STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106099	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGES REHABILITATION AND NURSING CENTER (THE)	900 HIGHWAY 466 LADY LAKE, FL 32159

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and policy and procedure review, the facility failed to notify the physician following a change in condition for 1 (Resident #1) of 3 sampled residents. Finding included: Review of the facility's Policy and Procedure titled Change of Condition Process, last reviewed [DATE] reads: Intent: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents physician and notify, consistent with his or her authority, residents representative when there is a change requiring notification. Procedure: The facility must inform the resident, consult with the resident's physician and/or notify the residents family member or legal representative when there is a change requiring such notification. Situations requiring notification include: 2. A significant change in the residents physical mental or psychosocial status that is a deterioration in health, mental psychosocial status in either life threatening conditions or clinical complications. This may include: 1. Life threatening conditions or 2. Clinical complications. 1. A need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. This may include: 1. A decision to transfer or discharge the resident from the facility. 2. Discontinuing a treatment or changing a medication due to a) adverse consequences or b) acute condition. 3. Upon the identification of a change in condition in a resident, the nurse will complete an evaluation in the resident status and document the findings on the SBAR (Situation, Background, Assessment, Recommendation) Change of Condition in the resident's electronic medical record. Review of the clinical record for Resident #1 revealed an [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#1 revealed the order dated [DATE] at 9:31 AM for nephrology consult related to BUN (blood urea nitrogen) and creatinine; the order dated [DATE] at 12:19 PM for nephrology consult related to acute [MEDICAL CONDITION], Saccharomyces Bloulardii capsule 250 mg (milligrams), give one capsule by mouth two times a day for [MEDICATION NAME] for 14 days, and [MEDICATION NAME] Solution Reconstituted 1 GM (gram), use 1 gram intravenously one time a day for leukocytosis (high white blood cell count) for 7 days; and the order dated [DATE] at 2:38 PM to send to ER (emergency room) for further evaluation related to hydro[DIAGNOSES REDACTED] (a condition that typically occurs when a kidney swells due to urine failing to properly drain from the kidney to the bladder). Review of the physician's orders [REDACTED].#1 revealed the order dated [DATE] at 7:15 PM to insert a midline (peripheral venous access device); the order dated [DATE] at 10:42 PM for Sodium Chloride Solution 0.9%, use 125 ml/hr (milliliters per hour) intravenously every shift for hydration; and the order dated [DATE] at 10:44 PM for Stat (Latin for urgent or rush) CBC (Complete Blood Count), BMP (Basic Metabolic Panel) at 5:00 AM. Review of the physician progress notes [REDACTED]. Pt (Patient) today evaluated requested by nurse due to abnormal labs. BUN-99 (61), Creat (Creatinine) 4.2 (2.6), WBC (White Blood Cell) 16.3 (6.7), INR (International Normalized Ratio: how long it takes blood to form a clot) 7.2 ([MEDICATION NAME] on hold). At evaluation patient is alert, c/o (complaining of abdominal pain), at PE (Physical Exam) there is abdominal mild distention, possible due to bladder distention. Pt has a meatal stenosis (abnormal narrowing of the urethral opening), urologist consulted last week, and is pending for dilation. Abdominal ultrasound ordered stat report: Conclusion: Marked urinary bladder distention resulting in mild right hydro[DIAGNOSES REDACTED]. Electronically signed by (the Medical Doctor's signature) on [DATE]. A Foley Cath (catheter) was placed by nurse and urine started to drain with clamping every 400 cc (cubic centimeter). Nephrologist was consulted to evaluate Pt for AKI (Acute Kidney Injury) on CKD ([MEDICAL CONDITION]). He evaluated Pt and discussed case by phone and decide to send Pt to ER (emergency room). Send Pt to ER for AKI. Review of the weights and vitals summary in the clinical record for Resident #1 revealed blood pressure (BP) documented on [DATE] at 2:33 AM as ,[DATE] mmHg (millimeter of mercury). Warnings section read: Diastolic Low of 60 exceeded. Systolic Low of 90 exceeded. Blood pressures were documented as ,[DATE] mmHg on [DATE] at 9:54 PM and ,[DATE] mmHg on [DATE] at 10:12 AM. Review of the [DATE] Medication Administration Record for Resident #1 revealed an order dated [DATE] at 6:25 PM: Vital signs every shift. On [DATE], blood pressure was documented as ,[DATE] by (Staff D's name), Licensed Practical Nurse (LPN). Review of the clinical record for Resident #1 revealed no documentation of review of condition by Staff D, LPN related to the low blood pressure, no SBAR (Situation, Background, Assessment, Recommendation) Change in Condition documentation, and no notification of the Attending Physician of low blood pressure of ,[DATE]. During an interview with the Attending Physician on [DATE] at 10:57 AM, she stated: I gave the order for (Resident #1's name) to be discharged on [DATE] to the emergency room for evaluation of his hydro[DIAGNOSES REDACTED] found on ultrasound. He was having difficulty passing