| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245187 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villas at the Cedars | 7900 West 28th Street<br>Saint Louis Park, MN 55426 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618<br><br>Based on interview and record review the facility failed to report allegations of neglect to the state agency immediately, but not later than two hours for one of one resident (R1) reviewed when R1's change in condition was not assessed, the physician was not notified, and R1's change in condition was not monitored by licensed nurses. R1 began vomiting on [DATE] and died in the facility on [DATE].<br><br>Findings include:<br><br>R1's face sheet indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of schizoaffective disorder. R1's additional diagnoses included esophageal varies with bleeding, dysphagia, cognitive communication deficit, schizophrenia, peptic ulcer without hemorrhage or perforation, and personal history of a traumatic brain injury. R1 died while in the facility on [DATE].<br><br>R1's care plan dated [DATE] indicated staff would continue to follow the facility vulnerable adult and abuse reporting policy.<br><br>R1's brief interview for mental status (BIMS) assessment dated [DATE] indicated R1 had a score of fourteen, which indicated R1 was cognitively intact.<br><br>R1's minimum data set (MDS) dated [DATE] indicated R1 required substantial/maximal assistance with dressing and transfers, dependent upon staff for bathing and hygiene, and partial/moderate assistance with oral hygiene. MDS indicated R1 did not experience vomiting. MDS indicated R1 did not reject evaluation or care.<br><br>R1's medical record indicated no nursing progress notes for [DATE].<br><br>R1's vital sign documentation indicated licensed practical nurse (LPN)-C took R1's vital signs on [DATE] at 9:40 p.m. Those readings included blood pressure was ,d+[DATE], oxygen was 97% on room air, pulse was 88, respirations were 18, temperature was 97.8 on the forehead. Normal blood pressure is ,d+[DATE] to , d+[DATE]. Normal temperature is 97.8 to 99.1. Normal Pulse is 60 to 100. Normal respirations are 12 to 18. Normal oxygen is 95% to 100%.<br><br>(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 |
|---|---|---|

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R1's progress note dated [DATE] at 9:02 p.m. indicated R1 stated she did not feel well, had an upset stomach, and refused to eat dinner. R1 had two episodes of vomiting and her abdomen was slightly distended. R1 had a large bowel movement and stated she felt better. The progress note indicated the licensed nurse heard bowel sounds in all four quadrants, blood pressure was ,d+[DATE] temperature was 97. 8 degrees Fahrenheit, pulse was 85, respirations were 18, and oxygen was at 92% on two liters of oxygen. The note indicated licensed nurses would continue to monitor R1.<br><br>R1's electronic medication administration record (eMAR) dated [DATE] at 5:22 a.m. indicated R1 was vomiting.<br><br>R1's medication administration record (MAR) dated [DATE] indicated R1 was to receive omeprazole at 6:00 a.m. but LPN-A documented 9 which meant other-see nursing note.<br><br>R1's progress note dated [DATE] at 6:17 a.m. indicated R1 refused to have her incontinent brief changed.<br><br>R1's progress note dated [DATE] at 10:24 a.m. indicated the director of nursing (DON) arrived and checked on R1, noting black emesis after postmortem care was completed. The DON swabbed R1's mouth, washed her face, helped the nursing assistants (NA) change her bedding, and notified the funeral home that R1 was ready to be transferred to the funeral home. R1 left the facility at 12:30 p.m.<br><br>R1's progress note dated [DATE] at 2:42 p.m. indicated a NA reported to the licensed nurse at 7:30 a.m. that R1 had vomited when the NA was getting her up for the morning. The licensed nurse responded immediately and found R1 in her wheelchair and leaning forward with a NA supporting R1's back. The vomit looked coffee in color and smelled metallic. The licensed nurse asked NAs to put R1 back to bed for a better assessment. R1's vital signs were checked but were not reading and the licensed nurse placed a call to emergency services regarding R1's condition. The paramedics arrived around 8:30 a.m. and they pronounced R1 deceased .<br><br>R1's emergency medical services (EMS) report indicated EMS arrived at the facility at 8:14 a.m. and placed a four-lead echocardiogram (ECG) on R1 at 8:22 a.m. and showed R1 was in ventricular fibrillation and at 8:26 a.m. R1 was in asystole (no heartbeat).