, in part: 1. The Physician and staff will help define the individual's current hydration status (fluid and electrolyte balance or imbalances). 1. a. The physician will distinguish various types of fluid and electrolyte imbalance (for example, hyponatremia, hypernatremia, pre-renal azotemia, etc.) from true dehydration (clinically significant loss of total body water). 2. The staff, with the physician's input will identify and report to the physician individuals with signs and symptoms (for example, delirium, lethargy, increased thirst, etc.) or lab test results that might reflect existing fluid and electrolyte imbalance. 3. The physician and staff will identify significant risk for subsequent fluid and electrolyte imbalance; for example, individuals with prolonged vomiting, diarrhea, or fever, or who are taking diuretics and/or ACE inhibitions and who are not eating or drinking well. Cause Identification: 1. The physician will help identify the cause(s) of any existing fluid and electrolyte imbalance or help the staff document why the individual should not be tested or evaluated. a. A limited review for causes (for example, based on the clinical situation and basic metabolic panel (BMP) may be appropriate even if an extensive work-up is not. Treatment Management: c. Any medications that are contributing to fluid and electrolyte imbalance should be tapered or stopped (at least temporarily), or the physician should provide clinically valid documentation as to why they cannot or should not be changed, even temporarily.<br><br>R1 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, schizophrenia, psychosis, paranoid personality disorder, delusional disorder, major depressive disorder, generalized anxiety disorder, personality disorder, dysphagia, and pain.<br><br>R1 MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 1/21/22, indicates R1 had a BIMS (Brief Interview of Mental Status) of 9/15 indicating moderately impaired cognition. Section GO110 indicates R1 required extensive assistance with all areas of activities for daily living, except required supervision and set up for eating. Section J1550 C indicates R1 was not dehydrated. Section K0300 indicates R1 had no weight loss and Section K0510 indicates R1 was not on a mechanically altered diet.<br><br>R1 has DNR orders (Do Not Resuscitate) and an APOAHC (Activated Power of Attorney for Health Care).<br><br>On 1/17/22 the facility tested R1 for COVID-19. R1 was asymptomatic at the time she was tested . On 1/19/22 R1's test result indicated R1 is COVID-positive (+) and she was moved to the COVID-positive wing and put on contact and droplet isolation precautions.<br><br>On 1/20/22 the facility updated R1's Comprehensive Plan of Care from At risk for infection, signs and symptoms, of COVID-19 to COVID+ 1/19/22, collected 1/17/22. Goal: Will be free of s/sx (signs/symptoms) of COVID-19 through next review date. Will receive recommended treatment per MD (Medical Doctor) if contracts/becomes infected with COVID-19 through next review date. Interventions .Monitor resident's hydration needs. Offer fluids of choice to ensure adequate hydration. Update physician as indicated regarding change in condition/treatment.<br><br>R1's Nutritional Risk Assessment, dated 12/10/21, states, in part: resident daily fluid needs 1400 - 1680 cubic centimeters [cc's] daily. Swallowing difficulty r/t [related to] dysphagia dx [diagnosis], hx [history] of pneumonia, and aspiration risk AEB [as evidenced by] refusal of modified textures with monitoring of coughing or oral residue.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility began monitoring R1's fluid intake on 1/24/22. R1's fluid intake (in milliliters) is as follows:<br><br>1/24: 0<br><br>1/25: 0<br><br>1/26: 0<br><br>1/27: 960<br><br>1/28: 0<br><br>1/29: 800<br><br>1/30: 0 (admitted to hospital)<br><br>1/31: hospitalized<br><br>2/1: hospitalized<br><br>2/2: hospitalized<br><br>R1's current Physician Orders, signed 2/23/22, indicate R1 an order for Furosemide 20mg (milligrams) by mouth one time a day for edema. R1's MAR (Medication Administration Record) indicates R1 received Furosemide daily.<br><br>It is important to note, the facility's January MAR demonstrates that facility staff did not hold or attempt to hold R1's furosemide despite R1's lack of fluid intake which further contributed to dehydration.