urine and required a catheter to empty his bladder. We placed a catheter on [DATE] and I consulted a nephrologist. We spoke on the phone on [DATE] sometime in the afternoon and decided that he should be transferred to the emergency room and I called the nurse and gave orders to transport the resident to the Emergency Department (ED) for evaluation. That is the last call that I received from the facility or the nephrologist on [DATE]. Early on [DATE], the facility called me and told me that the resident had abnormal labs worse than on the 19th. I was very upset because I thought that he was already in the hospital. I was not called to discontinue the order to transfer to the hospital and I would not expect that a consultant would discontinue my order to transfer without calling me and discussing the need to discontinue that order. I was never informed of any changes in the resident's condition. No one called me to let me know that the resident had a low blood pressure in the 80's. I would have sent the patient immediately. I expect that all staff will notify me immediately whenever there is a change in a resident's condition so they can get prompt attention. I expect that any drop-in blood pressure below 90 systolic would be rechecked and reported immediately. During a follow-up telephone interview with the Attending Physician on [DATE] at 7:35 AM, she stated: I was at the facility until about 5:30 PM seeing (Resident #1's name) and other residents. I was there when they placed a Foley catheter. I did not tell the facility staff to discontinue the transfer, but I believe that I instructed them to hold the transfer until I spoke with (the Nephrologist's name). I did speak with him and we agreed the resident should be transferred to the hospital and I gave the telephone order. I think this was a miscommunication and (the Nephrologist name) and I should have communicated our plans. It is my expectation that staff call me to clarify any orders or for any orders that they are unable to carry out. I also expect that staff will notify me immediately when a patient has a change in condition. Had I been called at 2:30 in the morning I would have sent the patient to the emergency department immediately. During a telephone interview with the Nephrologist on [DATE] at 11:42 AM, he stated: I was called on consult for (Resident #1's name). I spoke to the (Attending Physician's name) over the telephone regarding his acute [MEDICAL CONDITION] and ultrasound results. We may have spoken about hospitalization and transfer to the ED related to his meatal stenosis and renal ultrasound results of [MEDICAL CONDITION] and hydro[DIAGNOSES REDACTED]. I saw the patient later that evening about 7 PM or so. I thought he was dry and needed fluids. (The Administrator's name) assured me that they could administer those at the nursing home, so I ordered a midline and an IV (Intravenous) bolus of normal saline and then a continuous IV of normal

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

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) saline at 125 ml/hr (milliliter/hour). The resident was confused but I was told that was his usual state of health. He was awake and alert when I examined him. I ordered a normal saline fluid bolus and to get repeat labs later that evening and if they were not improved to transfer the patient to the hospital. I was not called during the rest of the evening or night about the patient. I was not aware that the labs were not completed until early in the morning and was not notified of any blood pressure drop into the 80's systolic. If I had been called, I would have transferred the patient to the ED immediately for evaluation given he had a supratherapeutic INR (International Normalized Ratio, a laboratory measurement of how long it takes blood to form a clot) and new leukocytosis and worsening [MEDICAL CONDITION]. I did not know when I saw the patient that he was ordered to transfer to the hospital by (the Attending Physician's name) and I did not discontinue that order. As a consultant if I changed any orders I would have spoken to the attending before I did, so they are aware of my findings, and why I chose to change something. I expect that the staff call me when I have requested labs and they cannot be gotten. If my patients have any change in their conditions, I would expect that the nurses do a full assessment of the patient when they find that a patient is hypotensive, recheck the blood pressure and notify the attending or myself immediately. During a follow-up telephone interview with the Nephrologist on [DATE] at 9:13 AM, he stated: I was not notified that his blood pressure dropped, I would have advised the staff to call (the Attending Physician's name) and transfer the resident. I feel the resident was stable when I left the facility and did not know that there was an order to transfer and I think that his hydro[DIAGNOSES REDACTED] would have improved with emptying his bladder. I know that he had an elevated INR and his [MEDICATION NAME] was being held. I do believe that a delay of hours with that low a blood pressure will affect many organs including the kidneys. During consults I will review the medication administration record, the patient's history and physical, the patient's laboratory data, I speak with the nurses and will speak with the physician who called the consult to me. I did not call (the Attending Physician's name) after I saw the