STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235350	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gaylord	508 Random Lane Gaylord, MI 49735

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 - Minimal harm or potential for 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** 40330 This citation relates to Intake #MI00145643. Based on observation, interview, and record review, the facility failed to ensure comprehensive and timely cardiac and respiratory assessments per professional standards of practice for two residents (R1, R2) of two residents reviewed with cardiac and respiratory conditions. Findings include: Resident 1 (R1): Review of R1's Minimum Data Set (MDS) assessment, dated [DATE], showed R1 was admitted to the facility on [DATE], with diagnoses including status post heart surgery, heart failure, hypertension (high blood pressure), shortness of breath, arteriosclerotic heart disease (hardening of the arteries), longstanding atrial fibrillation (heart rhythm disorder), and mixed hyperlipidemia (elevated cholesterol/fats). The assessment revealed R1 was independent with feeding and grooming, and required maximal assistance for toileting, dressing, bed mobility, and transfers. The cognitive assessment showed R1 was fully oriented with no mental status changes upon admission. The assessment revealed R1 had frequent pain and was taking an anticoagulant (to prevent blood clots), a diuretic (water pill to reduce edema), an opioid (controlled pain medication), and an anti-platelet (cholesterol) medication. The assessment revealed death in facility on [DATE], and R1 was not on hospice care. R1 was 75 tall, weighed 162 pounds, and had no communication impairment. Review of a complaint received by the State Agency on [DATE], read as follows: [R1] was transported [to the facility] on [DATE] via ambulance. [R1] was hospitalized for a triple bypass [heart] procedure on [DATE] and his cardiologist recommended [R1] to be transferred to a rehab facility to gain strength in order to be discharged home. [Family Member (FM) Q] followed him to the facility. Upon arrival, no vitals were taken. [R1's] oxygen was not evaluated. During his 48 hour or less stay, no physician seen [sic] [R1], no vitals were taken, and no assistance was provided .[FM Q] spoke to [R1] on the morning of [DATE] in which [R1] could barely speak. I sent [FM R] there. [FM R] called stating [R1] needed to be transferred from the facility due to lack of care and the condition [R1] was in now. Within minutes, I received a call from [FM R] stating [R1] collapsed in his arms .[R1] immediately passed away. Having a patient lie in bed after a heart surgery is unheard of. If no one listened to his chest, were his lungs congested? Doesn't lying [in bed] and no mobility result in blood clots . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 1:00 p.m. with the complainant, FM Q, they reiterated their concerns, and reported R1 was not wearing his TED hose compression stockings at the facility during their stay, from [DATE] through [DATE], when R1 passed at the facility, which concerned them. FM Q clarified they had seen them on once, when R1 had an incontinence episode, and they were not reapplied. FM Q reported R1 had been up in a chair and walking at the hospital and participated in therapy regularly, and stated they had not seen therapy working with R1 when they were at the facility on [DATE] and [DATE]. FM Q asked Surveyor to speak with FM R, who was reportedly at the facility when R1 passed. During a phone interview on [DATE] at 1:09 p.m. FM R confirmed they were at the facility when R1 passed and described how when they arrived (could not recall the time) they could not understand a word R1 said, and they had to feed R1 lunch, which was unusual, as R1 typically fed himself. FM R explained the physical therapist came by while R1 slept, and they could not get R1 out of bed. FM R described a few minutes later R1 tried to get up from bed for therapy and stopped breathing. FM R reported they screamed for the nursing staff to help, who they reported stood there 5 to 10 minutes not knowing what to do while R1 was turning white, instead of trying to get him to breathe. FM R stated they were asked to leave the room, and left, while staff were trying to lay down R1. FM R reported EMS [Emergency Medical Services] arrived next and told them soon after R1 had passed. FM R reported they had a video chat with R1 the day before (on [DATE]) and he was talking. FM R reported they or FM Q had not been notified R1 was struggling to talk and feed himself on [DATE], which they expected would have occurred. Review of R1's Care Plan, accessed [DATE], confirmed R1 had been independent with feeding, and required one person assistance with dressing, bed mobility and transfers. The Care Plan revealed R1's discharge plan was home with home health. Review of R1's Blood pressure summary, revealed