| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125066 | A. Building<br>B. Wing | 01/26/2024 |

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| Kalakaua Gardens | 1723 Kalakaua Avenue<br>Honolulu, HI 96826 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853<br><br>Based on interviews and record review, the facility failed to provide information to one Resident's (R)1 representative about the right to formulate an advanced health care directive (AHCD). The facility staff documented advanced directive information was provided to R1, and she agreed to the status of full code (resuscitation). R1 was not competent to make that decision or understand the information, and her representative was not involved. In addition, the physician wrote a conflicting order of do not resuscitate (DNR) on admission. As a result of this deficiency there was the potential the resident/representatives wishes were not taken into consideration during her treatment.<br><br>Findings include:<br><br>1) R1 is a [AGE] year old female admitted from an acute care hospital for short term physical and occupational therapy after having a cerebral vascular accident (CVA/stroke) with right arm flaccidity. R1 has a cognitive deficit due to dementia. She wears a hearing aid on the left side and can only hear 2% on the right. There was a writing board in her room used for reminder cues and for communication.<br><br>2) R1's admission progress note 01/11/2023 at 08:23 PM by Registered Nurse (RN)1, included R1 was alert and orient 1-2x (knows who they are and where they are, but not what time it is or what is happening to them) on arrival. The Baseline Care Plan developed on admission by Registered Nurse (RN)1 included she was Confused.<br><br>Record Review revealed an order written by R1's physician (MD)1 dated 01/12/2023, DNR (do not resuscitate)<br><br>Review of Social Service (SS) note by SS1 dated 01/25/2023 at 05:06 PM, included: No POLST or AHCD on file, writer offered education and blank copies, resident does not wish to complete at this time and is okay with full code status.<br><br>P1's record included a General Durable Power of Attorney (appoints someone to handle finances and make medical decisions if you're unable to) dated July 1, 2016, designating family members (FM)1, FM2 and FM3 in consecutive order to make her decisions if she was unable.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) Reviewed the facility policy titles Resident Rights Advanced Directives dated 11/2017. The policy statement was The facility will have a process for determining and following the resident's advanced care planning decisions and informing residents of their right to formulate an advance directive. Policy Guidelines included:<br><br>1. Upon admission, staff will verify the formulating of an advance directive or the resident's wishes with regards to formulating an advance directive. Resident's wishes may be communicated through the resident representative.<br><br>'2. The facility will provide information on advance directives in a manner easily understood by the resident or the resident representative about the right to refuse medical .treatment and to formulate an advance directive.<br><br>3.Documentation in the medical record will reflect the discussion of advance directives occurred, and that assistance has been offered to the resident, and the resident's acceptance or declination of assistance.<br><br>7. Facility staff will communicate the resident's wishes to the resident direct care staff and physician.<br><br>10. The facility identifies the primary decision maker. This includes assess the resident's decision-making capacity and identifying or arranging for an appropriate representative for the resident assessed as unable to make relevant health care decisions.<br><br>4) On 01/25/2024 at 01:40 PM, during an interview with SS1, she said there usually is a meet and greet with the resident and family three to five days from admission and they discuss advanced directives at that time. Reviewed the documentation of the IDT (interdisciplinary departmental team) Meeting dated 01/17/2023 at 11:14 AM. Documentation of that meeting was on a a form titled IDT Care Conference/Welcome Form-V4, signed by Social Services (SS)1. The form has a section Invitation and Attendance, which was left blank, indicating R1's representatives were not invited or notified of the meeting. The form did indicate the Resident (R)1 was in attendance, but she would not have been able to understand the content of such a meeting. SS1 said she did not have any recall of that meeting. Reviewed the SS note dated 01/25/2023 at 06:05 AM noted above, and SS1 confirmed it was her note. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853<br><br>Based on interviews, and record review (RR), the facility failed to include one resident's (R)1 representative in the development of the comprehensive care plan. In addition, R1's physician (MD)1 does not attend the care planning IDT (interdisciplinary team) meetings. As a result of this deficiency, there was the potential the facility was not aware of R1's goals and desired outcomes, which could have a negative impact on her quality of life, as well as the quality of care and services received.<br><br>Findings include:<br><br>R1 is a [AGE] year old female admitted to the facility on [DATE] from an acute care hospital for short term physical and occupational therapy after she had a cerebral vascular accident (CVA/stroke) with right arm flaccidity. Her medical history included but not limited to Alzheimer's, hypertension, atrial fibrillation, orthostatic hypotension (low blood pressure with change of positions), muscle weakness and age-related physical debility, with unsteadiness on feet. R1 had a General Durable Power of Attorney (POA/appoints someone to handle finances and make medical decisions if you're unable to) dated July 1, 2016, designating family members (FM)1, FM2 and FM3 in consecutive order to make her decisions if she was unable. At the time of admission, R1 was confused with a documented baseline by the transferring hospital of being oriented only to self.<br><br>On 01/11/2023, the day of admission, Registered Nurse (RN)1 developed the baseline care plan and reviewed it with R1's FM's who were present in the facility.<br><br>On 01/17/2023 at 11:14 AM, there was an IDT (interdisciplinary departmental team) Meeting. Reviewed the documentation of that meeting, which was a form titled IDT Care Conference/Welcome Form-V4, signed by Social Services (SS)1. The form had a section Invitation and Attendance, which was left blank, indicating R1's representatives were not invited or notified of the meeting. The form did indicate the Resident (R)1 was in attendance, but she would not have been able to understand the content of such a meeting.<br><br>On 01/24/2023 at 09:03 AM Social Services (SS)1 documented a note Writer received phone call from RP (Family Member (FM))1 regarding updates on resident. She would like for her sister, FM2 to be a part of care plan meeting also.<br><br>On 01/25/2024 during an interview with SS1, she said they usually have a welcome meeting 3-5 days after admission which includes herself, MDS coordinator, dietician, Admissions Director and the Director of Rehabilitation. She went on to say they reach out to the family and send an invitation to attend. When asked it there was documentation an invitation was sent, she said it would have been done by the MDS coordinator at that time, who was no longer employed at the facility. There was no documentation that family had been invited to the welcome meeting. SS1 said the first meeting with family member (FM) was on 01/31/2023. Inquired if the physician (MD)1 attended the meeting, and she said No, the physician does not attend the IDT meetings. The facility was unable to provide any documentation of the 01/31/2023 meeting. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853<br><br>Based on record review (RR) and interviews, the facility did not ensure one residents (R)1 care plan was revised timely to include changes in therapy and new diagnoses. This deficient practice failed to ensure the continuity of care, and communication between facility staff and resident/ family members regarding care that is being provided to the resident.<br><br>Findings include:<br><br>1) R1 is a [AGE] year old female admitted to the facility on [DATE] from an acute care hospital for short term physical and occupational therapy after she had a cerebral vascular accident (CVA/stroke) with right arm flaccidity. Her medical history included but not limited to Alzheimer's, hypertension, atrial fibrillation, orthostatic hypotension (low blood pressure with change of positions), muscle weakness and age-related physical debility, with unsteadiness on feet.<br><br>2) RR revealed there were several changes to R1's status during her stay which required new treatments. These included the following:<br><br>02/07/2023: diagnosed with dehydration and urinary tract infection (UTI). Treatment for the UTI was Ciprofloxacin (antibiotic) 250 mg (milligrams) po (oral) bid (twice a day) x 7 days. Treatment for the dehydration was IV (intravenous) fluids, D5 1/2 NS (normal saline) at 50 cc (cubic centimeters)/hr (hour) for 7 days.<br><br>02/16/2023: PICC line (peripheral intravenous central catheter- longer than a regular IV and goes all the way up to a vein near the heart or just inside the heart) placed in Left arm due to infiltration (fluid leaks into tissue) of the IV.