patient, I really should have but I had spoken to her earlier and didn't think to call her after I saw the patient. During a telephone interview with the facility Medical Director on [DATE] at 3:50 PM, he stated: As Medical Director, I am responsible for attending monthly meetings related to quality improvement, patient safety and am involved in staff education and training for the facility nurses. I usually attend in person, but with the COVID-19 (Coronavirus Disease 2019) crisis, we have been meeting via telephone conference. As a physician, I would expect to be called immediately with any changes in a resident's condition. A blood pressure of ,[DATE] should be rechecked. The resident should be assessed from head to toe for any other changes and if accurate, an immediate call should be placed to the attending physician for further orders. All physician orders [REDACTED]. I would expect the facility to send a resident to the emergency department if there was an order to do so. During an interview with Staff C, Registered Nurse (RN), on [DATE] at 11:15 AM, she stated: I did get orders on (Resident #1's name) on [DATE] to transfer him to the emergency room at about 2:30 PM in the afternoon after we informed the doctor of the retroperitoneal ultrasound results. I called (the Attending Physician's name) and took the verbal order to transfer based on the ultrasound results. I am not sure what happened or why we did not transfer the resident per the orders. The next morning when I came in the resident was still here and I called (the Attending Physician's name) to get the order to send him to the emergency room based on his abnormal morning labs. I did not assess the patient and was not aware that his blood pressure was low. During an interview with Staff H, Licensed Practical Nurse (LPN), on [DATE] at 1:15 PM, she stated: I was the nurse caring for (Resident #1's name) on the evening of [DATE]. I started my shift at 3:00 PM, I was not given in report that there was an order to transfer (Resident #1's name) to the hospital. The resident had a Foley catheter and the nephrologist came in that evening to see the resident. No one told me that there was an order and I did not look at the start of the shift for any orders and any incomplete orders, usually the nurse will tell me in report. When (the Nephrologist's name) came in, I wrote orders to place a midline, start a fluid bolus and after the bolus start NS (normal saline) at 125 ml/hr. I called (the Nephrologist's name) to let him know that I didn't have the midline in, and I wrote an order to do stat labs at 5:00 AM and discontinued the order for labs after fluid bolus at about 10:45 PM. When I ended my shift, (Resident #1's name) did not have a low blood pressure. I think his blood pressure was in the 140's systolic that evening. I did talk with (the Nephrologist's name) when he came in about 6:30 PM or 7 PM that evening. He let me know that he thought the resident needed IV fluids and a line was placed. He wanted to get repeat labs after the fluid bolus to see if his kidney function improved after getting the fluids and after the Foley was placed. When the nurse couldn't get the midline in for several hours (she had two others to do before his), I called (the Nephrologist's name) back to let him know. When I cannot get an order done, I am supposed to let the doctor know. So, I couldn't do the fluid bolus until the midline was in and I couldn't get any repeat labs after the bolus, so he told me to get the labs stat at 5 AM. I am supposed to call the doctors with any change in condition for a resident. Changes of condition are like a fever, a fall, high or low blood pressures, high or low Accuchecks, confusion, anything that is a change from normal for the resident. I don't do any type of a chart review with the outgoing or oncoming nurses. The night nurses usually do 24-hour checks. During a telephone interview with Staff D, Licensed Practical Nurse (LPN) on [DATE] at 6:19 PM, she stated: I was the nurse taking care of (Resident #1's name) the morning he was transferred to the hospital. I saw but didn't really notice the blood pressure and I can't really tell you what time that I saw it. I think that I was the person who documented his vital signs. Usually the aide will give me a paper with all the vital signs and I will put them in the computer. Usually the aide will tell you of any abnormal blood pressures or temperatures but that night the aide did not. I float on every unit, so I don't always work with the aide that was on that night. I did not check to see what his normal blood pressure was, if I had checked and knew that it was in the 140's earlier, I would have called the doctor. Many residents have low blood pressures at night, so I just wasn't concerned. I should have checked to see what the earlier blood pressure trends were. I would have rechecked the residents blood pressure and called the doctor. I did not check on the resident and don't know what time I knew that was the blood pressure. I really should have followed up that blood pressure and I did not check and typically redo the blood pressures when they are that low. It is policy to call the doctor for any changes in residents' condition. I did not call until the abnormal labs came back. I did not repeat the resident's vital signs for the transfer to the hospital. I really should have done a new set of vital signs. During an interview with the Director of Nursing (DON) on [DATE] at 4:15 PM, she stated: I was not aware that (Resident #1's name) had an order to transfer to the hospital that was not discontinued or carried out. It is my expectation that all physician orders [REDACTED]. I was not aware that (Resident #1's name) had a low blood pressure in the middle of the night that was not followed up on. There does not appear to be any other blood pressure documented and it was documented on the MAR (Medication Administration Record) by the nurse taking care of him that night. So, I have to assume that the nurse was aware of the low blood pressure at some point within the night because she documented this in her MAR. I would expect that all staff that see a blood pressure in the 80's would do a recheck immediately and because he had received fluid bolus for being dry/dehydrated and started on fluids. I would expect that to be considered by the nurse caring for the resident and acted on by calling the doctor immediately to notify them. I did not look into this after we found out he expired in the ED. I was not aware that the previous order to discharge the patient to the ED for evaluation was present and that it had not been discontinued. A consulting physician can discontinue an attending physicians' orders. The nephrologist came to see (Resident #1's name) that evening and ordered IV fluids, a midline and to recheck labs later that evening. I really cannot tell you why the resident wasn't transferred or why there isn't an order to have the resident stay here. We are expected to follow all doctor's orders as they are written and if they cannot be followed, we are expected to notify the doctor. (The Attending Physician's name) was not notified that the order was not carried out, there are no notes or orders indicating that she was notified. I don't know if the nephrologist spoke to (the Attending Physician's name) about keeping the resident here. I think that a blood pressure in the 80s is a change of condition that must be followed up on and reported so treatment can begin immediately. This should have been assessed and treated and it seems like it wasn't. During a follow-up interview with the DON on [DATE] at 1:34 PM, she stated: My expectation is that the doctors communicate with each other when they make changes. The nursing staff should be passing on incomplete orders and incoming nurses look up new orders. If there is a pending order, staff should contact physicians to clarify the orders in case there was a change. Right now, night shift confirms all orders. When the night shift nurse came on duty that night, she should have called the physician to clarify the order. The night nurse that documented the low blood pressure, should have assessed the resident and called the physician. During an interview with the Assistant Director of Nursing (ADON) on [DATE] at 1:15 PM, she stated: I was not aware that (Resident #1's name) had a drop in his blood pressure during the night. I wasn't aware that (Resident #1's name) did not get any follow-up vital signs or assessment. It is my expectation that all staff notify the doctor with any changes in condition. All staff should fill out a change of condition whenever they call with changes. The nurse should have called the doctor and rechecked the blood pressure and temperature. During an interview with the Administrator on [DATE] at 4:45 PM, she

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) stated, I was not aware that (Resident #1's name) had a low blood pressure in the middle of the night. I was not aware that the staff did not call the attending physician. I was not aware that the staff did not do a follow-up assessment after getting a low blood pressure. During a follow-up interview with the Administrator on [DATE] at 1:32 PM, she stated: I expect nursing staff to communicate changes in report, to clarify any incomplete physician orders [REDACTED]. Consultants and attending doctors should communicate clearly so there is no confusion for the nursing staff. Review of the receiving hospital's records revealed: Service Date/Time: [DATE], 08:57 EDT (Eastern Daylight Time). Emergency Documentation: History of Present Illness: 88-y/o (year old) male presents to the ED from The Villages Rehab for evaluation of altered mentation compared to his baseline, duration unclear. Patient was sent here by his rehab facility for abnormal labs and evaluation of a Foley that is not draining properly. According to report, the patient is currently at a rehab facility s/p (status [REDACTED]. Patient's Foley catheter was placed about ,[DATE] days ago and had approximately 1700 mL of urine drained before it started to malfunction. Vitals & Measurements: Gastrointestinal: soft, distended abdomen, bowel sounds distant, tenderness to lower abdomen, Foley catheter with dark bloody urine in early portion. Disposition: Time: 1029 (10:29 AM). Decision to dispo: deceased . Condition at disposition: deceased . Assessment/Plan: 1. deceased . 2. [MEDICAL CONDITION]. 3. [MEDICAL CONDITION] with septic shock ([MEDICAL CONDITION] is when the infection is severe enough to affect the function of your organs, such as the heart, brain, and kidneys. Septic shock is when you experience a significant drop in blood pressure that can lead to respiratory or heart failure, stroke, failure of other organs, and death. 4. Gross hematuria (when a person can see the blood in his or her urine). 5. History of closed distal fibula fracture.
