STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Nursing Center	123 Pecan Grove Pittsburg, TX 75686

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical and mental status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) 1 of 3 (Resident #1) residents reviewed for notification of change. The facility did not notify the physician of Resident #1's decreased fluid intake, decreased urine output, increased confusion, or urinary analysis not being obtained which resulted in Resident #1 being admitted to the hospital with diagnoses of acute metabolic encephalopathy (a problem in the brain that encompasses delirium and the acute confusional state with causes including dehydration, malnutrition, and metabolic imbalances), dehydration, fluid depletion, and acute kidney injury (a condition in which kidneys suddenly cannot filter waste from the blood with causes including severe dehydration, low blood volume after bleeding, and excessive vomiting or diarrhea). This failure resulted in an identification of an Immediate Jeopardy (IJ) at 11:00 a.m. on 1/19/23. While the IJ was removed on 1/20/23, the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk for not receiving care and services to meet resident needs. Findings include: 1. Record review of the consolidated physician orders dated 1/20/23 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including diabetes, cognitive communication disorder, urinary tract infection, hypokalemia, and paranoid schizophrenia. The physician orders indicated Resident #1 had an order to document fluid intake every shift starting 5/31/21 and was discontinued on 1/19/23. The physician orders indicated Resident #1 had an order to document urine output every shift starting 5/31/21 and was discontinued on 1/19/23. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and usually made herself understood. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 did not reject evaluation or care. The MDS indicated Resident #1 required supervision with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. The MDS indicated Resident #1 was occasionally incontinent. Record review of the care plan revised on 12/27/22 indicated Resident #1 had a potential fluid deficit related to diuretic use with intervention including obtain and monitor lab/diagnostic work as ordered, observe and document intake and output as per facility policy, monitor/document/report to the physician signs and symptoms of fluid deficits including but not limited to: decreased or no urine output, cracked lips, new onset of confusion, and fatigue/weakness. Record review of a dietician progress note dated 1/17/22 indicated Resident #1's estimated daily fluid needs were 2682 milliliters. The dietician progress note indicated Resident #1 had good intake. Record review of Resident #1's intake and output record indicated her average fluid intake for 12/31/22 through 1/06/23 was 487 milliliters and her averaged urine output was 216 milliners. The intake and output record indicated her average fluid intake for 1/07/23 through 1/13/23 was 297 milliliters and her average urine output was 1 milliliter. Record review of the nursing progress note dated 1/05/23 at 3:03 p.m. indicated Resident #1 received a new order for a UA. Record review of the nursing progress note dated 1/06/23 at 3:03 p.m. indicated Resident #1 was hard to arouse. The progress note indicated Resident #1 required spoon feeding by the nurse and only drank a small amount of water. Record review of the nursing progress note dated 1/09/23 at 1:13 p.m. indicated Resident #1 refused breakfast and lunch. The nursing progress note indicated Resident #1 drank 8 ounces of water. The nursing progress note indicated Resident #1 voided a small amount of urine. The nursing progress note indicated mouth care was performed on Resident #1. Record review of the nursing progress note dated 1/09/23 at 6:55 p.m. indicated Resident #1 refused her supper tray and consumed 4 ounces of water per nurse. The nursing progress note indicated Resident #1 had an incontinent episode and peri-care was performed. Record review of the nursing progress note dated 1/10/23 at 6:33 a.m. indicated Resident #1 did not void on the 10:00 p.m.- 6:00 a.m. shift. The nursing progress note indicated the nurse got Resident #1 to drink 8 ounces of water. Record review of the nursing progress note date 1/10/23 at 9:38 a.m. indicated Resident #1 refused breakfast. Record review of the nursing progress note dated 1/10/23 at 12:38 p.m. indicated Resident #1 refused lunch. The nursing progress note indicated Resident #1 would not open her eyes to verbal stimuli. The nursing progress noted indicated Resident #1 was assessed by the Medical Director. The nursing progress noted indicated Resident #1 received an order to transfer her to the emergency department for evaluation and treatment. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the nursing progress noted dated 1/10/23 at 12:50 p.m. indicated Resident #1 was transferred to the emergency department via ambulance. Record review of Resident #1's hospital records dated 1/10/23 indicated she was admitted to the hospital with diagnoses of acute metabolic encephalopathy (a problem in the brain that encompasses delirium and the acute confusional state with causes including dehydration, malnutrition, and metabolic imbalances), dehydration, fluid depletion, and acute kidney injury (a condition in which kidneys suddenly cannot filter waste from the blood with causes including severe dehydration, low blood volume after bleeding, and excessive vomiting or diarrhea). The hospital records indicated Resident #1's sodium level was elevated with a level of 155 milliequivalents/liter (normal sodium level is 135-145 milliequivalents/Liter). The hospital records indicated Resident #1 was suffering from urinary retention and altered mental status upon arrival at the hospital. The hospital records indicated the nursing home staff noted Resident #1 had altered level of consciousness since 1/03/23 and progressively getting worse. The hospital records indicated the nursing home staff noted Resident #1 was not eating, drinking, or urinating. During an interview on 1/18/23 at 12:40 p.m. CNA B said signs and symptoms of dehydration included dry mouth and lethargy. CNA B said Resident #1 had a dry mouth, decreased urine output, and was lethargic. CNA B said she reported Resident #1's dry mouth, decreased urine output, and lethargy to the charge nurse. CNA B said she noticed Resident #1's change in condition on 1/09/23. During an interview on 1/18/23 at 12:53 p.m. LVN C said when a lab order was received for a UA a lab requisition should be completed and nurses should obtain the UA. LVN C said if a resident refused a UA the nurse should document the refusal in the electronic medical records. LVN C said signs and symptoms of dehydration included headache, dizziness, poor skin turgor, decreased urine output, dark urine, and confusion. During an interview on 1/18/23 at 12:58 p.m. LVN D said signs and symptoms of dehydration included lethargy, swollen tongue, not communicating, and decreased urination. LVN D said Resident #1 had signs and symptoms of dehydration including swollen tongue, not waking up, and not voiding. LVN D said she was aware Resident #1 had an order for a UA. LVN D said the UA was not obtained. LVN D said the UA was not obtained because Resident #1 was incontinent. LVN D said an in and out catheter was not attempted on Resident #1. During an interview on 1/18/23 at 1:06 p.m. The Medical Director said when he assessed Resident #1 on 1/10/23 while making rounds she looked very dehydrated. The [NAME] Director said he gave the order for Resident #1 to be sent to the emergency department on 1/10/23. The Medical Director said he was not aware whether the facility had notified him or his nurse practitioner of Resident #1's change in condition prior to him making rounds on 1/10/23. During an interview on 1/18/23 at 1:29 p.m. CNA A said she had reported Resident #1's change in condition to the charge nurse on 1/09/23. During an interview on 1/18/23 at 1:32 p.m. LVN D said she notified the physician on 1/10/23 of Resident #1's signs and symptoms of dehydration while he was in the facility making rounds. LVN D said she did not notify the physician or nurse practitioner that the UA was not obtained on Resident #1. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/18/23 at 1:43 p.m. the Nurse Practitioner said she was vaguely familiar with Resident #1. The Nurse Practitioner said she was aware of the order for the UA on Resident #1. The Nurse Practitioner said the order for the UA was wrote by the Psychiatric Nurse Practitioner. The Nurse Practitioner said she had been notified by an evening nurse the facility was unable to obtain the UA on Resident #1. The Nurse Practitioner said she recommended the facility perform an in and out catheterization on Resident #1 to obtain the UA. The Nurse Practitioner said she was not informed the in and out catheter had not been performed. The Nurse Practitioner said she expected to be informed if the in and out catheter was unsuccessful or unable to be performed. The Nurse Practitioner said she had not been notified of Resident #1's dehydration or change in condition. During an interview on 1/19/23 at 8:17 a.m. the Psychiatric Nurse Practitioner said she had ordered the UA on Resident #1 on 1/05/23. The Psychiatric Nurse Practitioner said she had ordered the UA on Resident #1 due to the nursing facility reporting increased hallucinations