blood pressure was logged twice by nursing during a three day stay, as follows: [DATE] at 16:59 [4:59 p.m.]: ,d+[DATE] [DATE] at 11:48 [11:48 a.m.]: ,d+[DATE]. There was no documentation of why R1's blood pressure was only taken twice by nursing staff during their stay. It was noted therapy staff took R1's blood pressure on [DATE], before and after activity. There was no documentation in the nursing or therapy notes showing communication of the vitals between nursing and therapy. Respiration rate was documented taken twice, oxygen saturation was taken 5 times and pulse rate was taken three times. There was no mention of heart or lung assessments on [DATE]. Review of the Electronic Medical Record (EMR) revealed there was no vital monitoring upon admission to the facility on [DATE], until 16:59 p.m. (5:59 p.m.), which was over three hours after the documented time of arrival to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Nursing Admission Evaluation, Part 1 - V7, dated [DATE], revealed nine sections/assessment categories in the Electronic Medical Record (EMR), which included: Background, Activities of Daily Living (ADLs), Fall Risk Evaluation, Risk of Elopement and Wandering, Skin Assessment, Pain Assessment, Alcohol Abuse Assessment, Resident Education, and Nursing Evaluation Summary. It was noted there were no sections for cardiac or respiratory assessment completed/triggered on the date of admission. These two assessments, cardiac and respiratory, were found in the Nursing Admission Evaluation, Part 2-V6, which was not completed until [DATE], two days after R1's admission to the facility. Review of R1's Nursing Admission Evaluation, Part 2 - V6, Cardiovascular/circulatory Assessment, dated [DATE] at 11:52 a.m., was completed approximately two hours prior to R1 passing away at the facility. The assessment revealed R1 had a pulse of 94, deemed normal and their skin was described as pale, with no further explanation. R1 had bilateral lower extremity edema of 1+, which showed mild pitting edema. There was no narrative description of R1 noted under comments, including R1's presentation. There was no stethoscope assessment for heart sounds to assess the heart's rhythm and rate. Review of R1's Nursing Admission Evaluation, Part 2 - V6, Respiratory/Safe Smoking Evaluation, was also not completed until [DATE] at 11:52 a.m., at the same time as the cardiac assessment. This assessment revealed R1 was checked for Labored, difficulty breathing, short of breath, respiratory medications ., with labored breathing and short of breath with exercise (activity) or when lying flat. It was noted there was no concern with lung sounds. This was the first notation of R1's lung sounds, two days after R1's transfer to the facility. Review of the Physician Orders revealed R1 was designated as a Full Code upon admission. Review of R1's nursing progress notes and nursing assessments throughout their stay revealed no description of clinical condition for R1. The EMR showed Physician A had been called and reviewed R1's orders and status with nursing staff. Review of R1's hospital discharge summary revealed R1 was a pleasant [AGE] year-old male who had a 3 vessel heart bypass on [DATE], due to cardiac artery blockages. Hospital admission was [DATE] and date of hospital discharge was [DATE] at 12:48 p.m. R1 remained in Atrial Fibrillation post the operation, which was addressed with medications. His CPAP (continuous positive airway pressure machine) was continued at night and R1 was placed on ,d+[DATE] Lpm (liters per minute) of O2 (Oxygen) throughout the day. The discharge summary showed R1's lungs sounds were decreased at the bilateral bases, and cardiovascular assessment revealed: irregular, controlled rate. R1's discharge diagnoses included coronary heart disease post bypass surgery, atrial fibrillation (abnormal heart rhythm), fluid volume excess heart failure with reduced heart function, morbid obesity, sleep apnea, high blood pressure, hyperlipidemia (high cholesterol), and physical deconditioning. Patient Discharge Condition was noted as: Stable to ECF [Extended Care Facility]. Activity level showed: PT/OT up in chair as much as tolerated. Review of R1's transfer discharge documentation (from the hospital) titled, Patient Transfer Form, dated [DATE] at 13:46 [1:46 p.m.] revealed, Surgical Procedure: (3 Vessel Heart Bypass), on [DATE]. Appliances or supports: TED hose [compression stockings] on during day, off at night, pulmonary push, ambulate 4 times a day, use incentive spirometer [to improve respirations] 10x (times) [day] when awake . signed by R1's hospital physician and hospital nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's discharge instructions (from the hospital) titled, (Heart Bypass) Care After Surgery, dated [DATE], revealed on Page 13, .Care of Your Leg Incision: Wear your elastic [compression] stockings while you are up, for at least 