<br><br>During an interview on [DATE] at 11:16 a.m., LPN-A stated she worked the overnight hours on [DATE] into [DATE]. She received report from LPN-D that R1 had vomited on the evening shift. She requested for NA-A to clean R1 up and after that, R1 had been resting. LPN-A stated she only saw R1 twice that shift. At 5:22 a. m. R1 had an order for omeprazole to be given at 6:00 a.m., but LPN-A had held it from R1 due to the report LPN-D had given her about R1 vomiting on the evening shift. LPN-A stated she wrote an eMAR note stating R1 had been vomiting. She did not notify the physician about R1 vomiting because she was told LPN-D had already notified the physician. She wrote a progress note at 6:18 a.m. on [DATE] that R1 had refused to have her incontinent brief changed but it did not concern LPN-A because R1 was able to make her needs known. She did not assess R1 after she had vomited throughout her shift because she was really busy with other residents yelling at each other and a phone call. LPN-A stated R1's episodes were out of her baseline and thought it was a change in condition.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 1:00 p.m., LPN-D stated she worked the evening of [DATE]. R1 was at her baseline prior to dinner. At dinner, R1 refused to eat dinner, had an upset stomach, and stated she wanted to go to bed. R1 had vomited around 7:00 p.m. R1's vomit was brown in color but could not describe any more. LPN-D stated we cleaned R1 up after she vomited. This was not unusual for R1 to vomit. NA-C reported to her that R1 had a large bowel movement and had felt better. LPN-D stated R1 had vomited again around 8:00 p.m. LPN-D stated R1's vomit was brown in color but could not describe any more. She took R1's vital signs and they read within normal limits. She also assessed R1's bowel sounds because she had thought R1 was constipated. She did not notify the physician about R1's vomiting on [DATE] because it was not unusual for her to vomit. LPN-D stated after she took R1's vital signs at 8:00 p.m. she did not continue to monitor R1 because she got too busy.<br><br>During an interview on [DATE] at 1:35 p.m., the administrator stated the facility investigated R1's death and the outcome was LPN-A did not assess or document R1's condition. The administrator stated LPN-A was placed on leave during the investigation and LPN-A was then terminated.<br><br>During an interview on [DATE] at 2:40 p.m., LPN-A stated she did not recall what times R1 had vomited on her overnight shift on [DATE] to [DATE]. LPN-A stated she held R1's 6:00 a.m. omeprazole dose due to the report she received about R1 vomiting during dinner time on the PM shift on [DATE]. LPN-A stated LPN-D had called the physician to report R1's vomiting episodes. LPN-A stated LPN-D reported to her the physician recommended R1 to be monitored overnight. LPN-A stated she would have expected LPN-D to put a progress note in about her conversation with the physician but did not look to see whether there was a progress note entered or not. LPN-A stated she trusted LPN-D when she said she had notified the physician. LPN-A stated she checked on R1 twice did her overnight shift on [DATE] to [DATE] but could not recall the times she checked on her. LPN-A stated when she checked on R1, she was giving medications to other residents, and she slowly walked past R1's room. LPN-A stated both times she walked past R1's room, she had been sleeping. LPN-A stated she never went in R1's room during her shift. LPN-A stated that at 5:22 a.m. when she wrote the eMAR note about R1 vomiting, LPN-A stated she never tried to give R1 her omeprazole dose because LPN-D recommended not to give R1 any medications. LPN-A stated after her shift ended on the morning of [DATE], she gave report to LPN-E that R1 had vomited twice during her shift and LPN-D had reported R1's episodes of vomiting on the evening shift on [DATE]. LPN-A stated she was terminated from the facility two hours prior to this interview. LPN-A stated she was terminated from the facility due to not following the charting procedures. LPN-A stated the last day she worked at the facility was on [DATE].<br><br>During a follow up interview on [DATE] at 11:38 a.m., LPN-A stated she remembered during her overnight shift on [DATE] into [DATE] that NA-A had told her something but she had forgot about it. She did not remember exactly what NA-A told her but R1 had not been feeling good. She was too busy working with other residents that she did not go into R1's room and assess her during her shift. LPN-A stated she did not recall if she told the oncoming morning shift on [DATE] about R1's condition.