STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 1) was provided treatment and care in accordance with professional standards of practice when nurses did not act on the deterioration of Resident 1's physical condition, which included Congestive Heart Failure (is a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen) and edema (swelling caused by too much fluid trapped in the body's tissues) and weight gain. Facility staff failed to provide the necessary treatment, personalized plan of care, nutritional support, and the facility's Interdisciplinary team (IDT) did not collaborate to address the resident's critical medical needs. These failures resulted in Resident 1's transfer to the emergency department (ED) and admission to the acute care hospital (ACH) for a right foot infection with erythema (reddening of the skin), desquamation (shedding the outer layers of skin) and sepsis (a life-threatening medical emergency caused by the body's extreme response to an infection) caused by pitting edema (when excess fluid builds up in the body causing swelling and when pressure is applied to the area it causes a pit measured on a scale from 1+ [least] to 4+ [most]) to her bilateral lower extremities (lower legs) and a ruptured blister to the right foot. The right foot infection and sepsis contributed to Resident 1's death on [DATE]. Findings: During a review of Resident 1's Admission Record (AR-a document containing resident demographic information and medical diagnosis), undated, the AR indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included congestive heart failure (CHF-heart does not pump enough blood to meet the body's needs), severe protein-calorie malnutrition (nutritional deficiency), iron deficiency anemia (a lack of iron in the body), and atrial fibrillation (irregular heart rhythm). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental process) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 13 (a score of ,d+[DATE] indicates cognitively intact, ,d+[DATE] indicates moderately impaired, ,d+[DATE] indicates severe impairment). The BIMS assessment indicated Resident 1 was cognitively intact. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Medical Provider Note, dated [DATE] at 6:17 p.m., written by Resident 1's Physician (PHY), the note indicated, . History and Physical . Patient is admitted for rehab s/p [status post] recent hospitalization for CHF . Extremities: no edema . decreased peripheral pulses (impaired blood flow) . CHF: Monitor for fluid overload (too much fluid in the body) . During a review of Resident 1's ACH document titled H&P [history and physical], dated [DATE] at 9:56 p.m., the H&P indicated, . Assessment/Plan . Acute [severe and sudden onset] right foot infection . with erythema and desquamation, pitting edema up to the ankle . given 1 dose of antibiotics [medicines that fight bacterial infections] in the ER [emergency room] though family decided comfort care [end-of-life medical treatment] . new onset A-fib [atrial fibrillation] with RVR [rapid ventricular response-rapid contractions of the ventricles (lower chambers of the heart)] likely secondary to severe dehydration [condition when the body loses too much water and other fluids] and sepsis secondary to problem #1 [foot infection] . Very malnourished [diet does not contain the right amount of nutrients] and cachectic [physical loss of weight and muscle mass due to disease] with history of dementia [impaired ability to remember, think or make decisions] . Chief Complaint . Wound Infection . BIBA [brought in by ambulance] from [name of facility] with right foot infection X 2 weeks . presents to the ED (Emergency Department) for evaluation of Wound Infection . the SNF [skilled nursing facility] reported that the infection has been present for about 2 weeks . gotten worse over the last couple days . does have a history of severe malnourishment . past medical history . CHF . physical exam . severely malnourished and cachectic, appears to be in significant pain with any movement of the right lower extremity . Cardiovascular [relating to heart and blood vessels] . Tachycardia [rapid heart rate] . Skin . Right foot infection with erythema and desquamation, pitting edema up to the ankle . unable to palpate (examine by touch) DP [dorsalis pedis-upper surface of the foot] pulse secondary to edema . During an interview on [DATE] at 12:07 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she had cared for Resident 1 while she was in the facility. CNA 1 stated Resident 1 was very thin, and the staff would turn her every two hours because her weight made her a high risk for skin breakdown. CNA 1 stated Resident 1 had a lot of swelling in her lower legs, and staff would try to elevate her lower legs, but she was not compliant. During an interview on [DATE] at 12:41 p.m. with CNA 2, CNA 2 stated, she [Resident 1] was really skinny. CNA 2 stated she remembered Resident 1 because her lower legs were really swollen, and she would not keep her feet elevated. During an interview on [DATE] at 12:54 p.m. with CNA 3, CNA 3 stated she was familiar with Resident 1. CNA 3 stated Resident 1's feet were really swollen and pinkish while she was at the facility. CNA 3 stated Resident 1's legs were really big for a little skinny lady. CNA 3 stated Resident 1 had supplement drinks ordered for nutrition, but she usually refused them. During a telephone interview on [DATE] at 2:24 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was familiar with Resident 1 and was the charge nurse on [DATE] when she was transferred to the hospital. LVN 1 reviewed Resident 1's electronic medical record (EMR) and stated Resident 1 had a weight gain of 6 pounds (lbs.