4 weeks. Take them off at bedtime. They will help reduce swelling . Review of R1's admission physician orders for the facility, including all discontinued orders, revealed no order for TED hose or similar compression stockings during R1's stay at the facility, from [DATE] through [DATE]. During an interview on [DATE] at 2:47 p.m., Licensed Practical Nurse (LPN) E (R1's nurse on [DATE]) recalled R1 had open heart surgery. LPN E reported they observed R1 at 6:00 a.m. in his bed sleeping, with the head of bed elevated, and they awoke to take their medications, and had eaten breakfast. LPN E described R1 was able to carry on a conversation and stated, 'I am just tired today.' LPN E confirmed they did not take any vitals at that time. LPN E stated floor staff (certified nurse aides [cna's]) did this during their shift. LPN E reported the next time they saw R1 was when FM R called them into R1's room. LPN E reported FM R was holding R1 up, who was blue in the face, with his eyes rolled back, staring at the ceiling. LPN E stated they worked to get R1 onto the bed and a flat surface (to administer CPR), and performed life saving measures (Code Blue). Review of R1's vitals revealed R1's blood pressure and pulse were taken on [DATE] at 11:48 a.m., nearly six hours after R1 reported feeling tired. R1's oxygen saturation was not taken after LPN E's observations; the last documented O2 saturation was taken on [DATE] at 3:00 a.m. During an interview on [DATE] at 4:00 p.m., Unit Manager, LPN F, was asked why R1's cardiac assessment was not completed until Day 3 of their facility admission. LPN F reported a clinical narrative assessment (description of resident) including resident observations was typically completed upon admission and they could not explain why it would have been left blank. LPN F reported they could not explain why the cardiac and respiratory assessment did not trigger for completion in the EMR until Day 3. LPN F stated this assessment should have been completed on Day 1 during admission. LPN F was asked why no TED hose were ordered for R1. LPN F reviewed the EMR with this Surveyor, and confirmed there was no order in the EMR, on the Medication/Treatment Administration Records, and TED hose were not on the care plan. LPN F indicated the expectation would be the admitting nurse (Registered Nurse - RN I) makes sure admission orders are processed. LPN F acknowledged the concerns with orders not being entered accurately. During a phone interview on [DATE] at 4:47 p.m., RN G confirmed they were present when R1 passed, on [DATE]. RN G reported when they arrived at the room it appeared R1 was already deceased , and CPR was started immediately. RN G reported FM R stated R1 had just eaten lunch, started to feel sick, stopped talking, and got very shaky. RN G stated CPR was done for 30 minutes prior to the time of death being called. RN G described R1 as appearing pale, and stated they looked diaphoretic (excessive sweating), with skin cool and clammy to touch. RN G clarified R1 was not breathing and had no pulse, and was slumped over to the side, with their mouth open. When asked about the assessment documentation, RN G reported staffing of nurses was a concern at that time, and reported some nurses were working up to 70 hours per week, or two 16 hour shifts in a row, and they could not always complete their assessments timely, given the nursing staff shortages. RN G acknowledged this may have contributed to R1's incomplete and untimely nursing assessments, progress notes, and vital monitoring. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:30 a.m., the DON recalled R1 was short of breath, tired and deconditioned and could talk and communicate his needs on admission. The DON reported they had not seen R1 again until he coded and subsequently passed. During an interview on [DATE] at 9:00 a.m., RN I, who admitted R1 on [DATE], was asked if they recalled R1. RN I reported they did not recall a transfer form. RN I reported they would only have completed Section 1 of the nursing assessment (with no cardiac or respiratory assessment) of the three-part assessment as only Section 1 flagged on Day 1 of a residents' admission. RN I stated, It did not pop up for me. RN I reported since R1 was admitted several months ago, they could not recall this resident, or provide any observations or a description. RN I stated, We don't usually write a progress note on every single person. RN I stated they should have added a resident description to the nursing assessment, which they typically completed. RN I reported they had to work overtime on occasion, and were mandated to stay over their 12 hour shifts about twice a week. RN I stated they would get tired when working over, which may have affected their documentation. During an interview on [DATE] at 9:48 a.m., the DON was asked about the lacking order for the TED hose. The DON stated the expectation would have been