and an increase in incontinent episodes for 2-3 days. The Psychiatric Nurse Practitioner said she was not notified of the UA not being obtained on Resident #1. During an interview on 1/19/23 at 8:27 a.m. CNA B said she first noticed the change in condition with Resident #1 on 1/09/23. During an interview on 1/19/23 at 8:31 a.m. CNA A said Resident #1 had tried to drink 4-6 ounces of water by assistance from the nurse. CNA A said Resident #1 would not arouse to eat on 1/09/23. CNA A said on 1/05/23 or 1/06/23 Resident #1 required assistance with eating and drinking. CNA A said Resident #1 did not usually require assistance with eating and drinking. CNA A said Resident #1 usually drank lots of fluids, fed herself, and carried a pitcher of water at all times. CNA A said on 1/05/23 or 1/06/23 Resident #1 was not getting up or carrying around her water pitcher. CNA A said she reported the changes in Resident #1 to the charge nurse. During an interview on 1/19/23 at 8:40 a.m. LVN D said on 1/09/23 she noticed Resident #1 was not eating or drinking. LVN D said on 1/09/23 Resident #1 drank some water in the morning but would not arouse for food or fluid the rest of the day. LVN D said Resident #1 had been incontinent of bladder on 1/09/23 which was outside of her baseline. LVN D said she did not report to the physician Resident #1's decrease in food intake, decrease in fluid intake, increased need for assistance, or incontinence on 1/09/23 when she noticed the change in condition. Record review of the facility's undated Notification to Physician, Family, and others policy indicated, The facility will remain compliant with reporting guidelines as outlined by state and federal regulations. The facility will inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative and document in the residents' medical record where applicable, when there is: . A significant change in the resident's physical, mental, or psychosocial status .Notifications of non-life threatening issues will be considered timely if made within the context of the respective staff members regularly scheduled shift and as early as practicable. The closes time to the event is considered ideal. Notifications of serious injury or the potential for serious injury, life threatening events or the potential for life threatening events and any significant health issue must be made immediately . The Administrator was notified on 1/19/23 at 11:36 a.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 1/19/23 at 11:36 a.m. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Plan of Removal was accepted on 1/19/23 at 4:33 p.m. and included: All residents with active physician orders Intake and Output monitoring were discontinued on 01/19/2023. Education (provided by DON or ADON) All nurses were in-serviced on Appropriately Notifying the Physician of changes in condition in a timely manner on 01/19/2023. This in-service includes competency checks by pre-test post-test. Each nurse will be in-serviced prior to returning to shift. This will be completed by 01/19/2023. Nursing will not return to shift without the in-service and pre-test post-test. All nurses were in-serviced on Policy and Procedure for obtaining a UA on 01/19/2023 which includes entering the UA as a one-time order. This in-service will be completed by 01/19/2023. Nurse administration in-serviced to assign fluid consumption and voiding by CNA as monitoring tasks unless I/O monitoring ordered by physician on 01/19/2023. All nurses were in-serviced on appropriately monitoring I&Os to include monitoring residents who are at risk for dehydration to ensure they are being assessed appropriately and not dehydrated 01/19/2023. This in-service will be completed by 01/19/2023. Nursing will not return to shift without the in-service. All nurses were in-serviced on Notifying the Physician if a UA is not obtained on 01/19/2023. Nursing will not return to shift without the in-service. On 1/20/23 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of a randomly selected sample of residents indicated all residents reviewed who had an order for intake and output monitoring had that order discontinued on 1/19/23 Interviews of nursing staff (2-nurses on the 6:00 a.m.-2:00 p.m. shift; 1 nurse on the 7:00 a.m.- 3:00 p.m. shift, 2 nurses on the 8:00 a.m.- 5:00 p.m. shift, 2-nurses on the 2:00 p.m.- 10:00 p.m. shift; 1 nurse on the 10:00 p.m.- 6:00 a.m. shift) were performed. During these interviews' staff were able to correctly identify when to notify the physician of a resident's change in condition or unable to obtain labs; the appropriate procedure for obtaining a UA on a resident, and how to appropriately monitor resident's fluid intake and output who are at risk for dehydration. On 1/20/23 at 9:45 a.