

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Twin Oaks Center		STREET ADDRESS, CITY, STATE, ZIP CODE  63 Locust Street Danvers, MA 01923	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41019</p> <p>Based on record review and interview the facility failed to meet professional standards of quality for four Residents (#55, #48, #63 and #24) out of a total sample of 18 residents. Specifically:</p> <ol style="list-style-type: none"> <li>1. For Resident #55, #48 and #63 the facility failed to assess their hydration status, draw labs or notify the responsible party before administering intravenous (IV) hydration.</li> <li>2. For Resident #24 the facility failed to obtain his/her Depakote level as ordered by the Physician.</li> </ol> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. For Resident #55, the facility failed to assess his/her hydration status, draw labs or notify the responsible party before administering intravenous (IV) hydration.</li> </ol> <p>Resident #55 was admitted in 9/2021 with diagnoses including depression.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 5/9/24, indicated Resident #55 scored a 7 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated Resident #55 has an activated health care proxy in place.</p> <p>Review of the progress note, dated 5/3/24, indicated the following: Note Text: Resident alert and awake, 22 gauze piv inserted this shift as per MD order for IV fluids due to dx of dehydration as per MD order. Order given to infuse 1 liter of normal saline at rate 125 cc per hour. Site is clean and intact with no s/sx of infection, IV line is patent, flushing with no obstruction at this time. All parties notified, safety maintained.</p> <p>Review of the clinical record prior to 5/3/24 failed to indicate Resident #55 was assessed for hydration status or labs were performed to assess the Resident's hydration status. The clinical record failed to indicate that the health care proxy consented to the IV hydration.</p> <p>During an interview on 7/10/24 at 11:53 A.M., Resident #55's health care proxy said she was never made aware of the facility using IV hydration on Resident #55. The health care proxy said she has no idea why the facility would not call her before administering an IV and that she was upset about that.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/11/24 at 8:31 A.M., the Director of Nursing said that if a Resident presents with dehydration then the facility would try other non-invasive ways of introducing hydration before administering an IV. The Director of Nursing said that if a Resident has a health care proxy, then consent is always needed before proceeding and the health care proxy should be notified. The Director of Nursing said that the IV technician also makes sure they get full consent before administering any IV.</p> <p>During an interview on 7/11/24 at 10:59 A.M., the Regional Manager of the IV company said that for a PIV (peripheral intravenous line), the technician would not get consent and would expect that the facility got consent prior. If the technician received consent, then it would be documented on a separate consent form with a witness signature.</p> <p>Review of the IV paperwork for Resident #55 did not indicate that consent was obtained before inserting the PIV.</p> <p>46339</p> <p>2. For Resident #48, the facility failed to notify the health care proxy before administering intravenous (IV) hydration.</p> <p>Resident #48 was admitted to the facility in August 2020 with diagnoses including dementia and diabetes.</p> <p>Review of Resident #48's most recent Minimum Data Set (MDS) assessment, dated 4/16/24, indicated Resident #48 scored an 8 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated Resident #48 has an activated healthcare proxy in place.</p> <p>Review of the medical record indicated the following physician order dated 4/17/24: -Sodium chloride solution 0.9% use 1000 ml intravenously one time only for Dehydration for 1 Day Infuse 250MI/Hr through the peripheral line.</p> <p>Review of the medical record indicated:</p> <p>-A nurse's progress note dated 4/17/24: Per order, Patient received IV Normal saline for dehydration. No adverse reactions noted. will continue to monitor.</p> <p>-A nurses note dated 4/19/24: Order received to d/c 22G PIV to resident's RIGHT arm no complication, resident tolerated well with no s/sx of pain or discomfort. Site with no s/sx of infection or infiltration. Line D/c and secured with 2x2 gauze and tape.</p> <p>Review of Resident #48's medical record:</p> <p>-Failed to indicate labs were obtained in April 2024 to determine if the Resident was clinically dehydrated.</p> <p>-Failed to indicate the invoked health care proxy was notified or consented to the IV placement and IV hydration.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Failed to indicate the Resident was assessed for dehydration or had a change in condition assessment completed.