for nursing staff to have found this order. The DON acknowledged the compression stockings would have been important to prevent leg clots and improve circulation after a bypass surgery. The DON was asked about the three-part admission assessment, and why it triggered to be completed on two or more different days, beyond the date of a resident's admission. The DON reported this was how the EMR documentation program triggered the assessments. The DON acknowledged the concern of hospital discharge medical conditions not being monitored appropriately and stated they would address the concern. During an interview on [DATE] at approximately 1:45 p.m. CNA L recalled working with R1 on [DATE] and [DATE]. CNA L stated, It seemed like [R1] was ok .I worked the next day [[DATE]], and the girls [other CNA's] told me [R1] declined super-fast after I left that day [[DATE]]. It was super surprising [R1] went [passed] so quick. CNA L reported his skin color was not good and did not recall R1 wearing TED hose. [R1] looked bad. We were concerned [nursing staff] and we were in and out of his room most of the day [[DATE]]. When I came in that next morning, one of my first questions was, did they send him to the hospital yet? I felt he should not have come to the [nursing facility] and they shipped him [to the facility] way too soon. [R1's] color was mostly pale when [R1] came in. [R1] should have been on vitals every shift because he was new, when asked about missing the vitals. CNA L reported R1 became short of breath later on during their stay. CNA L reported R1 was short of breath even at rest, and stated, [R1] would do better when the nurses like [LPN N and RN I] cranked up the oxygen, but [R1] was not doing good at all to begin with . During a phone interview on [DATE] at 3:47 p.m., LPN N reported they were working short staffed recently as nurses and said there were times when they had 50 residents in their care, so they could not easily recall all the residents they had cared for in the past. LPN N explained when they were running short with nursing staff, they could not complete all the nursing assessments or their progress note documentation. Resident 2 (R2): (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's MDS, dated [DATE], revealed admission to the facility on [DATE], with diagnoses including atrial fibrillation (heart rhythm disorder), ventricular tachycardia (an irregular, rapid heart rate), coronary artery disease, chronic systolic heart failure, peripheral vascular disease (circulatory disorder), kidney disease, defibrillator (device shocking the heart into a normal rhythm), and sleep apnea (breathing interruptions during sleep). The assessment revealed R2 required minimal assistance for bed mobility, moderate assistance for transfers and fed himself. The Brief Interview of Mental Status (BIMS) assessment revealed a score of ,d+[DATE], which showed moderate cognitive impairment. On [DATE] at approximately 2:35 p.m., this Surveyor was informed R2 had coded (during the survey), and later was notified R2 had passed away at the facility from cardiac arrest. Review of R2's Nursing Admission Evaluation - Part 1 - V8, dated [DATE] at 21:48 (9:48 p.m.), revealed, [R2] arrived via EMS [Emergency Medical Services] with 2 attendants. Heart and Lung Sounds good. Known to have orthostatic BP [low blood pressure] which happens in standing after sitting or lying down . Review of R2's Nursing Admission Evaluation - Part 2 - V6, Cardiac evaluation, dated [DATE] at 1:08 (p.m.), revealed a pulse of 61, however there was no mention of heart sounds, and no description of type of pulse (pulse quality) or skin appearance (normal or other). These two categories were left blank. There was not a full set of vitals in the assessment, which was completed four days after R2's admission to the facility. Review of R2's Nursing Admission Evaluation - Part 2 - V6, Respiratory evaluation, dated [DATE] at 1:08 (p.m.), was completed four days after admission to the facility. Review of R2's blood pressure logs revealed the following dates and times when R2's blood pressures were low, on at least seven occasions during their stay: [DATE]: ,d+[DATE] at 4:59 (a.m.) no position noted [DATE]: ,d+[DATE] at 5:38 (a.m.) no position noted [DATE]: ,d+[DATE] at 00:32 (12:32 a.m.) sitting [DATE]: ,d+[DATE] 6:10 (a.m.) no position noted [DATE]: ,d+[DATE] 6:26 (a.m.) lying [DATE]: ,d+[DATE] 4:30 (a.m.) lying [DATE]: ,d+[DATE] 9:48 (a.m.) no position noted No other sets of orthostatic blood pressures were documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's emergency room Discharge Instructions, dated [DATE], (during their stay) revealed discharge diagnoses of syncope (fainting caused by decreased blood supply to brain, often from low blood pressure), chronic orthostatic hypotension (longstanding low blood pressure), and chronic kidney disease. Pt Instructions were attached for syncope