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and policy and procedure review, the facility failed to ensure a resident was free from neglect by not following the physician's orders [REDACTED].#1) of 3 sampled residents. Findings include: Review of facility's the Policy and Procedure titled Freedom from Abuse, Neglect, and Exploitation, last reviewed [DATE] read: Intent. The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. Definitions. Neglect is 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. Review of the facility's Policy and Procedure titled Change of Condition Process, last reviewed [DATE] reads: Intent: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents physician and notify, consistent with his or her authority, residents representative when there is a change requiring notification. Procedure: The facility must inform the resident, consult with the resident's physician and/or notify the residents family member or legal representative when there is a change requiring such notification. Situations requiring notification include: 2. A significant change in the residents physical mental or psychosocial status that is a deterioration in health, mental psychosocial status in either life threatening conditions or clinical complications. This may include: 1. Life threatening conditions or 2. Clinical complications. 1. A need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. This may include: 1. A decision to transfer or discharge the resident from the facility. 2. Discontinuing a treatment or changing a medication due to a) adverse consequences or b) acute condition. 3. Upon the identification of a change in condition in a resident, the nurse will complete an evaluation in the resident status and document the findings on the SBAR (Situation, Background, Assessment, Recommendation) Change of Condition in the resident's electronic medical record. 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Pt has a meatal stenosis (abnormal narrowing of the urethral opening), urologist consulted last week, and is pending for dilation. Abdominal ultrasound ordered stat report: Conclusion: Marked urinary bladder distention resulting in mild right hydro[DIAGNOSES REDACTED]. Electronically signed by (the Medical Doctor's signature) on [DATE]. A Foley Cath (catheter) was placed by nurse and urine started to drain with clamping every 400 cc (cubic centimeter). Nephrologist was consulted to evaluate Pt for AKI (Acute Kidney Injury) on CKD ([MEDICAL CONDITION]). He evaluated Pt and discussed case by phone and decide to send Pt to ER (emergency room). Send Pt to ER for AKI. Review of the weights and vitals summary in the clinical record for Resident #1 revealed blood pressure (BP) documented on [DATE] at 2:33 AM as ,[DATE] mmHg (millimeter of mercury). Warnings section read: Diastolic Low of 60 exceeded. Systolic Low of 90 exceeded. Blood pressures were documented as ,[DATE] mmHg on [DATE] at 9:54 PM and ,[DATE] mmHg on [DATE] at 10:12 AM. Review of the [DATE] Medication Administration Record for Resident #1 revealed an order dated [DATE] at 6:25 PM: Vital signs every shift. On [DATE], blood pressure was documented as ,[DATE] by (Staff D's name), Licensed Practical Nurse (LPN). Review of the clinical record for Resident #1 revealed no documentation of review of condition by Staff D, LPN related to the low blood pressure, no SBAR (Situation, Background, Assessment, Recommendation) Change in Condition documentation, and no notification of the Attending Physician of low blood pressure of ,[DATE]. During an interview with the Attending Physician on [DATE] at 10:57 AM, she stated: I gave the order for (Resident #1's name) to be discharged on [DATE] to the emergency room for evaluation of his hydro[DIAGNOSES REDACTED] found on ultrasound. He was having difficulty passing urine and required a catheter to empty his bladder. We placed a catheter on [DATE] and I consulted a nephrologist. We spoke on the phone on [DATE] sometime in the afternoon and decided that he should be transferred to the emergency room and I called the nurse and gave orders to transport the resident to the Emergency Department (ED) for evaluation. That is the last call that I received from the facility or the nephrologist on [DATE]. Early on [DATE], the facility called me and told me that the resident had abnormal labs worse than on the 19th. I was very upset because I thought that he was already in the hospital. I was not called to discontinue the order to transfer to the hospital and I would not expect that a consultant would discontinue my order to transfer without calling me and discussing the need to discontinue that order. I was never informed of any changes in the resident's condition. No one called me to let me know that the resident had a low blood pressure in the 80's. I would have sent the patient immediately. I expect that all staff will notify me immediately whenever there is a change in a resident's condition so they can get prompt attention. I expect that any drop-in blood pressure below 90 systolic would be rechecked and reported immediately. During a follow-up telephone interview with the Attending Physician on [DATE] at 7:35 AM, she stated: I was at the facility until about 5:30 PM seeing (Resident #1's name) and other residents. I was there when they placed a Foley catheter. I did not tell the facility staff to discontinue the transfer, but I believe that I instructed them to hold the transfer until I spoke with (the Nephrologist's name). I did speak with him and we agreed the resident should be transferred to the hospital and I gave the telephone order. I think this was a miscommunication and (the Nephrologist name) and I should have communicated our plans. It is my expectation that staff call me to clarify any orders or for any orders that they are unable to carry out. I also expect that staff will notify me immediately when a patient has a change in condition. Had I been called at 2:30 in the morning I would have sent the patient to the emergency department immediately. During a

