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F 428	Continued From page 15 recommended maximum dose of acetaminophen. I was there to do a review today. I didn't catch it. I would've asked the nurse to notify the doctor that the resident is over the recommended dose of acetaminophen." On 2/24/2012 at 1:00 PM E9 ADON (Assistant Director of Nursing) stated she received a call from Z5 on 2/23/2012 recommending physician be notified of R11 receiving more than recommended dose of acetaminophen. E9 ADON notified R11 physician on 2/23/2012 at 6:PM and received orders to discontinue acetaminophen 1000 mg every 6 hours as needed and change acetaminophen with codeine to every 12 hours.	F 428		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at	F9999		

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F9999	Continued From page 16 least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect	F9999		

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Continued From page 17

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met, as evidenced by the following:

Based on closed record review and interview, the facility failed to conduct and document timely assessment, monitoring and provision of emergency treatment for 1 resident (R26) in a sample of 28. R26 tested positive for C-diff 13 days after completing treatment. R26 became acutely ill after developing bilateral pedal edema and diminished breath sounds. R26 expired approximately 16 hours after arriving at the hospital. Primary cause of death was "Septic Shock Most Likely From Clostridium Difficile Colitis And Pneumonia."

Findings include:

Minimum Data Set (MDS) dated 12/29/11 shows R26 is an 82 year old resident admitted from an acute care hospital on 12/22/11. MDS progress notes shows admitting diagnoses of Congestive Heart Failure Exacerbation, Hypertension, Acute Pulmonary Edema, Atrial Fibrillation, C-diff. R26 has been receiving skilled physical and occupational therapy. MDS documentation shows no cognition, mood nor behavior concerns. R26 was the sole informant for Resident Assessment and Care Screening, with an expectation to be discharged to the community. R26 requires extensive, 2 persons assistance for transfer and toilet use and is continent of bowel.

Physician's Order Sheet dated 12/22/11 shows

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order for contact isolation for C-diff in stool, urinary catheter for Urinary Outlet Obstruction secondary to Enlarged Prostate. Medication regimen includes Metronidazole (Flagyl) 500 milligrams (MG) every 8 hours for 8 days (1500 MG in 24 hours for 8 days). Lexi-Comp's Drug Reference Handbook states that for the treatment of C-diff, the recommended dose is 20MG per kilogram of body weight every 6 hours. R26's weight on admission was 217 pounds (98.6 kilograms), requiring 1,972 MG of Flagyl every 24 hours. R26 compiled the prescribed treatment on 12/30/11. There was no evidence that a test of cure was done.

Bowel Movement Monitoring flow sheet for January 2012 does not support R26 being asymptomatic (absence of loose stools) upon completion of treatment. The flow sheet dated 1/1/12 through 12/1/12 shows frequency of bowel movement (0-2 per day) but does not describe characteristic of bowel movements. E2 (Director of Nursing) stated on 2/24/12 at approximately 1:50pm that the certified nurses aids (CNA) complete the flow sheet and it is the facility's policy to record the number of occurrence only, not consistency nor characteristic. E2 went on to say that the nurses document bowel pattern for residents. R26 had 2 bowel movements on 1/10/12 but nursing documentation addresses 1 of the 2 movements. There was no activity entered on 2 of 3 shifts on 1/11/12.

Nursing Notes dated 1/2/12, 2:05pm, states family member complained to staff regarding R26's complaint of numbness in his bilateral lower extremities. Upon assessment the nurse documented swelling of both lower extremities