<br><br>During an interview on [DATE] at 8:27 a.m., the director of nursing (DON) stated she did not report the incident to Minnesota Department of Health. DON stated she had talked to the corner, and they stated she did not need to report it. DON stated she had talked to the regional nurse consultant (RNC) who had stated they did not feel the need to report the incident. DON stated she had thought they needed to report the incident.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 8:45 a.m., the administrator stated she did not report R1's incident and death because the facility had investigated the incident with statements from the licensed nurses involved and discovered it was poor nursing. The administrator stated she did not think the actions of the licensed nurses was neglectful because based on regulations you only have to report if it was intentional neglect. The administrator stated overall the facility would not report poor nursing. The administrator stated she did not report the incident because R1 did not have a major injury in the last six months.<br><br>During an interview on [DATE] at 9:04 a.m., the RNC stated he had looked at R1's charting and concluded the licensed nurses had poor nursing. RNC stated the licensed nurses should have called the physician and document. RNC stated the licensed nurses' actions would fall into poor nursing. The nurses failed to do what was expected of them. RNC stated the facility did not report to Minnesota Department of Health. RNC stated if the facility reported poor nursing, Minnesota Department of Health would have a lot of reporting. There was a fine line with reporting. RNC stated the consequence of the licensed nurses' actions indirectly and directly resulted in a resident's death. RNC stated the facility did not report the incident because it was poor nursing judgment.<br><br>During an interview on [DATE] at 9:33 a.m., the regional director of operations (RDO) stated the licensed nurses' actions and incident was not reported to Minnesota Department of Health. RDO stated there was no reason to report the licensed nurses. The licensed nurse was licensed for two years and made a bad judgement call. It was not neglect of the licensed nurse. RDO stated the licensed nurse did not purposefully not call the physician. RDO stated if the facility reported potential of noncompliance every time something happened, the facility would be reporting to Minnesota Department of Health every day.<br><br>The facility's Abuse Prohibition and Vulnerable Adult Policy and Procedure revised on ,d+[DATE] indicated neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress was to be reported to Minnesota Department of Health. The policy and procedure indicated all serious injuries that are determined to be a result of abuse, neglect, exploitation or misappropriation, even those considered accidental would be reported to Minnesota Department of Health. |

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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** 49618<br><br>Based on interview and record review, the facility failed to develop a comprehensive care plan for one of three residents (R1) reviewed when R1 had a history of gastrointestinal bleeds that was not identified on her care plan.<br><br>Findings include:<br><br>R1's medical record indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of schizoaffective disorder. R1's additional diagnoses included esophageal varies with bleeding, dysphagia, cognitive communication deficit, schizophrenia, peptic ulcer without hemorrhage or perforation, and personal history of a traumatic brain injury. R1 died while in the facility on [DATE].<br><br>R1's brief interview for mental status (BIMS) assessment dated [DATE] indicated R1 had a score of fourteen, which indicated R1 was cognitively intact.<br><br>R1's provider visit note dated [DATE] indicated R1 was diagnosed with an erosive esophagitis. The visit notes indicated R1 was admitted to the hospital from [DATE] to [DATE] for a gastrointestinal bleed. The visit notes indicated R1 was admitted to the hospital from [DATE] to [DATE] for a gastrointestinal bleed. The visit notes indicated R1 was admitted to the hospital where she received two units of blood from [DATE] to [DATE] with a gastrointestinal bleed. The visit notes indicated R1 had a history of gastrointestinal bleeding and recommended for R1 to be on proton pump inhibitors (PPI's) (PPI's are a class of drugs that prevents gastrointestinal bleeding) for the rest of her life.