STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE RETIREMENT COMMUNITY	5501 GORDON DRIVE EAST SIOUX CITY, IA 51106

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** Based on record review and staff interview, the facility failed to provide adequate assessment for dehydration and failed to notify the physician and family of a change in condition in a timely manner for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 60 residents. Findings include: According to the Minimum Data Set ((MDS) dated [DATE], Resident #1 did not have a score on the Brief Interview for Mental Status (BIMS) assessment, indicating a severe cognitive deficit. The Resident's [DIAGNOSES REDACTED]. The resident was a full code. The care plan for Resident #1, updated on 2/13/20, indicated that she received a pureed diet with thin liquids and required assistance to dine. Staff were directed to encourage increased calories with mighty shakes three times daily and to offer Magic Cup ice cream every shift. The care plan documented they anticipated further decline in nutritional status as the disease progressed. A nursing progress note dated 4/8/20 dictated at 1:04 PM, indicated a psychiatrist saw the resident via teleconference. According to the documentation, the nurse updated the psychiatrist of the resident's increased anxiety and restlessness and described it occurring almost all the time. The nurse informed the doctor that the resident would thrash and squirm in her chair. As a result, the doctor increased the resident's prescriptions for [MEDICATION NAME] (cognition-enhancing medication) from 5 milligrams (mg.) twice a day to 10 mg twice a day and increased the [MEDICATION NAME] (for depression and anxiety) from 125 mg daily to 150 mg daily and increased [MEDICATION NAME] (antianxiety) from 0.25 mg to 0.5 mg every 12 hours as needed. According to the dietician's quarterly evaluation dated 2/10/20 11:25 AM, Resident #1 had variable intakes of 25-75%. The documentation included notation of snacks often and shakes being offered three times a day. The dietitians note included that the resident at risk for malnutrition. The recommendation for nutritional needs were an average of 62 grams of protein, 1500-1600 calories a day and 1500-1600 cubic centimeters (cc) fluid per day. A review of the clinical documentation revealed a nursing note dated 4/9/20 at 6:19 AM, that identified the resident as awake at 1:00 AM and at that time, the resident ate some ice cream, consumed some water and staff repositioned the resident. Staff also administered [MEDICATION NAME] at 4:58 AM for restlessness. A nursing note dated 4/10/20 9:06 PM, indicated that the resident slept throughout all shifts. that day. The chart lacked a narrative nursing note for 4/11/20 to identify a follow up on the resident's condition from the previous day. Staff documented the resident ate 100% of her dinner and no other meals. The resident drank two sips of fluid and 200 milliliters of fluid throughout the day. A nursing note on 4/12/20 at 1:45 PM documented the resident with increased lethargy. Her eyes remained closed when repositioned by staff. The note indicated that the resident was very slow to respond to verbal cues, with poor appetite only eating a few bites. staff obtained vital signs and identified the readings as within normal limits. At 10:06 PM staff documented the resident slept the entire shift and did not take her medications. Intake records for 4/12/20 identified intake for the day as breakfast bites, throughout the day 240 cc of fluid and 50% of a shake and just sips of fluid in the evening. A note on 4/13/20 at 9:41 PM recorded the resident slept the entire shift, did not move in bed and did not respond when repositioned and did not take medication that evening. Intake records for 4/13/20 identified sips/bites at breakfast and lunch and sips of fluids at supper. Nursing documentation revealed on 4/14/20 at 2:41 AM , staff notified the physician in the form of a facsimile (fax) regarding increased lethargy since 4/10/2020 and requested an urinalysis (UA). The fax revealed the resident experienced increased lethargy since 4/10/20. During that time the resident spent most of her time resting in bed. the resident had a decrease in food and fluid. When the resident did get out of bed, she sat in her wheelchair and moved constantly but eyes remained closed. The resident appeared very slow to respond to verbal cues. The fax identified the resident as a full code. On 4/14/20 at 7:40 AM nursing note identified the resident's mouth as open and eyes closed. The resident's mouth contained green/yellow drainage. The resident appeared flaccid with shallow respirations. The resident's feet contained mottling. Staff measured the following vital signs: 97.8 temperature, 63 heart rate, 26 respirations 83/65 blood pressure and oxygen saturation 90% on room air. Staff placed a call to the physician at that time. At 8:29 staff placed a second call to the physician and at 8:36 they the physician returned the call and directed staff to transport the resident to the emergency room (ER) for evaluation. The clinical record lacked any nursing assessments for dehydration or notification of the physician from 4/10/20 through 4/13/20. According to the medication record, the resident admitted to the hospital on [DATE]. A hospital history and physical (H & P) dated 4/14/20 identified the resident arrived from the nursing home because of [MEDICAL CONDITION]ly from a combination of underlying severe dementia, hypoxemia,[MEDICAL CONDITION] and metabolic derangements including [MEDICAL CONDITION] and uremia. The physical exam revealed the following signs of dehydration: the resident's oral cavity appeared dry with tongue fissuring. The resident's extremities appeared lean and thin with prolonged turgor and poor capillary refill. Facility records failed to identify that the facility staff assessed the signs of dehydration identified in the 4/14/20 hospital H & P A consultation report dated 4/15/20 identified the resident admitted on [DATE] at 10:57 a.m. with a sodium level of 180 (high), BUN (blood urea nitrogen) 112 (critical high) and creatinine 3.7 (high). The consultation revealed the resident had severe dehydration, acute kidney injury and bilateral pneumonia. The resident remained in the hospital for 10 days where she was treated with antibiotics, intravenous fluids and a feeding tube. The resident returned to the nursing home facility on 4/23/20 with Hospice services, and passed away on 4/27/20. In an interview on 6/29/20 at 1:00 PM Staff B RN (registered nurse) stated that he worked as a full time nurse on the overnight shift. He remembered having worked on Friday night, 4/10/20 with his shift starting at 10:00 PM. Staff B identified Resident #1 as very sleepy with very little activity throughout the shift. Staff B then worked again on Monday the 13th at 10:00 PM, and remembered that the resident as even more lethargic. Staff B indicated that he felt disappointed that no one contacted the doctor that day to communicate the decline in the resident's condition. Staff B sent a fax to the doctor at 2:41 AM on 4/14/20 and requested a urinalysis due to her history of urinary tract infections. Staff B stated that he didn't feel it was an emergency because the vital signs seemed stable and he did not observe mottling in the feet. In an interview with the physician on 6/29/20 at 4:00 PM and again on 6/30/20 at 11:17 AM, he stated he remembered Resident #1 as a difficult case because she was mostly non-verbal with a lot of agitation and behaviors related to anxiety. He said that the resident's condition gradually declined over the previous months leading up to her death. When asked if the facility would have notified him sooner of her condition change, would it have made a difference in the outcome for the resident. The doctor said that getting the fluids and antibiotics to the resident sooner would have helped but he couldn't say if that would have changed the outcome. He did agree that if the nurses had assessed for dehydration they may have been prompted to call him sooner. On 6/30/20 at 12:15 PM, the Director of Nursing (DON) stated she would expect the nurses to assess a resident for hydration status, particularly if that resident experienced decreased food and fluid intake for several days. A policy titled: Hydration Program and dated 9/18/19 directed staff to identify residents are at risk for dehydration. The policy indicated residents at risk should receive close monitoring of intake and output and the dietary

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) department should be notified of the amount of fluids the resident has consumed. The policy also directed staff to monitor for dry skin and mucous membranes and low intake and output. A policy titled: Managing Condition Changes, directed staff to notify the physician when there is a decline in the resident's condition.