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) telephone interview with the Nephrologist on [DATE] at 11:42 AM, he stated: I was called on consult for (Resident #1's name). I spoke to the (Attending Physician's name) over the telephone regarding his acute [MEDICAL CONDITION] and ultrasound results. We may have spoken about hospitalization and transfer to the ED related to his meatal stenosis and renal ultrasound results of [MEDICAL CONDITION] and hydro[DIAGNOSES REDACTED]. I saw the patient later that evening about 7 PM or so. I thought he was dry and needed fluids. (The Administrator's name) assured me that they could administer those at the nursing home, so I ordered a midline and an IV (Intravenous) bolus of normal saline and then a continuous IV of normal saline at 125 ml/hr (milliliter/hour). The resident was confused but I was told that was his usual state of health. He was awake and alert when I examined him. I ordered a normal saline fluid bolus and to get repeat labs later that evening and if they were not improved to transfer the patient to the hospital. I was not called during the rest of the evening or night about the patient. I was not aware that the labs were not completed until early in the morning and was not notified of any blood pressure drop into the 80's systolic. If I had been called, I would have transferred the patient to the ED immediately for evaluation given he had a supratherapeutic INR (International Normalized Ratio, a laboratory measurement of how long it takes blood to form a clot) and new leukocytosis and worsening [MEDICAL CONDITION]. I did not know when I saw the patient that he was ordered to transfer to the hospital by (the Attending Physician's name) and I did not discontinue that order. As a consultant if I changed any orders I would have spoken to the attending before I did, so they are aware of my findings, and why I chose to change something. I expect that the staff call me when I have requested labs and they cannot be gotten. If my patients have any change in their conditions, I would expect that the nurses do a full assessment of the patient when they find that a patient is hypotensive, recheck the blood pressure and notify the attending or myself immediately. During a follow-up telephone interview with the Nephrologist on [DATE] at 9:13 AM, he stated: I was not notified that his blood pressure dropped, I would have advised the staff to call (the Attending Physician's name) and transfer the resident. I feel the resident was stable when I left the facility and did not know that there was an order to transfer and I think that his hydro[DIAGNOSES REDACTED] would have improved with emptying his bladder. I know that he had an elevated INR and his [MEDICATION NAME] was being held. I do believe that a delay of hours with that low a blood pressure will affect many organs including the kidneys. During consults I will review the medication administration record, the patient's history and physical, the patient's laboratory data, I speak with the nurses and will speak with the physician who called the consult to me. I did not call (the Attending Physician's name) after I saw the patient, I really should have but I had spoken to her earlier and didn't think to call her after I saw the patient. During an interview with Staff C, Registered Nurse (RN), on [DATE] at 11:15 AM, she stated: I did get orders on (Resident #1's name) on [DATE] to transfer him to the emergency room at about 2:30 PM in the afternoon after we informed the doctor of the retroperitoneal ultrasound results. I called (the Attending Physician's name) and took the verbal order to transfer based on the ultrasound results. I am not sure what happened or why we did not transfer the resident per the orders. The next morning when I came in the resident was still here and I called (the Attending Physician's name) to get the order to send him to the emergency room based on his abnormal morning labs. I did not assess the patient and was not aware that his blood pressure was low. During an interview with Staff H, Licensed Practical Nurse (LPN), on [DATE] at 1:15 PM, she stated: I was the nurse caring for (Resident #1's name) on the evening of [DATE]. I started my shift at 3:00 PM, I was not given in report that there was an order to transfer (Resident #1's name) to the hospital. The resident had a Foley catheter and the nephrologist came in that evening to see the resident. No one told me that there was an order and I did not look at the start of the shift for any orders and any incomplete orders, usually the nurse will tell me in report. When (the Nephrologist's name) came in, I wrote orders to place a midline, start a fluid bolus and after the bolus start NS (normal saline) at 125 ml/hr. I called (the Nephrologist's name) to let him know that I didn't have the midline in, and I wrote an order to do stat labs at 5:00 AM and discontinued the order for labs after fluid bolus at about 10:45 PM. When I ended my shift, (Resident #1's name) did not have a low blood pressure. I think his blood pressure was in the 140's systolic that evening. I did talk with (the Nephrologist's name) when he came in about 6:30 PM or 7 PM that evening. He let me know that he thought the resident needed IV fluids and a line was placed. He wanted to get repeat labs after the fluid bolus to see if his kidney function improved after getting the fluids and after the Foley was placed. When the nurse couldn't get the midline in for several hours (she had two others to do before his), I called (the Nephrologist's name) back to let him know. When I cannot get an order done, I am supposed to let the doctor know. So, I couldn't do the fluid bolus until the midline was in and I couldn't get any repeat labs after the bolus, so he told me to get the labs stat at 5 AM. I am supposed to call the doctors with any change in condition for a resident. Changes of condition are like a fever, a fall, high or low blood pressures, high