<br><br>On 1/28/21 Order to push fluids / encourage meals - every shift for weakness<br><br>On 1/28/22 at 4:42 AM, R1's Progress Note indicates the following: Resident has poor intake, refusing meals and meds, VS [vital signs] Temp 97.8, Respirations 26, Blood Pressure 82/54, O2 saturation 90% RA [room air], resident has audible wheezing, and crackles on bilateral lower lobes, called on call Physician who gave order for 1 view chest x-ray, BMP [Basic Metabolic Panel] and CBC [Complete Blood Count] with diff [differential] labs for weakness/lethargy, to continue pushing fluids and update PCP [Primary Care Provider], message left for NP [Nurse Practitioner], message left for R1's APOAHC.<br><br>On 1/28/22 NP wrote the following in-person visit note: R1 is an [AGE] year old female who is seen today for follow up for change in condition as reported by nurse. Chief Complaint: COVID positive 10 days ago with decrease in oral intake for the past 2 days, refusing to eat and drink, or take medications last night. Assessment at that time revealed crackles at lung bases and some wheezing. CXR [chest x-ray], CBC [complete blood count] and BMP [Basic Metabolic Panel] ordered by on-call physician earlier this morning.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Today, upon exam, she is lying in bed with HOB [head of bed] elevated a meal tray sitting in front of her. She is alert and oriented to self. Answers some questions with short answers and other questions she just stares. Patient reports not feeling hungry but is thirsty and requests assistance with fluids. Intention tremor and intermittent congested cough noted during exam. Denies shortness of breath, fevers or chills. Vitals: Blood Pressure 116/58, Pulse 88, Temperature 98.1, Respirations 18, SpO2 94%. Exam General: chronically ill appearing, tired but not toxic appearing, in no acute distress female, lying in bed, Skin: red and flaky skin surrounding her mouth and chin, Neuro: alert and oriented x1 [person/place/situation] with limited speech; intention tremor. Psych: somnolent [abnormally drowsy]. Decreased oral intake [primary encounter diagnosis]. Comment: Patient reports not feeling hungry, denies nausea and no vomiting reported. Tolerating fluids, abd [abdomen] soft and non-tender, BS [bowel sounds] active. Two loose and formed BMs yesterday. Cough - Comment: Congested sounding. Nurse reported crackles and wheezing previously. No dyspnea, hypoxia or fevers. Plan: CXR ordered, BMP and CBC results pending. Mucinex PRN [as needed].<br><br>R1's chest x-ray results indicates the following: There are mild patchy bibasilar densities, right greater than left, compatible with pneumonia. The costophrenic angles are sharp with no pleural effusion. Impression: 1. Mild patchy bibasilar densities, right greater than left, compatible with pneumonia. Follow up chest x-ray suggested.<br><br>On 1/28/22 at 3:17 PM, staff called R1's NP to report a critical lab value HCT [hematocrit] of 61 waiting to call back. R1's BMP was not able to be run and was not re-attempted.<br><br>On 1/28/22 at R1's Physician ordered Amoxicillin-Pot Clavulanate 875-125 milligram - 1 tab BID [two times a day] x 10 for pneumonia and Flagyl 1 tab PO every day for 10 days. R1's MAR demonstrates R1 started receiving this antibiotic on 1/28/22 at 8:00 PM.<br><br>On 1/28/22 at 3:22 PM, R1's Progress Note indicates the following: Spoke with mobile imaging x-ray was obtained, radiologist is reading that and they will fax results. Labs were drawn this AM from residents left hand. Lab called they had to reject BMP, but can run CBC. Left message to update NP.<br><br>On 1/30/22 the facility obtained an order for supplemental oxygen 1-4 liters per minute via nasal cannula or mask to maintain oxygen saturation equal to or greater than 90% [as needed for hypoxia O2 sat less than 90%].<br><br>On 1/30/22 at 10:45 AM, R1's Progress Note indicates the following: Writer updated Physician on patient's change in condition. Physician made a verbal order to send patient to ER if she cannot maintain O2 greater than 90% on 2L. Writer rechecked patient's O2, O2 was 88% on 2L. Writer called ambulance for pick up to go to hospital, called and spoke with R1's APOAHC, and update the facility's nurse on call.<br><br>R1 was hospitalized on [DATE] (4 days) and readmitted to the facility on [DATE].