- unit of measurement) between admission and [DATE]. Resident 1's Change in Condition, (CIC) dated [DATE] was reviewed. LVN 1 stated the CIC indicated Resident 1 had a new onset of edema to her bilateral lower extremities. LVN 1 was unable to answer why it was important to monitor residents with CHF for weight gain and/or edema. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on [DATE] at 2:56 p.m. with the Director of Nursing (DON), Resident 1's weight measurements were reviewed. Resident 1's weights were: [DATE] - 83 lbs. [DATE] - 84 lbs. [DATE] - 86 lbs. [DATE] - 89 lbs. (6.74 % gain since [DATE]) The DON stated Resident 1's weight had increased six pounds between her admission on [DATE] and [DATE], which is a weight gain of more than 5%. The DON stated a weight gain of more than 5% in less than one month would be considered significant and was a change in condition. The DON reviewed Resident 1's Change in Condition, dated [DATE], the CIC indicated, . Signs & symptoms identified Edema in both feet Started on . [DATE] . Date and time of clinician notification . [DATE] 14:30 [2:30 p.m.] Recommendation . Furosemide Oral Tablet 20 MG . The DON stated Resident 1's CIC indicated the physician was notified of the edema but was unable locate documentation indicating the provider was notified of her weight gain. The DON stated Resident 1's weight gain and edema was considered a change in condition. The DON stated the facility's IDT normally met and discussed any residents with a change in condition, but they did not meet regarding Resident 1's weight gain and edema. The DON stated IDT meetings were important to discuss the changes in condition, identify the causes and make recommendations for care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 12:14 p.m. with the Nurse Practitioner (NP), the NP stated she saw Resident 1 on [DATE] for edema to her bilateral lower extremities. The NP stated she was not notified Resident 1 had a six-pound weight gain between [DATE] and [DATE]. The NP stated Resident 1's CHF could have caused the six-pound weight gain from fluid retention (body is unable to maintain fluid levels) and edema in her legs. The NP reviewed Resident 1's EMR and stated she prescribed Resident 1 furosemide (a diuretic medication- used to reduce extra fluid in the body) 20 mg (milligrams-unit of measurement) twice daily for 10 days for the edema. The NP stated she evaluated Resident 1 after 10 days and the resident continued to have edema, so she ordered to continue the diuretic, elevate her feet, and place TED (thromboembolic deterrent-prevent blood clots) hose (compression stockings to help maintain blood circulation and decrease the odds for severe swelling) on the resident. The NP reviewed Resident 1's Order Summary Report [OSR], and stated she was unable to locate an order for the TED hose. The NP stated she had given the nurse an order verbally and was unsure why it was not entered. Resident 1's progress notes written by the NP were reviewed. The progress notes dated [DATE], [DATE], [DATE], indicated, . Pitting edema 3 + to to [sic] bilateral lower extremities noted with SOB [shortness of breath-intense tightening in the chest] with activity . The NP stated she thought Resident 1 had probably finished physical therapy before her visits which may have caused the SOB. Resident 1's NP progress note dated [DATE] indicated . cardiovascular . Edema 3+ to bilateral lower extremities . Respiratory . non-labored respirations . Assessment/Plan . ted hose application for bilateral lower extremities . may elevate bilateral feet with pillows for fluid retention . Resident 1's NP progress note dated [DATE] indicated . Addendum . Change furosemide 40 mg BID [twice daily] for 10 days . The NP stated she added the addendum because she had forgotten to document she increased the furosemide because Resident 1 continued to have edema to her extremities. Resident 1's edema care plan was reviewed, the care plan indicated, . Focus . edema in both feet . Goal . resolve without complication . Interventions . elevate feet . Furosemide Oral Tablet 20 MG . Notified RP [responsible party], NOTIFY MD [doctor] . The NP stated, there should have been more interventions to improve edema. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 1:29 p.m. with LVN 1, Resident 1's CIC dated [DATE] at 2:08 p.m., written by LVN 1 was reviewed. The CIC indicated, . Charge [nurse] noticed that resident has edema in both feet. Upon assessment resident denies any pain or discomfort, respiration even and unlabored. Vitals stable and skin intact. Laydown the resident in bed, put pillow under both feet . Plain [plan] of care going on . cardiovascular Status Evaluation . Is a cardiovascular assessment relevant to the change in condition . Not clinically applicable . Is a skin assessment relevant to the change in condition . not clinically applicable . LVN 1 stated Resident 1 had edema in both feet and the skin was intact on [DATE]. LVN 1 stated Resident 1 had a diagnosis of CHF with edema and the CIC should include cardiovascular and skin assessments as part of the CIC. Resident 1's CIC dated [DATE], at 3:48 a.m., was reviewed. The CIC indicated, . Signs and Symptoms Identified . edema in both feet, and blister pooped [popped] on right foot and weeping . resident has edema on both feet CNA informed this writer while ADL (Activities of Daily Living) care resident left foot is weeping, this writer did assessment resident have blisters on right foot blisters popped and watery discharge coming out . LVN 1 stated she was the day shift charge nurse on [DATE]. LVN 1 would not answer if the night nurse had communicated the change in condition to her during shift change report that Resident 1's blisters had popped, and her feet were weeping. Resident 1's CIC dated [DATE] at 3:35 p.m., written by LVN 1, was reviewed. The CIC indicated, . change . Edema to both feet/ popped blister to edema site . started on [DATE] . what time of day did this start? . morning . resident has edema on both feet treatment nurse informed this writer while doing treatment that resident left foot is weeping, this writer. Did assessment resident have blisters on right foot blisters pooped [sic] and water discharge coming out . foot covered with dressing, and put pillows under the foot to elevate, placed call MD, MD stated that transfer resident to hospital for further assessment . Were the change in condition and notifications reported to primary care clinician . yes . cardiovascular Status Evaluation . Is a cardiovascular assessment relevant to the change in condition . Not clinically applicable . Is a skin assessment relevant . Not clinically applicable . additional pertinent diagnosis . CHF . LVN 1 stated Resident 1 had blisters caused by the edema to both feet and she had documented which foot incorrectly as the left foot, but the blister had popped on the right foot. LVN 1 stated Resident 1's left foot blister was resolving. LVN 1 stated the CIC process was to complete the CIC note, call the physician, responsible party, progress note, start 72-hour charting and update the care plans. Resident 1's edema care plan, dated [DATE] was reviewed, LVN 1 stated the care plan should have been updated [DATE] when her blisters had popped and there was a CIC. LVN 1 stated the care plan did not have personalized interventions, which should have included care for the blisters and weeping to the lower extremities, weighing the resident frequently and to apply a dry dressing for the weeping. LVN 1 stated Resident 1's care plan should have included the interventions from the physician orders, such as a fluid restriction and I&Os (intake and output-measurements of fluid that enters and leaves the body). LVN 1 stated care plans should be updated whenever there was a change in condition and should include timeframes for interventions and meeting the resident's goals. Resident 1's NP notes were reviewed which indicated to apply TED hose. LVN 1 reviewed the OSR and stated she was unable to locate an order for TED hose. LVN 1 was unable to find the TED hose documented on the care plans, treatment administration record (TAR). LVN 1 stated she did not remember Resident 1 wearing TED hose. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 3:11 p.m. with the Unit Manager (UM), the UM stated, she [Resident 1] was a little lady. Resident 1's weights were reviewed, the UM stated Resident 1's six-pound weight gain between [DATE] and [DATE] was significant because she was very underweight and had CHF and edema. The UM stated the change in condition process was to assess the resident, notify the doctor and Responsible Party (RP), start 72-hour charting, and enter a care plan. The UM stated Resident 1's CIC note dated [DATE] documented the lower extremity edema but she was unable to find any documentation reporting the six-pound weight gain. The UM reviewed Resident 1's EMR and stated she was unable to locate an IDT note for Resident 1 regarding the weight gain or edema. The UM stated Resident 1 had CHF so it was important to monitor her for signs and symptoms of fluid overload including weight gain, lungs sounds if the resident was wheezing (high pitched lung sound from airflow throw a compressed airway) or gurgling (low pitched sound caused by obstruction in the airway), vital signs (measurement of the body's most basic function), pulse (number of heart beats per minute), BP (blood pressure-pressure of blood pushing against arteries), respirations (breaths per minute), and edema which could signify the heart was not pumping well. Resident 1's care plans were reviewed. The UM stated care plans were important because they were the basis of patient care and the way the facility meets the resident's goals. Resident 1's CHF care plan, dated [DATE], was reviewed, the care plan indicated, . The resident has Congestive Heart Failure . Goal . The resident will have clear lung sounds, heart rate and rhythm within normal limits through the review date . Interventions . Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles [muscles that assist in breathing, can signal respiratory distress] while breathing . Monitor/document/report to MD PRN (as needed) any s/sx [signs/symptoms] of Congestive Heart Failure: dependent [influenced by gravity] edema of legs and feet . weight gain unrelated to intake . crackles [rattling] and wheezes upon auscultation [listening to sounds] of the lungs . Monitor/document/report to MD PRN any s/sx of digitalis [medication to treat heart conditions] toxicity [poisonous]: Fatigue [exhaustion], muscle weakness, anorexia [eating disorder with low body weight], nausea, yellow halos around objects . Monitor/document/report to MD PRN any s/sx of hypokalemia [low potassium in blood] in residents receiving diuretic therapy . Vital signs as ordered . The UM stated the care plan was a generic, prepopulated care plan and was not accurate or personalized for Resident 1 because she was not on digitalis, it did not specify an individualized goal and did not address the symptoms she was having such as edema. The UM stated Resident 1's care plan was not acceptable to meet her needs. Resident 1's care plan for edema was reviewed, the UM stated the care plan was not customized to resident 1. The UM stated the care plan should have included interventions to monitor Resident 1's weight, lung sounds and vital signs frequently and addressed the fluid restriction and I&Os as ordered by the PHY. The NP's progress notes were reviewed. The UM stated the notes reference TED hose, but she did not remember if Resident 1 wore them. Resident 1's OSR was reviewed, the UM stated she was unable to locate an order for TED hose. The UM stated there should be an order and care plan for TED hose if they were worn. The UM stated she did not remember any signs of an infection to Resident 1's feet while she was at the facility. The UM stated when Resident 1's blisters had popped, she was transferred to the ACH. The UM stated she was not aware Resident 1 had a right foot infection when she was admitted to the ACH. The UM stated symptoms of a foot infection would be redness, warmness, and pain when touched and shiny skin from the swelling. The UM stated the open blisters on Resident 1's foot increased her risk to develop a skin infection. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on [DATE] at 1:10 p.m. with the Registered Dietitian (RD), Resident 1's Nutrition Assessment, dated [DATE], written by the RD was reviewed. The assessment indicated, . height 63 in (inches-unit of measurement) . Most Recent Weight . 83 lbs . Usual weight 101 [lbs.] . Desired/Goal Body Weight . Gradual wt [weight] gain to 115 lbs would be beneficial . Weight status . Underweight BMI [body mass index-measurement of body fat] < [less than] 18.5 . The RD stated he saw Resident 1 only for her initial assessment. The RD stated Resident 1 was slowly gaining weight when he saw her, and his focus was on residents with weight loss. The RD reviewed Resident 1's weights in the EMR and stated she had gained 6 pounds between admission and [DATE]. The RD stated the weight gain was greater than 5% within a month which would be considered a significant weight gain. The RD stated the EMR would automatically trigger a notification to the nurse there was a change in condition. The RD stated Resident 1 had CHF and the expectation would be for the nurse to assess the resident for edema, check the vital signs and notify the physician because the weight gain could be a sign of fluid retention. The RD stated he was not notified Resident 1 had gained weight and about the edema. The RD stated Resident 1 was malnourished which could also cause edema and he would have reassessed the resident's nutritional needs if had he known. The RD stated Resident 1's weight gain and edema was never reviewed by the IDT because the IDT's focus was on residents who were losing weight. The RD stated Resident 1's weekly weights were not continued after [DATE], because she was underweight and when he assessed her, she was gradually gaining weight which was considered desirable. The RD stated, If I knew about the edema, I would have continued the weekly weights. The RD stated when a resident had edema it was important to monitor their weight frequently to assess for fluid overload. The RD stated, The weights need to be monitored to make sure that we are not going overboard on the diuretics, it could lead to dehydration. The RD stated the protocol for routine