and hypotension, which included: Manage syncope .Check your blood pressure often. This is important if you take medicine to lower your blood pressure. Check your blood pressure when you are lying down and when you are standing. Ask [your provider] how often to check during the day. Keep a record of your blood pressure numbers. Your health care provider may use the record to help plan your treatment .Hypotension is a condition that caused your blood pressure (BP) to drop lower than it should be. Hypotension may be mild, serious, or life-threatening . Review of R2's EMR showed R2 had falls with injuries on the following dates: [DATE], [DATE], and [DATE]. Review of R2's progress note, dated [DATE] at 1:10 (a.m.), revealed R2 was observed sitting on floor next to foot of bed at 0032 (12:32 a.m.) hours. Pt c/o [complained of] bilateral hip pain, moving all extremities. VS [vitals signs]: ,d+[DATE] [blood pressure] .SaO2 78% [low oxygen saturation]. Oxygen applied at 4 lpm [liters per minutes], SaO2 at 99% [after receiving oxygen]. On call physician notified, ordered to send to hospital for further initiation .Pacemaker present . Review of R2's vitals revealed the BP was ,d+[DATE] on [DATE] at 5:38 (a.m.), with R2 experiencing hallucinations on [DATE] and [DATE]. There was no documentation of staff obtaining orthostatic blood pressures up to this date. R2 had documented low blood pressure, orthostatic hypotension and a syncopal episode requiring an ER visit on [DATE] related to orthostatic hypotension. Review of R2's Emergency Visit discharge instructions, dated [DATE], revealed diagnoses of fall, head contusion, and head injury defined in the report as A head injury is most often caused by a blow to the head. This may occur from a fall . Review of R2's progress note dated [DATE] at 5:01 a.m. revealed R2 was observed laying on floor next to bed on left side, c/o [complaint of] left hip pain. Pt stated was sitting on side of bed trying to go to the bathroom .VS ,d+[DATE] [blood pressure] ., showing low blood pressure. Review of R2's vitals revealed their BP was ,d+[DATE] at 4:30 a.m., a half hour before R2 fell . There was no documentation of any intervention after this low blood pressure was noted, or any orthostatic hypotension vital monitoring in the EMR up to this date. Review of R2's fall accident report, dated [DATE] at 5:21 a.m., revealed R2's pupils were uneven at the time of fall, with left pinpoint, and right dilated and non-reactive. This report revealed gait imbalance, recent change in medications/new medications, impaired memory, and ambulating without assist as contributing factors to falls. The narrative section of the revealed, Resident [R2] has had two falls since admission and both were related to [R2's] orthostatic hypotension .Medication review with provider and IDT [Interdisciplinary team] [showed] that falls are likely r/t [related to] orthostatic hypotension. New orders to increase parameters of midodrine [a medication for orthostatic hypotension]. Evaluate BP [blood pressure] in one week with provider. CP [Care Plan] updated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's orders showed no increased vital monitoring, or the addition of orthostatic blood pressure monitoring following the IDT meeting from the fall sustained on [DATE] at 5:21 a.m. Orthostatic hypotension was identified as the root cause of R2's falls on [DATE] and [DATE]. Review of R2's Care Plan, revealed no mention of history of orthostatic hypotension, monitoring, or interventions. Review of R2's Emergency Visit discharge instructions, dated [DATE], revealed diagnoses of closed head injury, strain of left hip, fall. Review of R2's Physical Therapy (PT) evaluation and treatment notes showed no vital sign monitoring other than one session, on [DATE], of 22 PT sessions. It was noted on [DATE] the PT staff documented R2 was dizzy, however, there was no vital sign monitoring documented. There was no patient education provided regarding fall prevention and how to overcome the signs and symptoms of orthostatic hypotension, given syncope was listed in their precautions, and dizziness was reported, per professional standards of best practice. There was no orthostatic hypotension vital monitoring documented, which included during therapeutic activities, other than the [DATE] note, on the day R2 passed away. Review of R2's Occupational Therapy (OT) evaluation and treatment notes showed Orthostatic hypotension and shortness of breath with exertion were noted on the OT evaluation precautions. A progress note dated [DATE] revealed R2 became dizzy during therapy, however no vitals were taken before or after the incident. A progress note dated [DATE] showed R2 had a fainting episode and became less responsive. Nursing informed to check vitals. Review of R2's progress notes confirmed R2 passed away on [DATE], when they became unresponsive at 14:47 (2:27 p.m.) after an apparent