<br><br>R1 was initially treated with ceftriaxone/azithro, then broadened to vanc/zosyn earlier this week in setting of septic shock requiring vasopressors, ultimately transitioned to Augmentin and will complete 7 days course. Lactate initially 2.1 then peaked at 3.4 then normalized. Multiple fluid boluses given, now nearly 6L (liters) + fluid balance. She was also started on stress dose HC earlier in week, which was weaned back to oral dexamethasone once more hemodynamically stable. Will complete 10-day course decadron for COVID pneumonia.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2/11: 240<br><br>2/12: 0<br><br>2/13: 240<br><br>2/14: 240<br><br>2/15: 360<br><br>2/16: 600 (On 2/16/22 R1 enrolled in hospice care.)<br><br>2/17: 0<br><br>2/18: 480<br><br>2/19: 0<br><br>2/20: 0<br><br>2/21: 1,000<br><br>2/22: 240<br><br>2/23: 900<br><br>2/24: 0<br><br>The facility has not notified R1's Physician or NP that R1 has not met her fluid requirements since she returned from the hospital 21 days prior. The facility is not: 1. Providing R1 with the necessary assistance to ensure her daily fluid intake requirement is met. 2. Identifying when R1 is not meeting her daily fluid intake requirements. 3. Contacting R1's Physician or NP when R1 is not meeting her fluid requirements. R1 has not met her fluid intake requirements for 21 days following readmission and the facility has not identified nor acted on this by consulting R1's Physician or NP.<br><br>On 2/23/22 at 10:04 AM, Surveyor spoke with R1's APOAHC. R1's APOAHC stated she is at the facility 6-8 hours per days since R1 returned from the hospital on 2/3/22. R1's APOAHC stated that R1 experienced a change in condition when she was diagnosed with Covid-19 and began requiring assistance from staff to eat and drink. R1's APOAHC stated when R1 was COVID positive (+) and on the COVID isolation wing, the facility did not identify R1's change in condition when she required assistance to eat and drink. R1's shaking increased a left her unable to eat independently. R1's APOAHC stated the facility's failure to identify her change in condition lead to her hospitalization and dehydration.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | It is important to note, the facility did not identify R1's change in condition and need for assistance with meals and fluid intake. As a result, R1 was hospitalized for 4 days and diagnosed with shock due to sepsis and hypovolemia (low fluid volume due to lack of intake), aspiration pneumonia and multiple cardiac arrhythmias. Of note, R1 did not meet her fluid requirement prior to being hospitalized and has not met fluid requirements since returning to the facility on [DATE]. The facility failed to assess and monitor R1's fluid intake prior to being hospitalized and after hospitalization .<br><br>On 2/24/22 at 9:25 AM, Surveyor spoke with CNA C (Certified Nursing Assistant). Surveyor asked CNA C if she is familiar with R1. CNA C stated, yes. Surveyor asked CNA C if she noticed any difference with R1's eating and drinking since she had COVID in January 2022. CNA C stated R1 used to be able to eat and drink herself, but now she can no longer eat by herself and needs assistance. CNA C stated R1's shaking has become so bad that she can no longer hold a fork or spoon to eat independently. Surveyor asked CNA C is R1 able to eat finger foods independently. CNA C stated, yes. Surveyor asked CNA C is R1 able to drink fluids independently. CNA C stated R1 is able to drink independently. CNA C stated before R1 had COVID she would eat independently.<br><br>On 2/24/22 at approximately 3:00 PM, Surveyor spoke with DON B (Director of Nursing). DON B stated she is not aware of any fluid related concerns with R1. DON stated she has not received any alerts related to R1 not meeting her fluid needs. Surveyor asked DON B if she is aware that R1 has not met her fluid needs for a single day over the past month. DON B stated she is unaware of this. DON B is not aware that 13 of the last 30 days, R1 has no fluid intake documented. DON B stated staff should have been actively monitoring R1 and aware of her daily fluid intakes. Surveyor asked DON B why is it important to monitor R1's fluid intake. DON B stated to monitor R1, to be aware of the need to push fluids, monitor signs and symptoms of dehydration, and to contact the Physician when necessary. DON B indicated staff should have been monitoring R1 closely (before and after hospitalization ) and identified that she was not meeting her fluid needs, holding furosemide, and contacting the Physician. |