<br><br>3) Reviewed R1's Care Plan (CP), which revealed R1 was identified as at risk for dehydration with the goal of adequate hydration of 1300 ml (milliliters) of fluid (oral) per day on 01/12/2023. The CP was not revised to include the new diagnoses of dehydration or the intravenous fluid therapy. In addition, the CP was not revised to include the new diagnosis of UTI, antibiotic therapy or the PICC line.<br><br>4) On 01/26/2024 at 09:00 AM, during an interview with the Assistant Director of Nursing (ADON), she said all licensed staff can revise the CP. She said it should be revised by the nurse who gets the orders or notification of new therapy. The ADON confirmed the CP should include short term plans that would include the new diagnoses of UTI and dehydration, as well as the PICC line, IV fluids and antibiotics.<br><br>On 01/24/2024 at 03:30 PM during an interview with Registered Nurse (RN)2, inquired whose responsibility it would be to update the care plan when a diagnosis is added or therapy changes. She said The RN who initiated the therapy or took the order should have updated the CP to include the UTI infection and the antibiotic order RN2 agreed the information should have been included in R1's CP |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853<br><br>Based on interviews and record review (RR), the facility failed to provide evidence that one Resident (R)1 received the required physician (MD) face-to-face initial comprehensive visit within 30 days of admission. As a result of this deficient practice, the resident's needs may not be met so she could meet her highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all new admissions.<br><br>Findings include:<br><br>1) R1 is a [AGE] year old female admitted to the facility on [DATE] at approximately 05:00 PM from an acute care hospital for short term physical and occupational therapy after she had a cerebral vascular accident (CVA/stroke). Her medical history included but not limited to Alzheimer's, hypertension, atrial fibrillation, orthostatic hypotension, muscle weakness and age-related physical debility, with unsteadiness on feet. On [DATE] at 11:22 AM, R1 was transferred to an acute care hospital for a change of condition. She was admitted to the ICU for sepsis and fluid overload and expired on [DATE].<br><br>2) RR revealed two progress notes documented by R1's Physician, MD1. One encounter on [DATE] (admitted ) and the other on [DATE] (transfer date). The progress notes were in template format, and included Seen by and Seen on. Both documents documented seen by MD1 on the respective encounter dates, and electronically signed by MD1.<br><br>Progress Note Encounter date [DATE] included:<br><br>S (subjective of SOAP (subjective, objective, assessment, plan) documentation format) ADM (admission)-Progress note LTC (long term care) Recertification Note Requested by the Nursing staff (Family; Patient) to evaluate this patient. HPI (history of present illness) and Chief Complaint = Pt seen for the above reasons: ADM (admission) --A.L FRONTAL CVA (stroke) -- ON ELIQUIS (anticoagulant); HERE for PT/OT (physical/occupational therapy). Except for chief complaint as above all eleven ROS (systems review for obtaining medical history from a patient)<br><br>O (objective signs as perceived by the clinician) listed findings for const (constitution/physical make up), eyes, ent (ear, nose throat), neck, resp (respiratory), CV (cardiovascular), GI (gastrointestinal) GU (genitourinary), MSK (musculoskeletal) skin, and Neuro (neurological).<br><br>A this section of note included diagnoses.<br><br>P this section included: Patient condition and plan of care being d/w (discussed with) nursing staff in details. Family at bed-side-multiple questions answered<br><br>On [DATE] at 10:15 AM, during an interview with Registered Nurse (RN1), he confirmed MD1 did not come to the facility for a face to face evaluation on [DATE], the day of P1's admission.<br><br>Progress Note Encounter date [DATE] included:<br><br>(continued on next page) |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | S D/C (discharge) --Progress note .: DC TO ER (emergency room ) ASAP (as soon as possible) AS PT (R1)CONFUSED/UNSTABLE VS (vital signs) = = ,d+[DATE]; HR 117. The remainder of Section S was the same as documented in encounter [DATE].<br><br>Section O was the same as documented in encounter [DATE].<br><br>Section P was the same as documented in encounter [DATE] with the exception of the last sentence: D/C to ER ASAP AS PT CONFUSED/UNSTABLE VS= = ,d+[DATE]; HR117.<br><br>On [DATE] at 10:30 AM, during an interview with RN2, she said MD1 did not have a face to face encounter to evaluate R1 on [DATE] when she was transferred, but that she spoke with him on the phone and he ordered her to be transferred.