<br><br>During an interview on [DATE] at 11:22 a.m., the nurse practitioner (NP) stated R1 had an extensive history of gastrointestinal bleeding.<br><br>During an interview on [DATE] at 11:53 a.m., the nurse manager (NM) stated the nurse managers are responsible for creating and updating a resident's care plan. NM stated R1's care plan did not include her history of gastrointestinal bleeding, signs, and symptoms to monitor in the event of a gastrointestinal bleed, and what staff should do if they see those signs or symptoms.<br><br>During an interview on [DATE] at 12:07 p.m., the director of nursing (DON) stated she did not find R1's history of gastrointestinal bleeding in her care plan. The DON stated she would have expected R1's history of gastrointestinal bleeding to be in her care plan. The DON stated the nurse managers are responsible for creating a resident's care plan.<br><br>During an interview on [DATE] at 1:35 p.m., the administrator stated she would expect to see a resident's history of gastrointestinal bleeding on their care plan.<br><br>Request for a care plan policy and procedure was made and none was received. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618<br><br>Based on interview and record review, the facility failed to monitor and notify the physician following a change in condition for one of three residents, (R1) who had multiple episodes of vomiting that began on [DATE] and continued through [DATE] when R1 died . This resulted in an Immediate Jeopardy (IJ) for R1.<br><br>The IJ began on [DATE] when R1's had a change in condition was not monitored, nor was the physician notified of R1's change in condition that started on the evening of [DATE] and continued through the morning of [DATE] when R1 passed away. The IJ was identified on [DATE]. The administrator and the director of nursing were notified of the immediate jeopardy at 10:47 a.m. on [DATE]. The immediate jeopardy was removed on [DATE] and the deficient practice was corrected on [DATE], prior to the start of the survey and was therefore past non-compliance.<br><br>Findings include:<br><br>R1's face sheet indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of schizoaffective disorder. R1's additional diagnoses included esophageal varies with bleeding, dysphagia, cognitive communication deficit, schizophrenia, peptic ulcer without hemorrhage or perforation, and personal history of a traumatic brain injury.<br><br>R1's care plan dated [DATE] did not indicate R1 had a history of gastrointestinal (GI) bleeding, history of vomiting, or concerns with stomach problems.<br><br>R1's minimum data set (MDS) dated [DATE] indicated R1 required substantial/maximal assistance with dressing and transfers, dependent upon staff for bathing and hygiene, and partial/moderate assistance with oral hygiene. MDS indicated R1 did not experience vomiting. MDS indicated R1 did not reject evaluation or care.<br><br>R1's provider orders for life-sustaining treatment (POLST) dated [DATE] indicated R1 did not want resuscitation (DNR) if she did not have a pulse and was not breathing. The POLST indicated R1 wanted comfort-focused treatment and to allow natural death.<br><br>R1's brief interview for mental status (BIMS) assessment dated [DATE] indicated R1 had a score of fourteen, which indicated R1 was cognitively intact.<br><br>R1's vital sign documentation indicated licensed practical nurse (LPN)-C took R1's vital signs on [DATE] at 9:40 p.m. Those readings included blood pressure was ,d+[DATE], oxygen was 97% on room air, pulse was 88, respirations were 18, temperature was 97.8 on the forehead. Normal blood pressure is ,d+[DATE] to , d+[DATE]. Normal temperature is 97.8 to 99.1. Normal Pulse is 60 to 100. Normal respirations are 12 to 18. Normal oxygen is 95% to 100%.<br><br>R1's medical record indicated no nursing progress notes for [DATE].<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's progress note dated [DATE] at 9:02 p.m. indicated R1 stated she did not feel well, had an upset stomach, and refused to eat dinner. R1 had two episodes of vomiting and her abdomen was slightly distended. R1 had a large bowel movement and stated she felt better. The progress note indicated the licensed nurse heard bowel sounds in all four quadrants, blood pressure was ,d+[DATE] temperature was 97. 8 degrees Fahrenheit, pulse was 85, respirations were 18, and oxygen was at 92% on two liters of oxygen. The note indicated licensed nurses would continue to monitor R1.