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to maintain acceptable parameters of hydration status for 1 of 3 (Resident #1) residents reviewed for nutrition and hydration The facility did not ensure Resident #1 was monitored for fluid intake per orders which resulted in her admission to the hospital with a diagnosis of severe dehydration. The facility did not ensure Resident #1 was monitored for urine output per orders which resulted in her admission to the hospital with a diagnosis of severe dehydration. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 11:00 a.m. on 1/19/23. While the IJ was removed on 1/20/23, the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of harm or death related to abnormal electrolyte balances, dehydration, and kidney failure. Findings include: 1. Record review of the consolidated physician orders dated 1/20/23 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including diabetes, cognitive communication disorder, urinary tract infection, hypokalemia, and paranoid schizophrenia. The physician orders indicated Resident #1 had an order to document fluid intake every shift starting 5/31/21 and was discontinued on 1/19/23. The physician orders indicated Resident #1 had an order to document urine output every shift starting 5/31/21 and was discontinued on 1/19/23. The medical records indicated Resident #1 had an order to obtain a urinary analysis (UA) on 1/05/23. The physician orders indicated Resident #1 had an order for furosemide (a diuretic used to treat fluid build-up that increases urination) 40mg daily starting 9/13/21. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and usually made herself understood. The MDS indicated Resident #13 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 did not reject evaluation or care. The MDS indicated Resident #1 required supervision with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. The MDS indicated Resident #1 was occasionally incontinent. Record review of the care plan revised on 12/27/22 indicated Resident #1 had a potential fluid deficit related to diuretic use with intervention including obtain and monitor lab/diagnostic work as ordered, observe and document intake and output as per facility policy, monitor/document/report to the physician signs and symptoms of fluid deficits including but not limited to: decreased or no urine output, cracked lips, new onset of confusion, and fatigue/weakness. Record review of a dietician progress note dated 1/17/22 indicated Resident #1's estimated daily fluid needs were 2682 milliliters. The dietician progress note indicated Resident #1 had good intake. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's intake and output record for 1/01/23 through 1/09/23 indicated her fluid intake had only been documented on the following dates and shifts: 1/02/23 at 1:01 a.m. 1/02/23 at 6:37 p.m. 1/03/23 at 1:15 am 1/04/23 at 1:27 a.m. 1/05/23 at 1:16 a.m. 1/06/23 at 1:19 a.m. 1/06/23 at 8:15 p.m. 1/07/23 at 7:05 p.m. 1/08/23 at 12:40 a.m. 1/08/23 at 10:09 a.m. 1/08/23 at 11:57 p.m. Record review of Resident #1's intake and output record for 1/01/23 through 1/09/23 indicated her urine output had only been documented on the following dates and shifts: 1/02/23 at 1:01 a.m. 1/02/23 at 6:44 p.m. 1/03/23 at 1:15 a.m. 1/04/23 at 1:27 a.m. 1/05/23 at 1:16 a.m. 1/06/23 at 1:19 a.m. 1/06/23 at 8:15 p.m. 1/07/23 at 7:02 p.m. 1/08/23 at 12:40 a.m. 1/08/23 at 10:09 a.m. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/08/23 at 11:57 p.m. Record review of Resident #1's intake and output record indicated her average fluid intake for 12/31/22 through 1/06/23 was 487 milliliters and her averaged urine output was 216 milliners. The intake and output record indicated her average fluid intake for 1/07/23 through 1/13/23 was 297 milliliters and her average urine output was 1 milliliter. Record review of Resident #1's medication administration record (MAR) indicated she had not missed any doses of her furosemide 40 mg from 1/01/23 through 1/09/23. The MAR indicated Resident #1 did not receive her furosemide 40 mg on 1/10/23 due to her condition. Record review of the nursing progress note dated 1/05/23 at 3:03 p.m. indicated Resident #1 required spoon feeding by the nurse and only drank a small amount of water. Record review of the nursing progress note dated 1/09/23 at 1:13 p.m. indicated Resident #1 refused breakfast and lunch. The nursing progress note indicated Resident #1 drank 8 ounces of water. The nursing progress note indicated Resident #1 voided a small amount of urine. The nursing progress note indicated mouth care was performed on Resident #1. Record review of the nursing progress note dated 1/09/23 at 6:55 p.m. indicated Resident #1 refused her supper tray and consumed 4 ounces of water per nurse. Record review of the nursing progress note dated 1/10/23 at 6:33 a.m. indicated Resident #1 did not void on the 10:00 p.m.