weights was to weigh new residents weekly for four weeks and then change to monthly. The RD stated the Restorative Nursing Assistants (RNAs) would perform the weekly or monthly weights and he would review the weights after they were all complete. The RD stated during that time, he was only at the facility two days a week which made it difficult to see all the residents he should have. The RD stated the facility was recently given a deficiency regarding the weight process, communication and follow up on weight changes and had recently improved the process. The RD stated he now visited the facility three times weekly which had improved his ability to follow up with residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on [DATE] at 2:41 p.m. with the Director of Nursing (DON), Resident 1's weights were reviewed. Resident 1's CIC dated [DATE], at 3:48 a.m., was reviewed. The CIC indicated, . Signs and Symptoms Identified . edema in both feet, and blister pooped [popped] on right feet and weeping . resident has edema on both feet CNA informed this writer while ADL care resident left foot is weeping, this writer did assessment resident have blisters on right foot blisters popped and watery discharge coming out . Date and time of clinician notification . [DATE] 03:59 [3:59 a.m.] . Recommendation of Primary Clinician [blank] .Is a cardiovascular assessment relevant to the change in condition . Not clinically applicable . Is a skin assessment relevant to the change in condition . Not clinically applicable . The DON stated the cardiovascular status assessment should have been completed by the nurse because the edema was caused by CHF and the skin assessment should have been completed because the skin weeping and ruptured blisters to the resident's feet. The DON stated Resident 1 was on a fluid restriction which was important to follow because if fluid was imbalanced, the resident could retain too much fluid which would stress the heart. The DON stated Resident 1's edema started on [DATE] and had not improved which eventually caused blisters to her feet. The DON stated on [DATE] a blister had popped on Resident 1's right foot, causing weeping and a watery discharge, so she was transferred to the acute care hospital. The DON stated she had examined Resident 1's feet on [DATE] and the edema had improved on the left foot, but the right foot was worse. The DON stated Resident 1's right leg was very swollen, hard to palpate the pedal (foot) pulse, the skin was tight when she was transferred to the hospital. The DON stated she did not remember seeing multiple blisters, but the right foot was reddish but cool. The DON reviewed Resident 1's EMR and stated her examination was not entered in the CIC note or a progress note but should have been. Resident 1's CHF care plan was reviewed. The DON stated the care plan had an intervention to monitor for signs and symptoms of digitalis toxicity and was obviously not customized to Resident 1 because she was not on digitalis. The DON stated the EMR had a care plan library, and the staff would select the focus, goals and interventions which applied to the resident's diagnosis. The DON stated the staff were expected to edit the prepopulated care plans and personalize them for each resident. The DON stated it was apparent the care plans entered were not specific to Resident 1. The DON stated the plan of care should be individualized to each resident's needs, and the purpose of care plans were to indicate what care and interventions were needed to meet a resident's healthcare goals. The DON stated care plans needed to indicate the time frame within which the interventions would be done, and goals would be met. Resident 1's care plan for edema was reviewed and the DON stated the care plan did not have the necessary interventions to meet Resident 1's needs for management of the edema. The DON stated the care plan should have included interventions such as the physician ordered fluid restriction and I&Os, and added monitoring the leg size, skin temperature, vital signs, and weights. The DON stated Resident 1's six-pound weight gain on [DATE], prior to the onset of edema should have been included in her care plans. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and policy and procedure (P&P) review on [DATE] at 3:25 p.m. with the DON, the P&P titled Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, dated ,d+[DATE] was reviewed. The P&P indicated, . The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time . The Staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline . The physician will review for medical causes of weight gain . For individuals with recent or rapid weight gain or loss . the staff will review for possible fluid and electrolyte imbalance (occurs when your body's minerals are too high or low) as a cause . Conditions such as heart failure and renal failure (is a condition when the kidneys suddenly become unable to filter waste products from the blood) can cause rapid weight gain . The physician, with the help of the multidisciplinary