<br><br>R1's medical record indicated no nursing progress notes for the remainder of [DATE] nor the morning of [DATE] until 6:17 a.m.<br><br>R1's electronic medication administration record (eMAR) dated [DATE] at 5:22 a.m. indicated R1 was vomiting.<br><br>R1's medication administration record (MAR) dated [DATE], indicated R1 was to receive omeprazole at 6:00 a.m. but LPN-A documented 9 which meant other-see nursing note.<br><br>R1's progress note dated [DATE] at 6:17 a.m. indicated R1 refused to have her incontinent brief changed.<br><br>R1's progress note dated [DATE] at 10:24 a.m. indicated the director of nursing (DON) arrived and checked on R1, noting black emesis after postmortem care was completed. The DON swabbed R1's mouth, washed her face, helped the nursing assistants (NA) change her bedding, and notified the funeral home that R1 was ready to be transferred to the funeral home. R1 left the facility at 12:30 p.m.<br><br>R1's progress note dated [DATE] at 2:42 p.m. indicated a NA reported to the licensed nurse at 7:30 a.m. that R1 had vomited when the NA was getting her up for the morning. The licensed nurse responded immediately and found R1 in her wheelchair and leaning forward with a NA supporting R1's back. The vomit looked coffee in color and smelled metallic. The licensed nurse asked NAs to put R1 back to bed for a better assessment. R1's vital signs were checked but were not reading and the licensed nurse placed a call to emergency services regarding R1's condition. The paramedics arrived around 8:30 a.m. and they pronounced R1 deceased .<br><br>R1's emergency medical services (EMS) report dated [DATE] indicated EMS received a call at 8:07 a.m. indicating EMS staff was called for someone who was vomiting. The report indicated EMS arrived at the facility at 8:14 a.m. and got to R1 at 8:20 a.m. Upon arrival, EMS noted R1 was in her bed in her room with a towel tucked in her shirt and had black emesis on the towel and on her shirt. Facility staff stated that a nurse went to check on R1 and was found that she was not speaking when she usually spoke. The facility staff reported R1 had been vomiting. The report indicated facility staff gave EMS staff paperwork, including R1's POLST form. The last time facility staff checked on R1 was at 7:30 a.m. and had not spoken since that time. EMS staff noted R1 to be pale, cold to the touch, did not find a radial or carotid pulse, and was not breathing. Rigor had not set in yet as R1's jaw was malleable. EMS staff noted R1 to be a DNR and therefore had not started cardiopulmonary resuscitation (CPR). EMS placed a four-lead electrocardiogram (ECG) on R1 at 8:26 a.m. to assess R1's cardiac rhythm and determined R1 deceased .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 8:49 a.m., NA-C stated he worked with R1 on [DATE]. He asked R1 if she wanted to get up for the day and she verbally said yes. He asked R1 if she could grab the grab bars on her bed to assist herself in turning over so that NA-C could change her incontinent brief and she did. R1 usually said more in the mornings and could usually verbalize what she wanted. Once he got R1 in her wheelchair, she began vomiting black coffee stuff and he reported R1's vomiting episode to LPN-E. NA-C stated LPN-E went to R1's room and then she called EMS. When LPN-E called EMS, trained medication assistant (TMA)-A attempted to take R1's vital signs. Once paramedics got to the facility, they had pronounced her deceased .<br><br>During an interview on [DATE] at 10:49 a.m., nurse manager (NM)-A stated her expectation is licensed nurses would notify the physician after every change in condition episode. She would be concerned about a change in condition when R1 was not feeling good on [DATE], she was vomiting on [DATE], and then died . She was unsure whether the licensed nurses notified the physician about R1's episode of vomiting overnight on [DATE] into [DATE]. NM-A stated she would expect the licensed nurse to notify the physician about a change in condition when the change in condition happens. She considered episodes of vomiting on and off for months a change in condition and the physician should be notified.<br><br>NM-A stated she did not get a report on [DATE], [DATE] or [DATE] that R1 had been vomiting. NM-A stated she usually received a report about the residents when a change in condition happened.