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F9999	Continued From page 19 which were cold to touch. Staff observed R26's room to be cold, adjusted the room temperature and covered resident with a warm blanket. Pitting edema of lower extremities continued through 1/12/12. Family also inquired about the when urinary catheter would be removed as resident seemed to be more confused than usual. R26's physician ordered urinalysis, urine culture, complete blood count (CBC) and basic metabolic panel. Urine specimen was collected on 1/3/12 (no time noted) and results reported to facility 1/3/12 at 1:01pm. Urinalysis showed presence of yeast, trace of protein, small occult blood, small leucocytes. Platelet count was critically low. These results were not reported to the physician until 1/5/12. The CBC was repeated 1/10/12, showed elevated white blood cells (WBC) and further drop in the platelet count. The results was reported to the facility at 12:03pm and relayed to physician at 6pm. Nursing Documentation dated 1/12/12, 5pm, states R26 had 3 episodes of foul smelling diarrhea. Notes also states R26 was feeling weak and experiencing shortness of breath during physical therapy. Nursing assessment shows diminished lung sounds. R26's physician was notified of these symptoms and notified of low blood Potassium level (2.7 milli-equivalent per liter) and gave order to increase potassium medication and repeat potassium level on 1/16/12, administer oxygen at 2 liters per minute as needed for shortness of breath and obtain stool specimen for C-diff. Nursing documentation on the 11pm - 7am shift of 1/12/12 shows oxygen saturation decreased to 94% on room air, lung sounds diminished and R26 incontinent of loose bowel movement. R26 was not receiving Oxygen.	F9999		

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Stool specimen was received by the laboratory on 1/13/12 and reported positive for C-diff to the facility on 1/16/12.

E27 (Nurse) documented on 1/13/12 at 11am that R26 complained of weakness, numbness in all extremities, shortness of breath, mouth breathing and pale. R26's blood pressure was 90/60 (low), pulse 124 beats per minute and respiratory rate 22 per minute. Temperature was documented as 97.9 degrees Fahrenheit and Oxygen saturation at 95% at room air. Z7 (attending physician) was paged and call not returned until 1 hour later, with order to send R26 to the hospital for evaluation. A private ambulance company was called and informed E that they would arrive at facility in 20 minutes. R26 was transported out of the facility at 12:30pm. There is no evidence to support continued monitoring of R26's condition over the 90 minutes period. E27 wrote at 1pm that R26 was diverted in transit to the nearest hospital due to unstable vital signs.

E27 told surveyor on 2/23/12 at approximately 2:25pm that he took care of R26 off and on as he floats to other units. E27 observed R26 in bed, complaining of weakness and numbness in lower extremities and slouching as if lethargic. R26's blood pressure was observed to be lower than normal. E27 further stated that he spoke with Z7 less that 30 minutes after the page was placed. E27 said he observed no further decline in R26's condition and had no explanation for why he did not document evidence of further monitoring.

Paramedic report dated 1/13/12 states R26 was diverted to hospital which was 3 minutes away due to drop in blood pressure. The destined

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hospital was estimated to be 20 minutes away. Emergency Department Record shows R26 arriving at 12:55pm with temperature of 102 degrees Fahrenheit, blood pressure 69/36, pulse rate 122 per minute and respirations at 24 per minute. R26 was diagnosed with Septic Shock most likely due to C-diff colitis and Pneumonia, Acute Renal Failure and Supratherapeutic INR, Dehydration. Hospital record also states R26 had a Stage I and Stage II pressure sore to the buttocks and Deep Tissue Injury to the right great toe. These conditions were not documented in the facility records.

Z7 stated on 2/24/12 at approximately 11:55am that R26's decline was insidious while in the emergency room and R26 had little chance of recovery given his multiple co-morbid conditions. Z7 listed all of R26's current and past medical history. Regarding the elevated WBC on 1/10/12 (from 5,000 k/mm cu to 10.3 k/mm cu) within one week, Z7 stated he didn't consider this as significant. Regarding treatment for C-diff, Z7 stated there are two choice of treatment, Vancomycin and Flagyl. Z7 went on to say that Vancomycin is a more aggressive choice of treatment for individuals in a compromised state of health and with co-morbid health concerns. Z7 went on to say that after treatment for C-diff, R26 exhibited no symptoms of diarrhea, abdominal pain, fever nor WBC greater than 15,000 (k/mm cu).

R26's WBC was noted to be 35.8 k/mm cu within 3 hours of being seen in the emergency room. It was last checked in the facility on 1/10/12.