- 6:00 a.m. shift. The nursing progress note indicated the nurse got Resident #1 to drink 8 ounces of water. Record review of the nursing progress note date 1/10/23 at 9:38 a.m. indicated Resident #1 refused breakfast. Record review of the nursing progress note dated 1/10/23 at 12:38 a.m. indicated Resident #1 refused lunch. The nursing progress note indicated Resident #1 would not open her eyes to verbal stimuli. The nursing progress noted indicated Resident #1 was assessed by the Medical Director. The nursing progress noted indicated Resident #1 received an order to transfer her to the emergency department for evaluation and treatment. Record review of the nursing progress noted dated 1/10/23 at 12:50 p.m. indicated Resident #1 was transferred to the emergency department via ambulance. (continued on next page)

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital records dated 1/10/23 indicated she was admitted to the hospital with diagnoses of acute metabolic encephalopathy (a problem in the brain that encompasses delirium and the acute confusional state with causes including dehydration, malnutrition, and metabolic imbalances), dehydration, fluid depletion, and acute kidney injury (a condition in which kidneys suddenly cannot filter waste from the blood with causes including severe dehydration, low blood volume after bleeding, and excessive vomiting or diarrhea). The hospital records indicated Resident #1's sodium level was elevated with a level of 155 milliequivalents/liter (normal sodium level is 135-145 milliequivalents/Liter). The hospital records indicated Resident #1 was suffering from urinary retention and altered mental status upon arrival at the hospital. The hospital records indicated the nursing home staff noted Resident #1 had altered level of consciousness since 1/03/23 and progressively getting worse. The hospital records indicated the nursing home staff noted Resident #1 was not eating, drinking, or urinating. During an interview on 1/18/23 at 12:44 p.m. CNA A said residents were monitored once every 8 hours for fluid intake and urine output. CNA A said Resident #1 was encouraged to drink often. CNA A said fluid intake was documented by estimating the size of the cups of fluid residents consumed. CNA A said urine output was estimated by how many wet briefs were changed during a shift or by asking continent residents how much they had urinated during a shift. CNA A said Resident #1 would not drink for 2 days. CNA A said signs and symptoms of dehydration included little to no urine output, chapped lips, tough skin, and lethargy. CNA A said Resident #1 had chapped lips. CNA A said Resident #1 always had chapped lips due to being a mouth breather. CNA A said she did not know why Resident #1's fluid intake or urine output had not been documented routinely. CNA A said fluid intake and urine output did not get documented when the CNAs ran out of time during their shift. During an interview on 1/18/23 at 12:40 p.m. CNA B said fluid intake and urine output should be documented every shift. CNA B said fluid intake was estimated and documented by the size of the cup of fluid the residents consumed. CNA B said urine output was estimated and documented by how many times a resident required a wet brief change or by measuring foley catheter contents. CNA B said if fluid intake or urine output was not documented it was due to the CNAs not charting. CNA B said signs and symptoms of dehydration included dry mouth and lethargy. CNA B said Resident #1 had a dry mouth, decreased urine output, and was lethargic. CNA B said she reported Resident #1's dry mouth, decreased urine output, and lethargy to the charge nurse. CNA B said she noticed Resident #1's change in condition on 1/09/23. During an interview on 1/18/23 at 12:53 p.m. LVN C said fluid intake and urine output was documented every shift by the CNAs. LVN C said if a resident had a foley catheter it was the nurse's responsibility to document urine output. LVN C said documenting fluid intake and urine output was listed in the electronic medical records under orders and was a physician's order. LVN C said she was unaware why fluid intake or urine output would not be documented. LVN C fluid intake and urine output should always be documented every shift. LVN C said the importance of documenting fluid intake and urine output was to monitor resident hydration status and could indicate a resident had a urinary tract infection. LVN C said signs and symptoms of dehydration included headache, dizziness, poor skin turgor, decreased urine output, dark urine, and confusion. (continued on next page)