team [IDT], will identify conditions and medications . The physician will help identify medical conditions (cancer, cardiac or renal disease .) and medications that may be causing weight gain or loss . The physician (or staff based on a discussion with the physician) will document relevant medical information regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations such as where multiple causes coexist . The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions . The DON stated the IDT should have met to discuss Resident 1's weight gain and edema. The DON stated when the CIC for edema was completed on [DATE], the physician should also have been notified about her weight gain. The DON stated Resident 1's weight gain was caused by CHF, fluid retention and edema. The DON stated the P&P was not followed. During a review of the ACH's document titled Discharge Summary, dated [DATE], the summary indicated, . Admission Diagnosis . severe malnutrition . Atrial fibrillation with rapid ventricular response . septic shock (occurs when a body wide infection leads to dangerously low blood pressure) . sepsis . Discharge Weight 80 lb. Hospital Discharge Diagnosis . Acute right foot infection X 2 weeks . New onset A-fib with RVR . Severe malnutrition from chronic illness . Advanced dementia . Hospital Course . presents to [hospital name] ED for evaluation R [right] foot infection . patient was hypotensive (sudden drop in blood pressure) and tachycardic (increased heart rate) . They [EMS] stated that the staff at the SNF reported that the infection has been present for about 2 weeks now and has gotten worse over the last couple days . Patient's family has requested hospice . Discharging to: Hospice Inpatient Facility . Condition: Poor . During a review of Resident 1's Certificate of Death, dated [DATE], the certificate indicated, . Cause of Death . Atrial Fibrillation with Rapid Ventricular Rate . Right Foot Infection . Advanced Dementia . Other Significant Conditions . Severe Malnutrition . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, dated ,d+[DATE], the P&P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The interdisciplinary team (IDT) . develops and implements a comprehensive, person-centered care plan for each resident . the comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . which professional services are responsible for each element of care . includes the resident's stated goals upon admission and desired outcomes . reflects currently recognized standards of practice for problem areas and conditions . Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . The interdisciplinary team reviews and updates the care plan . when there has been a significant change in the resident's condition . when the desired outcome is not met . when the resident has been readmitted to the facility from a hospital stay . During a review of a professional reference retrieved from https://www.ahajournals.org/doi/10.1161/HHF.0000000000000005 titled Heart Failure Management in Skilled Nursing Facilities, dated [DATE], the reference indicated, . Heart failure (HF) is a complex syndrome . Data available suggest that HF patients discharged to SNFs [skilled nursing facilities] are at very high risk for rehospitalization and death . avoidable hospitalization s are common in the general SNF population, many of whom have HF as a comorbidity (the condition of having two or more diseases at the same time) . Examples of factors related to avoidable hospitalization s include lack of on-site primary care clinicians . lack of integration of HF assessment and interventions into nursing care . Frailty is usually described by reduced function in multiple domains, including nutrition or body weight, muscle strength . management of decompensated HF, or volume overload resulting in worsened HF symptoms in SNFs . Decompensation [hearts inability to deliver oxygenated blood] is usually recognized by a gain in weight, worsened HF symptoms . On admission and with a change in status, goals of care should be identified . Monitoring for presence of increasing fatigue, dyspnea [difficulty breathing] on exertion, cough, edema, and weight gain should signal nursing staff to intervene to avoid further decompensation . Management of worsened congestion in SNF residents should be patient centered, highly individualized, and based on shared decision making between a knowledgeable, well-coordinated, proactive healthcare team . based on their goals for care . Initial management of volume overload is appropriate in the SNF. Nursing care staff should incorporate monitoring for symptoms and signs of volume overload and intervene to avoid symptomatic congestion . Diuretic agents are an essential component of HF symptom management and remain the most effective agents for relieving pulmonary congestion [too much fluid in lungs] and edema . Diuretic agents require careful monitoring of volume status (using weight and physical examination) . Nursing Care of HF patients in SNFs should include assessment of sym [TRUNCATED]