</p> <p>Review of Resident #48's MOLST (Medical Orders for Life- Sustaining Treatment) form indicated that the Resident did not want any artificial hydration.</p> <p>During an interview on 7/11/24 at 8:31 A.M., the Director of Nursing said that if a Resident presents with dehydration, then the facility would try other non-invasive ways of introducing hydration before administering an IV. The Director of Nursing said that if a Resident has a health care proxy, then consent is always needed before proceeding and the health care proxy should be notified. The Director of Nursing said that the IV technician also makes sure they get full consent before administering any IV. The Director of Nursing further said that if a Resident has a MOLST signed indicating no artificial hydration the healthcare proxy can make the decision to rescind and allow for IV hydration.</p> <p>During an interview on 7/11/24 at 10:59 A.M., the Regional Manager of the IV company said that for a PIV (peripheral intravenous line), the technician would not get consent and would expect that the facility got consent prior. If the technician received consent, then it would be documented on a separate consent form with a witness signature.</p> <p>41105</p> <p>3. For Resident #63, the facility failed to assess his/her hydration status, draw labs or notify the responsible party before administering intravenous (IV) hydration.</p> <p>Resident #63 was admitted to the facility in February 2023 with diagnoses that included asthma and hyperlipidemia.</p> <p>Review of Resident #63's most recent Minimum Data Set (MDS) assessment, dated 4/23/24, indicated Resident #63 was assessed by staff to have severe cognitive impairment.</p> <p>Review of Resident #63's physician orders, dated 4/17/24, indicated the following orders:</p> <p>-Normal Saline Flush Intravenous Solution 0.9 %. Use 1 dose intravenously one time only for Dehydration for 1 Day.</p> <p>-Sodium chloride solution .9%. Use 1000 ml intravenously one time only for dehydration for 1 day. Infuse 125ml/hr through the peripheral line.</p> <p>Review of Resident #63's medical record:</p> <p>-Failed to indicate labs were obtained in April 2024 to determine if the Resident was clinically dehydrated.</p> <p>-Failed to indicate the guardian was notified or consented to the IV placement and IV hydration.</p> <p>-Failed to indicate the Resident was assessed for dehydration or had a change in condition assessment completed.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/10/24 at 12:01 P.M., Resident #63's guardian said that he was never notified that Resident #63 was dehydrated or that an IV had been inserted on 4/17/24.</p> <p>During an interview on 7/11/24 at 8:31 A.M., the Director of Nursing said that if a Resident presents with dehydration then the facility would try other non-invasive ways of introducing hydration before administering an IV. The Director of Nursing said that if a Resident has a guardian, then consent is always needed before proceeding and the guardian should be notified. The Director of Nursing said that the IV technician also makes sure they get full consent before administering any IV.</p> <p>During an interview on 7/11/24 at 10:59 A.M., the Regional Manager of the IV company said that for a PIV (peripheral intravenous line), the technician would not get consent and would expect that the facility got consent prior. If the technician received consent, then it would be documented on a separate consent form with a witness signature.</p> <p>43846</p> <p>4. For Resident #24 the facility failed to obtain his/her Depakote level as ordered by the Physician.</p> <p>Resident #24 was admitted to the facility in October 2022 with diagnoses that included hemiplegia and hemiparesis, anxiety and vascular dementia.</p> <p>Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 4/9/24, indicated Resident #24 was assessed by nursing staff to have severe cognitive impairment.</p> <p>Review of Resident #24's most recent Physician note, dated 7/1/24, indicated Recently seen by psychiatry with no new recommendations. Depakote (an anticonvulsant drug that treats seizures, migraines, and bipolar disorder) level to be obtained on Monday, 7/8/2024.</p> <p>Review of Resident #24's most recent Nurse Practitioner progress note, dated 7/4/24, indicated Depakote level to be obtained on Monday, 7/8/2024.</p> <p>Review of Resident #24's active physician orders, indicated the Resident receives Depakote by mouth twice daily.</p> <p>Review of Resident #24's physician order, dated 7/4/24, indicated Check Depakote level on Monday 7/8/24.</p> <p>Review of Resident #24's nursing progress notes did not indicate that the Resident had refused a lab draw.</p> <p>During an interview on 7/10/24 at 10:40 A.M., the Director of Nurses said Monday is not the facility's regular lab day but nursing staff could have called the lab to book the lab draw for 7/8/24. The Director of Nurses said the lab was not drawn yet.