<br><br>3) On [DATE] at 09:40 AM, during an interview with MD1, he said he does his initial comprehensive admission visit as soon as he can come to the facility after the Resident is admitted . MD1 said he did not recall if he had been at the facility for a face to face encounter on [DATE], the date of R1's admission. He said he sometimes uses telemedicine or speaks with the resident or representative on the phone, reviews the records sent from the transferring facility and communicates directly with the RN's to determine the plan of care and generates the progress note.<br><br>At that time, discussed the fact that the progress note template does not include an option other than seen by, such as telemedicine, and that the note gives the impression the documentation was based on a face to face encounter at the facility. Reviewed the encounter progress notes for [DATE] with MD1. He confirmed the notes from that encounter were not from a face to face assessment. He went on to say the it would not be practical that he could see the resident in that circumstance because it was a situation where she needed to be transferred to the ER immediately, and the discharge note was generated after collecting information from the RN. Shared with MD1 that there were two nursing progress notes that indicated he was in the facility, and added new orders for R1, but there were no MD progress notes related to those nursing dates. He said sometimes he does not write a note, and will just address the issue with nursing.<br><br>4) RR revealed the following nursing progress notes:<br><br>On [DATE] entered by RN2 at 07:11 PM: This RN was alerted by assigned CNA this morning that resident (R1) has small skin abrasion on right upper thigh. MD came this morning and he ordered trid [sic] daily and cover with dry dressing until healed, .<br><br>On [DATE] entered by RN1 at 06:36 PM: MD came this afternoon with new order of bacitracin to right hip daily x2 weeks for the right hip abrasion.<br><br>There were no MD encounter notes that related to these notes. |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853<br><br>Based on interviews and record review, the facility nursing staff failed to demonstrate the competency (knowledge and skill set) to meet the needs of one Resident (R)1 of a sample size of three. The Nursing Staff: 1) did not identify a change in R1's level of consciousness, 2) did not report the trend Rl's high blood pressure (BP) medication was held due to low blood pressure. 3) administered medication twice when it should have been held because BP was outside parameters, and 4) did not administer oxygen timely or notify the physician (MD)1 when R1's oxygen level (PO2) remained below. Due to these deficiencies, R1's changing condition was not recognized and reported to the MD, which did not allow for timely interventions, and she suffered harm. On [DATE], R1 was transferred to the hospital where she was admitted in critical condition with diagnosis of urosepsis (sepsis due to urinary tract infection) and fluid overload. She expired on [DATE]. This could affect any resident who has a change of condition that is not recognized by the nursing staff.<br><br>Findings include:<br><br>1) R1 was a [AGE] year old female with past medical history for hyperlipidemia (disease related to conditions like heart attack, stroke, and peripheral artery disease), cognitive communication deficit, chronic kidney disease stage 3, dysphasia (difficulty swallowing), muscle weakness, atrial fibrillation and dementia. She presented to an ER with weakness in her right upper and lower extremities after a fall on [DATE]. R1 was admitted and diagnosed with acute CVA (Cerebral vascular accident/stroke). On [DATE], she was discharged to Kalakaua Gardens for short term rehabilitation. On [DATE], R1 was transferred to the hospital for shortness of breath and low oxygen saturation level, where she was admitted to ICU with sepsis (serious condition in which the body responds improperly to an infection) and fluid overload (too much fluid in your body). She expired on [DATE].<br><br>2) Reviewed R1's transfer notes, used by the hospital to convey information about her medical care to the receiving health care providers. The Hospitalist (MD)2 Progress Note dated [DATE] 06:49 AM, included Patient now with hypotension (low blood pressure) and mild bradycardia (slow heart rate) and metoprolol (lowers BP and heart rate) decreased on [DATE] (2023) to have 12.5 mg (milligrams) p.o (oral) daily (was 12. 5 mg PO BID (twice a day). MD2 also documented Much more sleepy today on exam. She even forgets her name upon awakening I informed nursing staff to notify me when family arrives and will reassess the patient. Given limited participation as well as patient's more somnolent state further subjective exam unable to be obtained. R1's baseline was documented to be oriented only to self due to the dementia, but her level of consciousness had not been somnolent until [DATE], the day before transfer to Kalakaua Gardens.