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/18/23 at 12:58 p.m. LVN D said fluid intake and urine output should be monitored daily. LVN D said it was the nurse's and CNA's responsibility to document fluid intake and urine output every shift. LVN D said documenting fluid intake and urine output every shift was listed under the orders in the electronic medical records and was a physician's order. LVN D said the importance if documenting fluid intake and urine output was to monitor for dehydration. LVN D said signs and symptoms of dehydration included lethargy, swollen tongue, not communicating, and decreased urination. LVN D said Resident #1 had signs and symptoms of dehydration including swollen tongue, not waking up, and not voiding. During an interview on 1/18/23 at 1:06 p.m. the Medical Director said he would not have ordered fluid intake and urine output to be monitored in a nursing home. The Medical Director said if there was a physician order for fluid intake and urine output to be monitored he expected the nursing facility to follow the physician order. The Medical Director said when he assessed Resident #1 on 1/10/23 while making rounds she looked very dehydrated. The [NAME] Director said he gave the order for Resident #1 to be sent to the emergency department on 1/10/23. During an interview on 1/18/23 at 1:29 p.m. CNA A said she had reported Resident #1's change in condition to the charge nurse on 1/09/23. During an interview on 1/18/23 at 1:32 p.m. LVN D said she notified the physician on 1/10/23 of Resident #1's signs and symptoms of dehydration while he was in the facility making rounds. During an interview on 1/18/23 at 1:43 p.m. the Nurse Practitioner said she was vaguely familiar with Resident #1. The Nurse Practitioner said she had not been notified of Resident #1's dehydration or change in condition. During an interview on 1/19/23 at 8:17 a.m. the Psychiatric Nurse Practitioner said she had ordered the UA on Resident #1 on 1/05/23. The Psychiatric Nurse Practitioner said she had ordered the UA on Resident #1 due to the nursing facility reporting increased hallucinations and an increase in incontinent episodes for 2-3 days. The Psychiatric Nurse Practitioner said she was not notified of the UA not being obtained on Resident #1. During an interview on 1/19/23 at 8:27 a.m. CNA B said she first noticed the change in condition with Resident #1 on 1/09/23. During an interview on 1/19/23 at 8:31 a.m. CNA A said Resident #1 had tried to drink 4-6 ounces of water by assistance from the nurse. CNA A said Resident #1 would not arouse to eat on 1/09/21. CNA A said on 1/05/23 or 1/06/23 Resident #1 required assistance with eating and drinking. CNA A said Resident #1 did not usually require assistance with eating and drinking. CNA A said Resident #1 usually drank lots of fluids, fed herself, and carried a pitcher of water at all times. CNA A said on 1/05/23 or 1/06/23 Resident #1 was not getting up or carrying around her water pitcher. CNA A said she reported the changes in Resident #1 to the charge nurse. (continued on next page)

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	675037	A. Building B. Wing	01/20/2023

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/19/23 at 8:40 a.m. LVN D said on 1/09/23 she noticed Resident #1 was not eating or drinking. LVN D said on 1/09/23 Resident #1 drank some water in the morning but would not arouse for food or fluid the rest of the day. LVN D said Resident #1 had been incontinent on bladder on 1/09/23 which was outside of her baseline. LVN D said she did not report to the physician Resident #1's decrease in food intake, decrease in fluid intake, increased need for assistance, or incontinence on 1/09/23 when she noticed the change in condition. During an interview on 1/19/23 at 9:04 a.m. the Dietary Manager said the Dietician came to the facility monthly. During an interview on 1/19/23 at 9:54 a.m. the Dietary Manager said there had not been a dietician assessment on Resident #1 since 2022. The Dietary Manager said Resident #1 had not had an assessment from the Dietician because she had not had any triggers such as significant weight loss. During an interview on 1/19/23 at 10:55 a.m. the Dietician said she had been working at the facility since September 2022. The Dietician said she had not performed and assessment on Resident #1 since she began working at the facility. The Dietician said she had not performed an assessment on Resident #1 because she had not had any triggers from a nutritional standpoint. Record review of the facility's Intake, Measuring and Recording policy dated 6/2020 indicated, The purpose of this procedure is too accurately determining the amount of liquid a resident consumes in a 24-hour period. Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy .Record the fluid intake as soon as possible after the resident has consumed fluids. At the end of your shift total the amounts of all liquids the resident consumed. Record all fluid intake on the intake and output record . Record review of the facility's Output, Measuring and Recording policy dated 6/2020 indicated, The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period. Verify there is a physician's order for this procedure and/or that the procedure is being performed per facility policy . Record review of the facility's undated Diets, Nutrition, and Hydration policy indicated, .The dietary manager, with assistance from the Dietician, will calculate daily fluid requirements for all residents with risk factors indicating a concern with fluid intake .Increased fluid needs may occur if the resident is suffering from one of the following: 1. Fever, 2. Dehydration, 3. Pressure Sores, 4. Burns, 5. Infections, 6. Urinary Tract Infection, 7. Hot Weather, 8. Vomiting, and 9. Diarrhea . The administrator was notified on 1/19/23 at 11:36 a.m. that an Immediate Jeopardy situation was identified due to the above failure. The administrator was provided the Immediate Jeopardy template on 1/19/23 at 11:36 a.m. The facility's Plan of Removal was accepted on 1/19/23 at 4:33 p.m. and included: All residents with active physician orders Intake and Output monitoring were discontinued on 01/19/2023. Education (provided by DON or ADON) (continued on next page)

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All nurses were in-serviced on Appropriately Notifying the Physician of changes in condition in a timely manner on 01/19/2023. This in-service includes competency checks by pre-test post-test. Each nurse will be in-serviced prior to returning to shift. This will be completed by 01/19/2023. Nursing will not return to shift without the in-service and pre-test post-test. All nurses were in-serviced on Policy and Procedure for obtaining a UA on 01/19/2023 which includes entering the UA as a one-time order. This in-service will be completed by 01/19/2023. Nurse administration in-serviced to assign fluid consumption and voiding by CNA as monitoring tasks unless I/O monitoring ordered by physician on 01/19/2023. All nurses were in-serviced on appropriately monitoring I&Os to include monitoring residents who are at risk for dehydration to ensure they are being assessed appropriately and not dehydrated 01/19/2023. This in-service will be completed by 01/19/2023. Nursing will not return to shift without the in-service. All nurses were in-serviced on Notifying the Physician if a UA is not obtained on 01/19/2023. Nursing will not return to shift without the in-service. On 1/20/23 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of a randomly selected sample of residents indicated all residents reviewed who had an order for intake and output monitoring had that order discontinued on 1/19/23 Interviews of nursing staff (2-nurses on the 6:00 a.m.-2:00 p.m. shift; 1 nurse on the 7:00 a.m.- 3:00 p.m. shift, 2 nurses on the 8:00 a.m.- 5:00 p.m. shift, 2-nurses on the 2:00 p.m.- 10:00 p.m. shift; 1 nurse on the 10:00 p.m.- 6:00 a.m. shift) were performed. During these interviews' staff were able to correctly identify when to notify the physician of a resident's change in condition or unable to obtain labs; the appropriate procedure for obtaining a UA on a resident, and how to appropriately monitor resident's fluid intake and output who are at risk for dehydration. On 1/20/23 at 9:45 a.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review the facility failed to ensure laboratory services were obtained to meet the needs for 1 of 3 (Resident #1) residents reviewed for laboratory services. The facility did not ensure Resident #1 had a urinary analysis performed per orders which resulted in Resident #1 being admitted to the hospital with diagnoses of acute metabolic encephalopathy (a problem in the brain that encompasses delirium and the acute confusional state with causes including dehydration, malnutrition, and metabolic imbalances), dehydration, fluid depletion, and acute kidney injury (a condition in which kidneys suddenly cannot filter waste from the blood with causes including severe dehydration, low blood volume after bleeding, and excessive vomiting or diarrhea). This failure resulted in an identification of an Immediate Jeopardy (IJ) at 11:00 a.m. on 1/19/23. While the IJ was removed on 1/20/23, the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place the residents at risk of not receiving lab services as ordered and suffering from an undetected infection. Findings include: 1. Record review of the consolidated physician orders dated 1/20/23 indicated Resident #1 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including diabetes, cognitive communication disorder, urinary tract infection, hypokalemia, and paranoid schizophrenia. The physician orders indicated Resident #1 had an order to document fluid intake every shift starting 5/31/21 and was discontinued on 1/19/23. The physician orders indicated Resident #1 had an order to document urine output every shift starting 5/31/21 and was discontinued on 1/19/23. The medical records indicated Resident #1 had an order to obtain a urinary analysis (UA) on 1/05/23. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 usually understood others and usually made herself understood. The MDS indicated Resident #13 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 did not reject evaluation or care. The MDS indicated Resident #1 required supervision with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. The MDS indicated Resident #1 was occasionally incontinent. Record review of the care plan revised on 12/27/22 indicated Resident #1 had a potential fluid deficit related to diuretic use with intervention including obtain and monitor lab/diagnostic work as ordered, observe and document intake and output as per facility policy, monitor/document/report to the physician signs and symptoms of fluid deficits including but not limited to: decreased or no urine output, cracked lips, new onset of confusion, and fatigue/weakness. Record review of the nursing progress note dated 1/05/23 at 3:03 p.m. indicated Resident #1 received a new order for a UA. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/18/23 at 12:53 p.m. LVN C said when a lab order was received for a UA a lab requisition should be completed and nurses should obtain the UA. LVN C said if a resident refused a UA the nurse should document the refusal in the electronic medical records. During an interview on 1/18/23 at 12:58 p.m. LVN D said when a lab order for a UA was received it should be entered into the electronic medical records, a lab requisition should be completed and put into the lab book, and the nurses should collect the UA. LVN D said if a resident refused a lab it should be documented in the electronic medical records. LVN D said she was aware Resident #1 had an order for a UA. LVN D said the UA was not obtained. LVN D said the UA was not obtained because Resident #1 was incontinent. LVN D said an in and out catheter was not attempted on Resident #1. During an interview on 1/18/23 at 1:32 p.m. LVN D said she did not notify the physician or nurse practitioner that the UA was not obtained on Resident #1. During an interview on 1/18/23 at 1:43 p.m. the Nurse Practitioner said she was vaguely familiar with Resident #1. The Nurse Practitioner said she was aware of the order for the UA on Resident #1. The Nurse Practitioner said the order for the UA was wrote by the Psychiatric Nurse Practitioner. The Nurse Practitioner said she had been notified by an evening nurse the facility was unable to obtain the UA on Resident #1. The Nurse Practitioner said she recommended the facility perform an in and out catheterization on Resident #1 to obtain the UA. The Nurse Practitioner said she was not informed the in and out catheter had not been performed. The Nurse Practitioner said she expected to be informed if the in and out catheter was unsuccessful or unable to be performed. During an interview on 1/19/23 at 8:17 a.m. the Psychiatric Nurse Practitioner said she had ordered the UA on Resident #1 on 1/05/23. The Psychiatric Nurse Practitioner said she had ordered the UA on Resident #1 due to the nursing facility reporting increased hallucinations and an increase in incontinent episodes for 2-3 days. The Psychiatric Nurse Practitioner said she was not notified of the UA not being obtained on Resident #1. Record review of the facility's Lab and Diagnostic Test Results-Clinical Protocol dated 6/2020 indicated, The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process the test requisition and arrange for tests . The Administrator was notified on 1/19/23 at 11:36 a.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 1/19/23 at 11:36 a.m. The facility's Plan of Removal was accepted on 1/19/23 at 4:33 p.m. and included: All residents with active physician orders Intake and Output monitoring were discontinued on 01/19/2023. Education (provided by DON or ADON) All nurses were in-serviced on Appropriately Notifying the Physician of changes in condition in a timely manner on 01/19/2023. This in-service includes competency checks by pre-test post-test. Each nurse will be in-serviced prior to returning to shift. This will be completed by 01/19/2023. Nursing will not return to shift without the in-service and pre-test post-test. (continued on next page)

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