<br><br>During an interview on [DATE] at 11:16 a.m., LPN-A stated she worked the overnight hours on [DATE] into [DATE]. She received report from LPN-D that R1 had vomited on the evening shift. She requested for NA-A to clean R1 up and after that, R1 had been resting. LPN-A stated she only saw R1 twice that shift. At 5:22 a.m. R1 had an order for omeprazole to be given at 6:00 a.m., but LPN-A had held it from R1 due to the report LPN-D had given her about R1 vomiting on the evening shift. LPN-A stated she wrote an eMAR note stating R1 had been vomiting. She did not notify the physician about R1 vomiting because she was told LPN-D had already notified the physician. She wrote a progress note at 6:18 a.m. on [DATE] that R1 had refused to have her incontinent brief changed but it did not concern LPN-A because R1 was able to make her needs known. She did not assess R1 after she had vomited throughout her shift because she was really busy with other residents yelling at each other and a phone call. LPN-A stated R1's episodes were out of her baseline and thought it was a change in condition.<br><br>During an interview on [DATE] at 11:22 a.m., nurse practitioner (NP)-A stated R1 had an extensive history with GI bleeds. She was notified that R1 had been vomiting only after R1 had died . Last time she was updated about R1 was on [DATE], and that was about R1 being constipated. She is usually notified from the facility via phone, but the facility also had her pager in case of an emergency. She was concerned that the facility had not notified her about R1's vomiting. NP-A stated if she would have been notified about R1's episodes of vomiting on [DATE], she would have recommended R1 go to the hospital immediately.<br><br>(continued on next page) |

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| | 245187 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Villas at the Cedars | 7900 West 28th Street<br>Saint Louis Park, MN 55426 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 12:07 p.m., DON stated she received a phone call after R1 had passed on [DATE] and after EMS had left the facility. She did not recall what time she received the phone call. She arrived at the facility to assist with postmortem care. The DON further stated R1's first episode of vomiting, should have warranted a change in condition. Her expectations with a change in condition would be to assess vital signs at a minimum, assess the resident, notify the physician, and notify the family. Her expectation was that after every episode of change in condition, the physician would be notified, and those orders and recommendations would be followed. Her expectation was when the licensed nurses talk with family about the residents change in condition, the licensed nurse would give their recommendations if they were waiting for a physician to call back or state the recommendations from the physician. Licensed nurses would also ask the family their preferences about the resident being sent to the hospital and if they are ok with that. DON stated her expectation was after every change in condition, the licensed nurses would put a nursing order in for licensed nurses to check vital signs every four hours for the next twenty-four hours. Any of the licensed nurses could enter those orders since it is a nursing order. Her expectation was the licensed nurse would round on the resident at least every two hours. DON stated she found it concerning when the licensed nurses did not notify the physician after each episode of vomiting.<br><br>During an interview on [DATE] at 1:00 p.m., LPN-D stated she worked the evening of [DATE]. R1 was at her baseline prior to dinner. At dinner, R1 refused to eat dinner, had an upset stomach, and stated she wanted to go to bed. R1 had vomited around 7:00 p.m. R1's vomit was brown in color but could not describe any more. LPN-D stated we cleaned R1 up after she vomited. This was not unusual for R1 to vomit. NA-C reported to her that R1 had a large bowel movement and had felt better. LPN-D stated R1 had vomited again around 8:00 p.m. LPN-D stated R1's vomit was brown in color but could not describe any more. She took R1's vital signs and they read within normal limits. She also assessed R1's bowel sounds because she had thought R1 was constipated. She did not notify the physician about R1's vomiting on [DATE] because it was not unusual for her to vomit. LPN-D stated after she took R1's vital signs at 8:00 p.m. she did not continue to monitor R1 because she got too busy.<br><br>During a subsequent interview on [DATE] at 1:07 p.m., DON stated LPN-D had assessed R1 on the evening shift on [DATE] but she would have liked to have known what color the emesis was. She would have liked to see the licensed nurses assess R1 more. If the licensed nurses had continued to monitor R1, they would have put in nursing orders to take vital signs every four hours for the first twenty-four hours. The licensed nurses should have laid eyes on R1 at least every four hours.