<br><br>3) Reviewed R1's orders, which included, but not limited to:<br><br>Order date [DATE]: Order Summary: Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG. Give 0.5 tablet by mouth one time a day for HTN (hypertension/high BP) Hold for SBP (systolic/first number) less than 120 and HR (heart rate) 60. Scheduled administration time was 08:00 AM.<br><br>Order date [DATE]: Order Summary Midodine HCL Oral Tablet 5 MG. Give 1(one) tablet by mouth as needed for hypotension (low BP) give meds if BP <100.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Review of the Medication Administration Record (MAR) for metoprolol revealed a pattern the medication was held several times due to BP outside of parameter (<120 SBP).<br><br>[DATE]th-31, 2023:<br><br>Metoprolol dose held 11 of 20 days.<br><br>[DATE]: BP ,d+[DATE] P 58<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE] [DATE]: ,d+[DATE]<br><br>[DATE]: Part of BP cut off of photocopy, but was out of range.<br><br>Metoprolol given twice when it should have been held.<br><br>[DATE] ,d+[DATE]<br><br>[DATE] ,d+[DATE]<br><br>February ,d+[DATE] (date of transfer), 2023<br><br>Metoprolol dose held seven of 19 days<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE]<br><br>[DATE]: ,d+[DATE] Midodine for low BP not administered per order.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Additional BP's recorded in Vitals Summary included:<br><br>[DATE] 11:12 PM ,d+[DATE]<br><br>[DATE] 10:57 PM ,d+[DATE]<br><br>[DATE] 11:11 PM ,d+[DATE]<br><br>[DATE] 11:14 PM ,d+[DATE]<br><br>Midodine not administered as ordered.<br><br>5) Review of facility Nursing progress notes included the following:<br><br>[DATE] (admission note) 05:52 PM: .res (resident/R1) appeared tired .<br><br>[DATE] 10:27 PM: .Affect lethargic (decreased level of consciousness)/tired this shift.<br><br>[DATE] 09:38 AM: Resident noted with intermittent pain behaviors-grimacing, yelling out. MD made aware with new orders received, as follows: Gabapentin 200 mg TID (three times a day) PO for pain, and PRN (as needed) Tramadol 50 mg QID (four times a day) for pain. (side effect of both gabapentin and tramadol include sleepy and tired).<br><br>[DATE] 10:49 PM: .she struggled with whole pills. Gave them crushed in pudding; .<br><br>[DATE] 10:17 PM: .Affect is tired/lethargic<br><br>[DATE] 07:42 AM: .Affect is tired/lethargic<br><br>[DATE] 10:22 PM: BP ,d+[DATE] .Very lethargic; asleep most of the time but, she is arousable. Appears to have difficulty swallowing due to lethargy. Might be safer to crush meds; .<br><br>[DATE] 11:11 PM BP ,d+[DATE] .Very lethargic; asleep most of the time but, she is arousable.<br><br>[DATE] 12:12 PM: Resident family concerned about resident sleepiness. Explained that resident is at baseline with behaviors that have been present since admission. Resident has normal assessment with no change in condition noted. Family requested to have MD1 call them to discuss issue. Message left in MD binder.<br><br>[DATE] 10:11 PM: BP ,d+[DATE] .Affect lethargic, baseline for resident at nighttime. [DATE] 11:29 PM . Lethargic.UA (urinalysis) done, pending results.<br><br>[DATE] 05:56 PM: lab result came in .bacteria many . Updated MD and ordered D5 (Dextrose) NS (Normal Saline) 500 cc/hr for Dx of dehydration, .family updated regarding the new order (antibiotic) and they have request to d/c (discontinue) tramadol and gabapentin. MD called back at 05:45 PM and .start Ciprofloxacin 250 mg PO BID x 7 days, and d/c tramadol and gabapentin.<br><br>[DATE] 11:40 PM BP ,d+[DATE] .Lethargic.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125066 | A. Building<br>B. Wing | 01/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kalakaua Gardens | 1723 Kalakaua Avenue<br>Honolulu, HI 96826 |

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

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | [DATE] 09:36 PM: .Weak in appearance.<br><br>[DATE] 10:19 PM: . Becoming more verbal, .<br><br>[DATE] 10:17 PM: .Very lethargic, but arousable.Resident has a reddened, systemic appearing, itchy rash to her trunk and arms. Unknown etiology.<br><br>[DATE] 02:41 AM: .Very lethargic, but arousable. Resident has a reddened, systemic appearing, itchy rash to her trunk and arms. Unknown etiology.<br><br>[DATE] 00:45 AM: Very lethargic, but arousable. Resident has a reddened, systemic appearing, itchy rash to her trunk and arms. Unknown etiology.<br><br>[DATE] 07:29 PM: CNA(Certified Nurse Assistant) alerted this RN this morning around Lunchtime resident has blood clot on the [sic] and tea colored urine, tried to reach MD1 and just called back around 7 PM, with new order to hold Eliquis (anticoagulant) for 2 days and monitor resident.<br><br>[DATE]: O2 (Saturation) 92% . Affect lethargic but able to be aroused.Facial grimacing and calling out noted with movement, resolves with reset. Pain managed with scheduled Tylenol.