or low Accuchecks, confusion, anything that is a change from normal for the resident. I don't do any type of a chart review with the outgoing or oncoming nurses. The night nurses usually do 24-hour checks. During a telephone interview with Staff D, Licensed Practical Nurse (LPN) on [DATE] at 6:19 PM, she stated: I was the nurse taking care of (Resident #1's name) the morning he was transferred to the hospital. I saw but didn't really notice the blood pressure and I can't really tell you what time that I saw it. I think that I was the person who documented his vital signs. Usually the aide will give me a paper with all the vital signs and I will put them in the computer. Usually the aide will tell you of any abnormal blood pressures or temperatures but that night the aide did not. I float on every unit, so I don't always work with the aide that was on that night. I did not check to see what his normal blood pressure was, if I had checked and knew that it was in the 140's earlier, I would have called the doctor. Many residents have low blood pressures at night, so I just wasn't concerned. I should have checked to see what the earlier blood pressure trends were. I would have rechecked the residents blood pressure and called the doctor. I did not check on the resident and don't know what time I knew that was the blood pressure. I really should have followed up that blood pressure and I did not check and typically redo the blood pressures when they are that low. It is policy to call the doctor for any changes in residents' condition. I did not call until the abnormal labs came back. I did not repeat the resident's vital signs for the transfer to the hospital. I really should have done a new set of vital signs. That night I think I had two TPNs (Total [MEDICATION NAME] Nutrition) running and tube feedings, and dementia patients in the halls. I was in the resident's room because his IV (Intravenous) bolus was done at shift start and I was checking to hang the new bag and was having trouble with the IV pump malfunctioning. I couldn't fix the problem and we did not have another pump to change it out. So, I finally had to take it off the pump and do it the old-fashioned way of free flowing by counting the drops per minute. The IV was not infusing by the pump because it had an air in line error. I really should have followed up that blood pressure and I did not check. Typically, I redo the blood pressures when they are that low. It is policy to call the doctor for any changes in residents' condition. I did not call until the abnormal labs came back. I did not repeat the resident's vital signs for the transfer to the hospital, I really should have done a new set of vital signs. I have received training on changes in condition and the expectations. I wish I had done that earlier. During an interview with the Director of Nursing (DON) on [DATE] at 4:15 PM, she stated: I was not aware that (Resident #1's name) had an order to transfer to the hospital that was not discontinued or carried out. It is my expectation that all physician orders [REDACTED]. I was not aware that (Resident #1's name) had a low blood pressure in the middle of the night that was not followed up on. There does not appear to be any other blood pressure documented and it was documented on the MAR (Medication Administration Record) by the nurse taking care of him that night. So, I have to assume that the nurse was aware of the low blood pressure at some point within the night because she documented this in her MAR. I would expect that all staff that see a blood pressure in the 80's would do a recheck immediately and because he had received fluid bolus for being dry/dehydrated and started on fluids. I would expect that to be considered by the nurse caring for the resident and acted on by calling the doctor immediately to notify them. I did not look into this after we found out he expired in the ED. I was not aware that the previous order to discharge the patient to the ED for evaluation was present and that it had not been discontinued. A consulting physician can discontinue an attending physicians' orders. The nephrologist came to see (Resident #1's name) that evening and ordered IV fluids, a midline and to recheck labs later that evening. I really cannot tell you why the resident wasn't transferred or why there isn't an order to have the resident stay here. We are expected to follow all doctor's orders as they are written and if they cannot be followed, we are expected to notify the doctor. (The Attending Physician's name) was not notified that the order was not carried out, there are no notes or orders indicating that she was notified. I don't know if the nephrologist spoke to (the Attending Physician's name) about keeping the resident here. I think that a blood pressure in the 80s is a change of condition that must be followed up on and reported so treatment can begin immediately. This should have been assessed and treated and it seems like it wasn't. During a follow-up interview with the DON on [DATE] at 1:34 PM, she stated: My expectation is that the doctors communicate with each other when they make changes. The nursing staff should be passing on incomplete orders and incoming nurses look up new orders. If there is a pending order, staff should contact physicians to clarify the orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106099	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGES REHABILITATION AND NURSING CENTER (THE)	**900 HIGHWAY 466 LADY LAKE, FL 32159**

