STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145958	A. BUILDING _____ B. WING _____	C 11/27/2013

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F 309	Continued From page 8 On 10/25/13 at 11:30 AM, Z2 (Gynecologist) stated, R1 "was in awful shape when (she) arrived. She was clammy, pale, and dying. 911 was called before I walked into the room (to examine R1)." The facilty should have taken vitals. It could have been an acute (sudden) change after R1 left the facility (between 12:45 PM and 1:00 PM. Z2's progress note dated 9/3/13 documents, "Pt (R1) found to be agonal (near death), very pale... Paramedics called. Son called... Pt (R1) taken to (local hospital Emergency Room). Pt (R1) without HR (heart rate) in ambulance as it (the ambulance) was leaving." Emergency room progress note dated 9/3/13 states, "This patient was brought to the emergency department via (local) EMS (Emergency Medical Services). She (R1) was DOA (Dead on Arrival) at a local physician's office. This writer notified notified coroner of body's arrival and the events leading to her (R1's) arrival..." R1's certification of death record dated 9/3/13 states, "Cause of Death - Shock, Congestive Heart Failure, Vaginal Bleeding." The manufacture guidelines (dated 8/2013) states, "(Warnings and Precautions) Risk of bleeding: XARELTO can cause serious and fatal bleeding. Promptly evaluate signs and symptoms of blood loss." and "Promptly evaluate any signs or symptoms of blood loss and consider the need for blood replacement. Discontinue XARELTO in patients with active pathological hemorrhage." (p 1-3)	F 309		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 9 STATEMENT OF LICENSURE VIOLATIONS 300.1010h) 300.1210b) 300.1210c) 300.1210d)3) 300.1220b)1) 300.1220b)2) 300.3240a Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification Section 300.1210 General Requirements for Nursing and Personal Care : b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and	F9999		

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F9999	Continued From page 10 be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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F9999	Continued From page 11 These requirements were not met as evidenced by: Based on interview and record review the facility failed to provide necessary care and services by not conducting a comprehensive assessment including vital signs. The facility failed to seek emergency treatment for a resident with continued bleeding as her condition worsened over five and one half hours. These failures contributed to R1 showing signs and symptoms of shock. This applies to 1 of 4 residents (R1) reviewed for care abd services in the sample of 4. The findings include: The August 2013 Physician Order summary shows R1 was taking Aspirin and was started on Xarelto (blood thinner) on 8/12/13 for Atrial Fibrillation. R1's Plan of Care (updated 9/4/13) states, "The resident is on Anticoagulant therapy; Monitor/document/report to Nurse/Dr. s/sx (signs/symptoms) of anticoagulation complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (Short of Breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs)..." On 11/26/13 at 1:30 PM, Z3 (R1's Power of Attorney for Healthcare) stated, "When we went to the facility there were multiple gowns with	F9999		

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blood on them. Her (R1's) roommate said she had been bleeding for several days."

On 10/24/13 at 2:00 PM, E4 (Transport CNA, Certified Nursing Assistant) said between 8:00 and 9:00 AM, The nurse (E3,Registered Nurse) told me R1 was having some vaginal bleeding. E3 stated R1 needed to be transported for an ultrasound (requested by Gynecologist) and then to her Gynecologist appointment. E4 continued. "I spoke with (R1) before leaving for the ultrasound. She looked sick; she had a spit pan and tissues. She looked tired, and had no energy... At the hospital, the condition of (R1) declined. During the ultrasound (R1's) breathing increased; it was a big difference... We got back (to the facility) around lunchtime... I told the nurse immediately, there was something wrong with (R1's) breathing, (R1's) color had changed. She (R1) was cold, clammy, and had wet skin. I took (R1) to her room (at 12:00 PM) and she (R1) was by herself (until we left for her Gynecologist appointment at 1:00 PM)'.

On 10/25/13 at 10:20 AM, E3 (RN) stated, "I saw (R1) about 7:45 AM (on the 9/3/13). (R1) was in her bathroom. One of her aides had called me to her (R1's) room for bleeding. I observed the blood; (there was a) fairly large amount (of blood). It covered the wheelchair, and there were many clots. There was about 500 ml of blood; there was a lot of blood... (R1) declined any pain. I looked at her perineum (area between the vagina and anus) and R1 was trickling blood... I couldn't identify the source. I called (Z1) physician and told him she (R1) was not feeling well and complained of nausea...I explained there was a lot of blood. I had no further communication with (Z1) that day... R1 left for the

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(ultrasound) at approximately 10:40 AM. She (R1) returned at 12:15 PM, I put pulse ox (pulse oximertry), and it was normal. I listened to her lungs. She was a little cold. It was reported to me (R1's) breathing was off... I remember her (R1) being a little bit wet. I didn't think at that time the change was significant. Vitals were not taken (after R1 returned from ultrasound)". E3 stated she did not call R1's primary physician after R1 returned from the ultrasound. E3 said she never took R1's vitals; That day R1's vitals were taken once, by a CNA before R1 left for her ultrasound appointment at 10:40 AM.

On 10/24/13 at 2:00 PM, E3 continued, We left shortly after 1:00 PM. The nurse at the Gynecologist's office took R1's blood pressure and it was 90/50.

R1's nursing note dated 9/3/13 at 3:41 PM, states, "Upon shift change nurse (at 7:00 AM) was called into resident's (R1) room to inspect bleeding from perineum area, nausea and vomiting. Nurse witnessed blood with numerous clots on residents wheelchair. Vitals taken at 1040 AM... MD (Z1, Primary Care Physician) notified and ordered for resident to be refereed to OB/GYN, due to bleeding being a chronic issue. OB/GYN called and required pelvic X-ray before he (Z2, Gynecologist) could see resident (R1). MD office (Z1) notified and agreed to order pelvic exam. When resident returned from pelvic exam at 1215 PM, the nurse called OB/GYN (Z2's office) to schedule appt. (appointment). Appt was made for 1:15 PM, Resident left facility at 1:00 PM."

On 10/25/13 at 9:15 AM, E2 (Director of Nursing) was asked when staff report to the nurse that a

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resident has a change in breathing, color, and is cold/clammy, or wet, how should the nurse respond. E2 stated, "I would expect the nurse assess the patient ASAP (As soon as possible). The nurse should go directly to assess the patient, and provide any treatment we could... Vital signs and a symptom specific assessment should be completed, and the primary (care physician) should be called to report the change in condition."

On 10/25/13 at 10:45 AM, Z1 (Primary Physician) stated, "I was called because (R1) was having vaginal bleeding. (At that time), (R1) had normal vital signs." Z1 continued, when it was reported that R1 had become cold, clammy, and pale in color, "The nurse should have checked (R1's) heart rate and blood pressure. If R1's blood pressure was low or if (R1) she showed signs of a change in condition, (The nurse) should have called me again. This didn't happen suddenly. I don't know if the lack of assessment contributed to the incident. I don't think it was Hypovolemic (low-blood volume) Shock".

On 10/25/13 at 11:30 AM, Z2 (Gynecologist) stated, R1 "was in awful shape when (she) arrived. She was clammy, pale, and dying. 911 was called before I walked into the room (to examine R1)." The facilty should have taken vitals. It could have been an acute (sudden) change after R1 left the facility (between 12:45 PM and 1:00 PM.

Z2's progress note dated 9/3/13 documents, "Pt (R1) found to be agonal (near death), very pale... Paramedics called. Son called... Pt (R1) taken to (local hospital Emergency Room). Pt (R1) without HR (heart rate) in ambulance as it (the

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