On 2/24/12 at approximately 9:30am, Z2 (nurse

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F9999	Continued From page 22 Consultant) stated nurses cannot transport resident to hospital without a physician's order even in the event of a life threatening emergency. Z2 went on to say that the facility has no policy that addresses when nurses can make decisions to send resident out to the hospital in the event of an emergency and physician not responding to a page in a timely manner. Regarding R26's change in condition, Z2 stated that there were multiple co-morbid conditions in question and, when R26 developed lower extremity edema and numbness, the family refused treatment. Z2 was not able to provide documentation to support this. Z2 went on to say that facility staff kept a diligent eye on R26, but again could not provide any written evidence to support this. Regarding timeliness of getting R26 to the hospital Z2 stated that, after physician's order for transport to the hospital, facility nurses did not call emergency response (911) because there was no physician's order for this and R26 had a DNR (do not resuscitate) status and emergency response paramedics usually attempt resuscitation. B 300.1230l) Section 300.1230 l) Staffing Skilled Nursing Care Residents needing skilled nursing care may only be cared for in facilities licensed as Skilled Nursing Facilities. Each resident needing skilled care shall be provided at least 2.5 hours of nursing-personal care each day, of	F9999		

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which 20% must be licensed nurse time.

This requirement is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that an
adequate number of certified nurses aid (80% of nursing personnel)
is provided to care for its 49 residents of the Skilled unit.

Findings include:

During the survey entrance on 2/21/12 at approximately 9:15am, E1
(Administrator) identified the 3rd floor of the facility as a skilled level of
care unit. The Unit has a bed capacity of 52 with a census of 49 residents
on 2/21/12.

During the resident group interview on 2/22/12 at approximately 1:00pm,
there were 12 residents representing each unit of the facility. It was the
consensus of the group that there is not enough certified nurses aid (CNA
to provide timely care especially at bed times and during meals.

On 2/22/12 during general observations on the 3rd floor skilled unit at
12:10pm, Z6 (Family member) stated that nursing staff are nice and
friendly and hard working. Z6 stated that the only concern is that there are
not enough "Aid's" working on the Unit. Z6 went on to say that on many

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F9999	Continued From page 24 occasions she has witnessed resident's call light going unanswered for greater than one-half hour and roommate visibly needing attention and not receiving it for hours. Utilizing the Department's recommended guidelines for calculating required number of CNA's for the facility's 49 Skilled Care residents residing on the 3rd floor, the following was obtained: Total Number of Hours of Care Needed 49 x 2.5 = 122 hours/day Number of nursing staff hours per shift: 7-3pm shift = 45% of 122 = 54.9 hours 3-11pm shift =35% of 122 = 42.7 hours 11-7am shift = 20% of 122 = 24.4 hours Licensed staff coverage (total/shift x 0.2) 7-3pm shift = 54.9 x 0.2 = 10.98 hours 3-11pm shift = 42.7 x 0.2 = 8.54 hours 11-7am shift = 24.4 x 0.2 = 4.88 hours CNA hours needed per shift (total nursing - licensed staff) 7am - 3pm = 54-9 - 10.98 = 43.92 3pm - 11pm = 42.7 - 8.54 = 34.16 11pm - 7am = 24.4 - 4.88 = 19.52 Number of CNA's needed per shift (hours per shift /8): 7am-3pm shift = 43.92/8.0 = 5.5 CNA's 3pm-11pm shift = 34.16/8.0 = 4.27 CNA's 11pm-7am shift = 19.52/8.0 = 2.44 CNA's	F9999		

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F9999	Continued From page 25 Review of facility's Daily Staffing and Sign-in Sheet dated 2/17/12 through 2/24/12 shows consistent insufficient CNA coverage on the 7am to 3pm shift and 11pm to 7am shifts. 7am-3pm shift: Of the 9 shifts (7-3) during this period, only 4 CNA's are scheduled on every shift. 6 of those shifts showed 3 CNA's signed on for duty; 1 shift showed only 2 CNA's signed in. 11pm - 7am shift: Of the 8 11pm-7am shifts, there are 3 CNA's scheduled on every shift. For 5 of those 8 shifts, 2 CNA's signed on for duty. 2/24/12 at approximately 1:15pm, E2 (Director of Nursing) stated that nursing staff are required to sign the daily staffing sheet as is the tool used to track staff attendance.	F9999		