fall. R2 had no vitals (breaths or pulse) and CPR was initiated. Review of the medical record revealed R2 was a full code. During an interview on [DATE] at 4:55 p.m., with the Nursing Home Administrator (NHA), DON, the Regional Director of Operations T, and Regional Clinical Director, RN U, concerns were reviewed related to R1's and R2's lack of comprehensive assessment for cardiac and respiratory assessments, lack of routine/comprehensive vitals, lack of documentation of regular cardiac or respiratory assessment, and orders not being carried over from the hospital discharge orders. The DON confirmed they understood the concerns, and explained R2 was also non-compliant with completing self-transfers. During a phone interview with the Medical Director, Physician A, on [DATE] at approximately 6:00 p.m., Physician A confirmed best practices for nursing staff would be to obtain a set of vitals immediately upon a resident's admission to the facility. Physician A agreed there was a clear indication for comprehensive cardiac and respiratory assessments and implementation of anti-embolic stockings if prescribed. Physician A stated they would expect a narrative description of residents upon admission, and as appropriate during the nursing assessments. Physician A also would have expected routine full vital sign monitoring for a newly diagnosed resident with orthostatic hypotension or a resident with chronic orthostatic hypotension and frequent falls with symptoms. Physician A acknowledged the concerns and stated they would address with their medical team at the facility. A policy was requested from the NHA and DON related to quality of care and standards of practice, with none received by survey exit. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the textbook, Textbook of Medical-Surgical Nursing, 14th Edition, by [NAME] L. Hinkle and [NAME] H. Cheever, Copyright 2018, Wolters Kluwer, revealed the following in part: Beginning on Page 486, an initial respiratory assessment should include the following: .Health history, breathing (including dyspnea - difficulty or labored breathing, breathlessness, and shortness of breath), cough, sputum production - nature of sputum (color and consistency), chest pain, wheezing (high pitched lung sound with breathing in or out), hemoptysis (coughing up blood), general appearance, including nail presentation and skin color, thoracic (outer lung area) inspection, thoracic percussion (physical examination) and thoracic auscultation (stethoscope listening to lung sounds for any abnormality). The assessment revealed pulse oximetry can also be used for evaluation of the blood oxygen saturation, to detect if the tissues are receiving enough oxygen, among other assessments. Beginning on Page 685, revealed Physical Assessment: Physical assessment is conducted to confirm information obtained from the health history to establish the patient's current or baseline condition, and in subsequent assessments, to evaluate the patient's response to treatment. Once the initial physical assessment is completed, the frequency of future assessments may be performed each time by the purpose of the encounter and the patient's condition. For example, a focused cardiac assessment should be performed each time the patient is seen in the outpatient setting, whereas patients in the acute care setting may require a more extensive assessment at least every 8 hours. During the physical assessment, the nurse evaluates the cardiovascular system for any deviations from normal . It was noted the assessment categories included: General Appearance [of the resident], which included the level of consciousness, mental status, patient presentation including any signs of distress such as shortness of breath, pain or discomfort, and anxiety, assessment of skin and extremities, which included skin color (including pallor - skin paleness), temperature, and texture, including for blood flow, edema, capillary (small blood vessel) refill time, hair and nail condition, blood pressure, including any postural (orthostatic) blood pressure changes, pulse rate (beats per minute), rhythm (for dysrhythmias), amplitude (strength of the pulse), heart inspection and palpation, and heart auscultation (using a stethoscope to auscultate (hear) heart sounds). Review of the article, Orthostatic Hypotension - StatPearls - NCBI Bookshelf (nih.gov), National library of Medicine, dated [DATE], accessed [DATE], revealed, .Orthostatic hypotension is defined as a sudden drop in blood pressure upon standing from a sitting or supine position to standing . Complications: Orthostatic hypotension leads to declining physical function and impaired balance to perform activities of daily living independently .Analysis reported an increased risk of the following with orthostatic hypotension: Falls, heart failure, coronary artery disease, stroke, atrial fibrillation, all-cause mortality (death).