<br><br>[DATE] 10:17 PM: BP ,d+[DATE] O2 92.0%: Affect lethargic but able to be aroused.Facial grimacing and calling out noted with movement, resolves with reset. Pain managed with scheduled Tylenol.<br><br>[DATE] 11:35 PM: BP ,d+[DATE] O2 91% : .Affect lethargic.Facial grimacing and calling out noted with movement, resolves with rest. Pain managed with scheduled Tylenol.<br><br>[DATE] 10:03 PM: O2 91% .Lethargic but able to arouses easily; .Facial grimacing and calling out noted with movement, resolves with reset. Pain managed with scheduled Tylenol.<br><br>[DATE] 02:34 PM: .Per night shift resident has oxygen sat of 90% and no crackles noted, recheck her oxygen sat and went up to 93% room air.Around 10:10 AM this RN went to check resident and noticed she is having slight SOB (shortness of breath), up HOB (head if bed) .RR 22 O2 sat ,d+[DATE]% with coarse lung sound on bilateral [sic] lungs. Initiated oxygen inhalation at 4LPM (liters per minute) via nasal cannula, called MD and he ordered to hold IV.maintain O2 at 92% or above.While doing nebulization resident's daughter came in and explained to her what's happening. Resident oxygen cannula changed to oxygen mask and boost up to 8 LPM, however resident O2 sat is not getting higher and went down to 80%. Called MD and informed him family wants to sent [sic] resident to ER for further evaluation. Called 911 and came here around 11AM.<br><br>[DATE] 04:00 PM: . resident admitted in the ICU with initial Dx of Sepsis.<br><br>6) Reviewed the Vitals Summary O2 sats (saturation), which revealed R1's O2 sat was recorded to be 91% (target 92%) on [DATE] at 09:44 PM and then again, 91% at 11:36 PM. It was not recorded again during the night. Next recorded 90% on [DATE] at 07:00 AM. R1 should have been administered oxygen when O2 Sat dropped below 92% the evening of [DATE]. The standard of care would be to monitor the O2 sat frequently throughout the night. MD1 should have been notified if it did not maintain at 92%.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 7) R1's level of consciousness changed. The day she was transferred from the hospital ([DATE]), the Hospitalist documented she was much more sleepy today on exam. She even forgets her name upon awakening. Her baseline had not been lethargic or very lethargic. The changing level of consciousness was not recognized by the nursing staff.<br><br>8) On [DATE] at 03:30 PM, during an interview with RN2, said if a resident had a 91% O2 sat, she would wait and repeat the vital and if still low, would then put oxygen on. On nights, they would not notify the MD if the resident maintained over 92% after the oxygen was applied. RN2 said the MD would be notified by the day shift and informed the resident required oxygen during the night. If it did not maintain 92% during the night, she said she would notify the MD. RN2 said if they are unable to reach any MD they have a back up on call.<br><br>On [DATE] at 10:30 AM, during a telephone interview with RN3, she said the general practice for notification of the MD is when something is unusual or if there is a change in level of consciousness. R1 acknowledged she held R1's metoprolol several times due to low blood pressure. When inquired what the practice was for notifying the MD if SBP was outside parameters (below 120), she said she checks the BP again, holds the medication, but would not necessarily notify the MD unless it was very low. If it was close, I would not notify. RN1 said she had not informed MD1 when she held the medication, and said the MD comes in a couple times a week and should see the documented BPs.<br><br>On [DATE] at 09:00 AM during an interview with the Assistant Director of Nursing (ADON), inquired what the practice was and expectation to notify MD if BP medication is held. She said there is not a policy, but if parameters are listed, it would depend on how low it is. If it is ,d+[DATE], I'm calling, but if it is ,d+[DATE], I'd put a note in the binder (physical binder staff make notes to communicate with MD), or tell the MD when came in. The ADON said she would expect the MD to be notified if a resident continued to be lethargic or increased lethargy, as well as if a resident developed a new rash as it may be an allergic reaction to the antibiotic.<br><br>On [DATE] at 10:15 AM, during an interview with RN1, he said his practice is if a BP is <120, he would repeat it in 30 minutes, and if the still remained below 120 and the medication needed to be held, he would notify the MD each time.<br><br>9) Progress notes (above) dated [DATE] indicated medications were crushed as the R1 was having difficulty with whole pills. The note on [DATE] documented Appears to have difficulty swallowing due to lethargy. Might be safer to crush meds; . Crushing medication requires an order by the physician. Neither RN notified the MD or followed through appropriately to have R1 reevaluated for swallowing difficulty. |