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to adequately maintain the nutrition and hydration status of one Resident (#37) out of a total sample of 18 residents. Specifically, the facility failed to provide adequate hydration for a Resident who requires assistance to full dependence for eating and drinking, resulting in a hospitalization due to dehydration, an acute kidney injury, and hypernatremia.</p> <p>Findings include:</p> <p>Review of the facility policy titled Resident Hydration and Prevention of Dehydration, dated 1/22/2015, indicated the following:</p> <ul style="list-style-type: none"> <li>-This facility will endeavor to provide adequate hydration and to prevent and treat dehydration.</li> <li>-Nursing will assess for signs and symptoms of dehydration as needed and notify the provider to determine needs for hydration.</li> <li>-If potential inadequate intake and/or signs and symptoms of dehydration are observed, dehydration protocol will be initiated and documented. Provider will be notify [sic] for further interventions.</li> <li>-Orders may be written for extra fluids to be encouraged between meals and/or with medication passes.</li> <li>-If nursing assessment indicates significant signs and symptoms of dehydration, labs may be ordered as needed.</li> </ul> <p>Resident #37 was admitted to the facility in 10/2018 with diagnoses including nontraumatic acute subdural hemorrhage, hypertension, peripheral vascular disease, and cognitive decline.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated that Resident #37 scored a 9 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Review of the MDS, dated [DATE], indicated Resident #37 required limited assist to one person physical assistance with eating and drinking.</p> <p>Review of the Comprehensive Nutrition Evaluation, dated 9/26/23, indicated Resident #37 had a decline in ability to feed self and required cueing with assistance and, at times, needed to be fed completely. The Dietitian recommended an occupational therapy evaluation. The notes provided by occupational therapy failed to indicate that Resident #37 had been evaluated for eating.</p> <p>Review of the Comprehensive Nutrition Evaluation, dated 12/26/23, indicated Resident #37 required continued assistance to full dependence on staff at meals.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the lab results for Resident #37, dated 12/27/23, indicated Resident #37 had an elevated sodium level of 157, an elevated chloride level of 122, and an elevated blood urea nitrogen (BUN) of 32. [BUN is a test used to assess kidney function and hydration status. Sodium and Chloride are tested to assess hydration status. The normal range for BUN is 10-24 mg/dL (milligrams per deciliter), the normal range for sodium is 133-145 mmol/L (millimoles per liter), and the normal range for chloride is 96-108 mmol/L.]</p> <p>Review of the Nurse Practitioner progress note, dated 12/29/23, does not indicate that the Nurse Practitioner addressed the elevated lab values.</p> <p>There is no indication in the clinical record that any hydration protocol was put in place for Resident #37 to address the elevated labs.</p> <p>Review of a second lab panel, dated 1/3/24, 5 days after the initial labs drawn, indicated Resident #37 had a critically high sodium level of 160, an elevated chloride level of 122, and an elevated BUN of 30.</p> <p>During an interview on 7/10/24 at 1:18 P.M., the lab company confirmed that Nurse #1 was notified of the critically high labs via telephone on 1/3/24 at 8:06 P.M.</p> <p>Review of the progress note, dated 1/4/24 at 12:01 P.M., 16 hours after the facility received notification of the elevated labs, indicated to send the Resident to the hospital due to dangerously high sodium levels.</p> <p>Review of the progress note, dated 1/4/24, indicated Note Text: Resident alert and confused, new order from NP to send resident to ER for abnormal result, 2 attends of Beauport ambulance picked him up at 5:30 pm.</p> <p>Review of Resident #37's hospital discharge paperwork indicated Resident #37 was treated in the hospital for hyponatremia (elevated blood sodium), dehydration, and an acute kidney injury.</p> <p>During an interview on 7/11/24 at 7:54 A.M., the Medical Director said that if a resident comes back with an elevated sodium level, then he would expect that resident to be treated with D5W (intravenous dextrose solution to treat dehydration) and if that could not be performed, then the resident should be sent out to the hospital. The Medical Director said he would expect to be notified immediately of any critically high or high laboratory levels and any sodium above 145 is considered to be high. The Medical Director said that Nurse #1 should have notified the Nurse Practitioner or physician immediately and considers this a delay in treatment for Resident #37.</p> <p>See tag F773.</p>		