<br><br>During an interview on [DATE] at 1:35 p.m., the administrator stated when a resident had a change in condition her expectation was the licensed nurse would monitor the resident, put monitoring nursing orders in, put a progress note in, and state what change of condition occurred. The administrator stated the physician would be notified of a change in condition along with the on-call supervisor, DON, and herself.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a subsequent interview on [DATE] at 2:40 p.m., LPN-A stated she did not recall what times R1 had vomited on her overnight shift on [DATE] to [DATE]. She held R1's 6:00 a.m. omeprazole dose due to the report she received about R1 vomiting during dinner time on the evening shift on [DATE]. LPN-D reported to LPN-A she had called the physician to report R1's vomiting episodes and the physician had recommended R1 to be monitored overnight. She would have expected LPN-D to put a progress note in the medical record about her conversation with the physician but did not look to see whether there was a progress note entered or not. She trusted LPN-D when she said she had notified the physician. She checked on R1 twice on the overnight shift on [DATE] to [DATE] but could not recall the times she checked on her. She checked on R1, when she was giving medications to other residents by slowly walking past R1's room. LPN-A stated both times she walked past R1's room, she had been sleeping. LPN-A stated she never went in R1's room during her shift. At 5:22 a.m. when she wrote the eMAR note about R1 vomiting, LPN-A stated she never attempted to give R1 her omeprazole dose because LPN-D recommended not to give R1 any medications. After her shift ended on the morning of [DATE], she gave report to LPN-E that R1 had vomited twice during her shift and LPN-D had reported R1's episodes of vomiting on the evening shift on [DATE]. LPN-A stated she was terminated from the facility two hours prior to this interview. She was terminated from the facility due to not following the charting procedures. LPN-A stated the last day she worked at the facility was on [DATE].<br><br>During a subsequent interview on [DATE] at 3:00 p.m., the administrator stated the facility investigated R1's death and concluded the licensed nurses did not assess or document the change in condition. The administrator stated LPN-A was placed on a leave during the investigation and was terminated from her position.<br><br>During an interview on [DATE] at 9:56 a.m., LPN-E stated when she got to the facility on [DATE] at 6:30 a.m. , she worked on a different unit. She was transferred to R1's floor around 7:15 a.m. where she received report from LPN-A that R1 had been vomiting all night. She asked LPN-A how she monitored R1 throughout the night and LPN-A did not respond. After she received report, and she started passing medications to residents. NA-C reported to her around 7:30 a.m. stated R1 had been vomiting and she was not looking good. She stopped passing medications and went to R1's room where she found R1 sitting in her wheelchair and was vomiting. R1's vomit looked like black coffee grounds. NA-D was supporting her back while she was vomiting. She requested to NA-C and NA-D to put R1 back in her bed so that she could assess her. Instead of assessing R1, she called EMS immediately. While she was calling EMS, she had instructed TMA-A to take R1's vital signs. After she got off the phone with EMS, LPN-E went to R1's room and attempted to take her vital signs but they did not read. R1 did not have a pulse but she was still breathing. R1 was not responding to her. Once EMS arrived around 8:00 a.m. they had pronounced her deceased .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 10:14 a.m., NA-A stated she was new to the facility and was still getting to know the residents. She worked with R1 during her overnight shift [DATE] into [DATE]. When she started her overnight shift on [DATE], she noted R1's call light was on. She went to R1's room where R1 stated she was not feeling well. She asked R1 if she wanted her to get LPN-A and R1 stated no. NA-A stated even though R1 had said she did not want NA-A telling LPN-A, NA-A told LPN-A that R1 was not feeling well. NA-A stated LPN-A stated R1 was not taking Zofran anymore, so she could not give it to R1. NA-A stated throughout the night during rounds, she would check on R1 to see if she had vomited. She