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) in case there was a change. Right now, night shift confirms all orders. When the night shift nurse came on duty that night, she should have called the physician to clarify the order. The night nurse that documented the low blood pressure, should have assessed the resident and called the physician. During an interview with the Assistant Director of Nursing (ADON) on [DATE] at 1:15 PM, she stated: I was here and placed the catheter in (Resident #1's name). (The Attending Physician's name) was here in the building and she knew we got the catheter in the resident. I did know that there was an order for [REDACTED]. I'm not sure why he didn't go. (The Attending Physician's name) did not give me any order to hold the transfer or any indication that the transfer should be delayed until (the Nephrologist's name) got in. I'm not sure honestly, so much has been happening with getting everyone tested for coronavirus and now retesting residents and staff. There was testing going on [DATE] and we did know that (Resident #1's name) died in the emergency room . I was not aware that (Resident #1's name) had a drop in his blood pressure during the night. I wasn't aware that (Resident #1's name) did not get any follow-up vital signs or assessment. It is my expectation that all staff notify the doctor with any changes in condition. All staff should fill out a change of condition whenever they call with changes. The nurse should have called the doctor and rechecked the blood pressure and temperature. During an interview with the Administrator on [DATE] at 4:45 PM, she stated: We did not investigate (Resident #1's name) and his transfer to the hospital. I was aware that he died in the emergency department. We had facility staff tested for COVID-19, we did not look at this. Then we found out that a staff member tested positive and we did the [MEDICATION NAME] for residents for the Department of Health and had those residents tested and now have seven positive non-symptomatic residents. We were busy with all that and this was not looked at. I did ask the ADON to look into it, but with everything going on we just haven't had the time. I did speak with the doctors about the hospital transfer orders. (The Attending Physician's name) held the transfer until (the Nephrologist's name) evaluated the resident. I don't know if they were communicating. I was not aware that (Resident #1's name) had a low blood pressure in the middle of the night. I was not aware that the staff did not call the attending physician. I was not aware that the staff did not do a follow-up assessment after getting a low blood pressure. We did not report this as we were not aware that it had occurred until this complaint survey. His needs were being met here. Review of the receiving hospital's records revealed: Service Date/Time: [DATE], 08:57 EDT (Eastern Daylight Time). Emergency Documentation: History of Present Illness: 88-y/o (year old) male presents to the ED from The Villages Rehab for evaluation of altered mentation compared to his baseline, duration unclear. Patient was sent here by his rehab facility for abnormal labs and evaluation of a Foley that is not draining properly. According to report, the patient is currently at a rehab facility s/p (status [REDACTED]. Patient's Foley catheter was placed about ,[DATE] days ago and had approximately 1700 mL of urine drained before it started to malfunction. Vitals & Measurements: Gastrointestinal: soft, distended abdomen, bowel sounds distant, tenderness to lower abdomen, Foley catheter with dark bloody urine in early portion. Disposition: Time: 1029 (10:29 AM). Decision to dispo: deceased . Condition at disposition: deceased . Assessment/Plan: 1. deceased . 2. [MEDICAL CONDITION]. 3. [MEDICAL CONDITION] with septic shock ([MEDICAL CONDITION] is when the infection is severe enough to affect the function of your organs, such as the heart, brain, and kidneys. Septic shock is when you experience a significant drop in blood pressure that can lead to respiratory or heart failure, stroke, failure of other organs, and death. 4. Gross hematuria (when a person can see the blood in his or her urine). 5. History of closed distal fibula fracture.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on record review and interview the facility failed to complete and submit a federal report of alleged staff physical abuse of 1 resident (Resident #4) as required of 2 residents reviewed for response to allegations of abuse/neglect/exploitation. Findings: Record review of the facility policy titled Freedom from Abuse, Neglect, and Exploitation (Last Modified: 10/18/2018) revealed the policy intent as The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrence. The policy defined physical abuse as Physical Abuse includes hitting, slapping, pinching, pulling, and kicking. Record review of the facility abuse prevention policy revealed the facility standards of practice: b. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. d. The facility must develop and implement written policies and procedures that: I. Ensure reporting of crimes occurring in federally funded long-term care facilities in accordance with section 1150B of the Social Security Act. The policies and procedures must include but are not limited to the following elements. e. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: I. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. IV. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Record review of facility reporting records revealed a state report (Submitted: 05/06/2020) that documented on 05/06/2020 at 18:03, Resident #4 reported two Certified Nursing Assistants had been mean to him on the previous 4 nights during care. The report documented that Resident #4 had reported one of the Certified Nursing Assistants hit him. Record review of a facility grievance form submitted by Resident #4 revealed on 05/06/2020 Resident #4 reported that a Certified Nursing Assistant had balled up her fist and punched him in his left hip. Record review of facility incident records failed to reveal documentation the facility had completed and submitted a Federal 2-Hour Immediate or 5 Day report related to Resident #4's allegation of physical abuse. During interview on 05/27/2020 at 12:44 PM, the facility Director of Nursing confirmed that the facility had not completed a Federal 2-Hour Immediate or 5 Day report related to Resident #4's 05/06/2020 allegation of staff physical abuse.