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<p>F 0773</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41019</p> <p>Based on record review and interview, the facility failed to promptly notify the physician/ nurse practitioner (NP) of a critically high sodium lab for one Resident (#37), out of a total sample of 18 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled Resident Hydration and Prevention of Dehydration, dated 1/22/2015, indicated the following:</p> <ul style="list-style-type: none"> <li>- This facility will endeavor to provide adequate hydration and to prevent and treat dehydration.</li> <li>- Nursing will assess for signs and symptoms of dehydration as needed and notify the provider to determine needs for hydration.</li> <li>- If potential inadequate intake and/or signs and symptoms of dehydration are observed, dehydration protocol will be initiated and documented . Provider will be notify [sic] for further interventions.</li> <li>- Orders may be written for extra fluids to be encouraged between meals and/or with medication passes.</li> <li>- If nursing assessment indicates significant signs and symptoms of dehydration, labs may be ordered as needed.</li> </ul> <p>Review of the Laboratory Services Agreement indicated the following:</p> <ul style="list-style-type: none"> <li>- Notification of Findings: As applicable, Laboratory shall provide immediate telephone notice of results of any critical lab value. Laboratory shall promptly report all other findings as appropriate to the facility.</li> </ul> <p>Resident #37 was admitted with 10/2018 with diagnoses including nontraumatic acute subdural hemorrhage, hypertension, peripheral vascular disease, and cognitive decline.</p> <p>Review of Resident #37's most recent Minimum Data Set (MDS) assessment, dated 6/19/24, indicated that Resident #37 scored a 9 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Review of the MDS, dated [DATE], indicated Resident #37 required limited assist to one person physical assistance with eating and drinking.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the lab results for Resident #37, dated 12/27/23, indicated Resident #37 had an elevated sodium level of 157, an elevated chloride level of 122, and an elevated blood urea nitrogen (BUN) of 32. [BUN is a test used to assess kidney function and hydration status. Sodium and Chloride are tested to assess hydration status. The normal range for BUN is 10-24 mg/dL (milligrams per deciliter), the normal range for sodium is 133-145 mmol/L (millimoles per liter), and the normal range for chloride is 96-108 mmol/L.]</p> <p>Review of the clinical record failed to indicate that the physician or NP were notified.</p> <p>Review of the Nurse Practitioner progress note, dated 12/29/23, does not indicate that the Nurse Practitioner addressed the elevated lab values. There is no indication in the clinical record that any hydration protocol was put in place for Resident #37 to address the elevated labs.</p> <p>Review of a second lab panel, dated 1/3/24, 5 days after the initial labs drawn, indicated Resident #37 had a critically high sodium level of 160, an elevated chloride level of 122, and an elevated BUN of 30.</p> <p>During an interview on 7/10/24 at 1:18 P.M., the lab company confirmed that Nurse #1 was notified of the critically high labs via telephone on 1/3/24 at 8:06 P.M. Review of the clinical record failed to indicate that the physician or NP was notified of the critically high sodium level upon notification from the laboratory.</p> <p>Review of the progress note, dated 1/4/24 at 12:01 P.M., 16 hours after the facility's initial notification of the elevated labs, indicated to send the Resident to the hospital due to dangerously high sodium levels.</p> <p>Review of the progress note, dated 1/4/24, indicated Note Text: Resident alert and confused, new order from NP to send resident to ER for abnormal result, 2 attends of ambulance picked him up at 5:30 pm.</p> <p>Review of Resident #37's hospital discharge paperwork indicated Resident #37 was treated in the hospital for hyponatremia (elevated blood sodium), dehydration, and an acute kidney injury.</p> <p>During an interview on 7/11/24 at 7:54 A.M., the Medical Director said that if a resident comes back with an elevated sodium level, then he would expect that resident to be treated with D5W (intravenous dextrose solution to treat dehydration) and if that could not be performed, then the resident should be sent out to the hospital. The Medical Director said he would expect to be notified immediately of any critically high or high laboratory levels and any sodium above 145 is considered to be high. The Medical Director said that Nurse #1 should have notified the Nurse Practitioner or physician immediately and considered this a delay in treatment for Resident #37.</p>		