had vomited several times throughout the night. NA-A stated the vomit was small and dark in color. R1 had vomited on her nightgown, so NA-A would have to assist R1 in changing her nightgown. NA-A stated she would give R1 a towel to vomit on. When she came back for the next round to check on R1, she would need to change her nightgown again and give her a new towel because she had vomited again. She told LPN-A throughout the night that she was concerned about R1 vomiting and didn't look good. NA-A stated she knew that the facility has sent other residents to the emergency department before, so NA-A knew that would be an option. Before the end of her shift on the morning of [DATE], she made sure R1 had a clean gown on. She worked directly with R1 overnight on [DATE] into [DATE]. When she started her overnight shift on [DATE], R1 did not have her call light on but NA-A had checked on her. R1 looked worse than she did on [DATE]. She told LPN-A again that R1 seemed to be worse than the night before and that is when LPN-A stated again that she could not give her anything because she was not prescribed Zofran. R1 had vomited several times during her shift. NA-A stated R1 would vomit on her blanket and pillow. The vomit was black in color. NA-A stated she brought R1 new sheets and new towels. During the last rounds of her shift, she had noted R1 looked way worse than she did earlier in the night. Before the end of her shift on the morning of [DATE], R1 was still vomiting. R1 was still able to talk and move. NA-A asked R1 if she wanted her to change her nightgown and R1 would take off her nightgown for her. She changed R1's incontinent brief throughout the night except when she refused once. R1 did not state why she refused to have her incontinent brief changed but noted she looked very uncomfortable. She reported R1's condition to the oncoming licensed nurse about R1's condition but could not recall the licensed nurse's name. NA-A stated she reported to the oncoming NA's about R1's condition but could not recall the NA's names.<br><br>During a follow up interview on [DATE] at 11:38 a.m., LPN-A stated she remembered during her overnight shift on [DATE] into [DATE] that NA-A had told her something but she had forgot about it. She did not remember exactly what NA-A told her but R1 had not been feeling good. She was too busy working with other residents that she did not go into R1's room and assess her during her shift. LPN-A stated she did not recall if she told the oncoming morning shift on [DATE] about R1's condition.<br><br>During an interview on [DATE] at 8:50 a.m., NA-A stated R1 started vomiting on [DATE] at 10:30 p.m. NA-A stated she was unsure whether R1 had been vomiting during the day on [DATE] but as soon as she got to the facility for her overnight shift on [DATE], R1 had already been vomiting.<br><br>During an interview on [DATE] at 10:12 a.m., TMA-A stated on the morning of [DATE] he received report from LPN-A that R1 had been vomiting overnight. NA-C was getting R1 up for the day and once NA-C got her in her wheelchair, she began vomiting. He attempted to get R1's blood pressure and it could not read it. He could not find a pulse on R1. He did get an oxygen reading and that reading read sixty-two percent while on two liters of air. LPN-E instructed him to turn R1's air flow to four liters. TMA-A stated LPN-E called EMS. When EMS arrived, they pronounced her deceased .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's notification of changes policy and procedure dated ,d+[DATE] indicated changes in a resident' condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. The policy stated, nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.<br><br>The past noncompliance immediate jeopardy began on [DATE]. The immediate jeopardy was removed, and the deficient practice corrected by [DATE] after the facility implemented a systemic plan that included the following actions: provided education to the licensed nurses from [DATE] through [DATE] on NA's charting needs to be done prior to the end of their shift, report to the nurse if NA's feel as though there is a change in the resident, and the NA feels as though something is not being addressed by the licensed nurse, to follow up with the NM or DON. Education was provided to the licensed nurses indicating nurse's assessments needing to be completed and physician notification needs to be done immediately. The audit indicated there was no orders for monitoring, the Physician was notified, a progress note was completed, and resident assessments were completed. |