Operation Guardians
Physician's Report
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The care of 15 current and former residents was reviewed. Systemic problems in the nursing department included the listing of inaccurate diagnoses, poor end-of-life care, avoidable dehydration and inadequate fall prevention. There did not appear to be adequate nursing monitoring in a number of cases, leading to potentially preventable hospitalizations. Discharge planning needs improvement.

I. Inaccurate diagnoses.

The diagnoses listed on resident face sheets were notably inaccurate. This is a problem because staff in all disciplines, but in particular nursing, rely on this information, and the face sheet is an important source for staff to refer to if they are unfamiliar with the resident. In an emergency, the ability to find diagnosis information rapidly is critical. For example, Resident 11 has a diagnosis of "hypokalemia" listed on her face sheet, which is the medical term for low potassium level in the blood. But this resident had actually experienced a high potassium level ("hyperkalemia"), a common and potentially life-threatening complication in persons receiving kidney dialysis such as Resident 11. It is very important that staff are aware that the resident has had this condition and is at risk for it in the future and the correct diagnosis should have been listed. The admitting orders as transcribed by a nurse state that one of her diagnoses was "hypeorkalemia" [sic], indicating that the nurse was not aware of her true diagnosis or how to spell it. Resident 11's list of diagnoses also did not include severe constipation, which was the precipitating cause for the surgery she had prior to admission. In another example, the primary diagnosis listed for Resident 14 is "cerebral palsy"; however, this resident is 90 years old and if she did have cerebral palsy at birth, it certainly isn't a problem for her now. Ensuring that each of a resident's diagnoses is listed and accurate is also important for the delivery of good nursing care. Licensed nurses, while administering medications, must know what each drug is used for in order to monitor for effectiveness, for example.

II. End-of-life care.

In two recent cases, nurses failed to provide adequate monitoring during the residents' last hours. Resident 9 died on 2/19/12. It was noted that she had developed a suspected deep tissue injury (pressure ulcer) on her sacral area two days before her death. Although this was a significant change in her condition, as well as one likely to cause her significant pain, there was a total absence of narrative charting by nurses in those two

days, representing a gap of almost 40 hours. Nurses should have been assessing and documenting their findings on a shift-by-shift basis, addressing both the appearance of the pressure ulcer and the resident's comfort level.

Resident 12, who died on 2/9/12, was dying from lung cancer that was metastatic to his brain and spine. There was evidence that his pain control was poorly controlled as of six (6) days before his death, and he had suffered an avoidable fall from the toilet five (5) days before death. Yet nurses failed to document any observations concerning his condition in the narrative notes for more than 48 hours prior to the time he was found dead. At a minimum, nurses should have been charting on an every-shift basis for three (3) consecutive days after the fall, yet failed to do even this. Likely both Resident 9 and Resident 12 did not receive adequate nursing care or pain control in their final days.

III. Avoidable dehydration.

Resident 8 was sent to the hospital on 12/6/11 after laboratory testing done at the facility the day before showed significant dehydration. The resident's sodium and blood urea nitrogen levels were significantly elevated, and she had been losing weight. She was suffering from Alzheimer's disease, and following firve (5) days in the hospital, her condition had declined to the point that she was judged to be terminal; she died within two (2) months. There is no evidence in the resident's chart that nursing staff were monitoring her intake of food and fluids during the days prior to her transfer to the hospital. In fact, the most recent weekly summary dated 12/2/11 states that she was consuming "80-100% of all meals with adequate [oral] fluids", which is very unlikely to have been true. The nurse who documented notifying her physician of the lab reports on 12/6 wrote that she was being sent to the hospital for "congestive heart failure" and a diagnosis of "chronic kidney failure". However, she clearly did not show any signs of congestive heart failure at the time, and the elevated sodium level could only have been caused by dehydration. It appears that the nurse was attempting to obfuscate the true reason for the resident's deterioration, and when she returned, the face sheet listed "end stage renal disease" (untrue) and "hyperosmolality" (true) but not dehydration. The diagnosis for hospice was "failure to thrive". Based on the failure of nursing staff to monitor her intake of fluids and recognize signs of dehydration before it became severe, it is likely that any such failure to thrive was caused by deficient nursing care and was avoidable.

Resident 13 has also been declining in weight and had laboratory evidence of dehydration fie (5) days before our inspection. He is also suffering from dementia, and Parkinson's disease, and has had progressive difficulty swallowing, and has been receiving a diuretic medication which increases the risk he will become dehydrated. There is no evidence in the nursing documentation that staff were monitoring his intake of fluids or conducting hydration assessments. The resident is at high risk for becoming avoidably dehydrated.

Resident 4 is the one resident the facility identified as being at risk for dehydration on the day of our inspection. The resident was admitted to the facility in late December from an acute care hospital and was supposed to be receiving weekly weights. However, an order

entered in his charts says not to weigh him for the week of 1/8/12 "due to possible norovirus". It is unclear whether there was an outbreak of diarrheal illness in the facility at the time or not, but Resident 4 was noted to have "contracted the stomach flu virus" according to a certified nursing assistant's entry for the night shift of 1/8. He was sent back to the hospital 3 days later, critically ill with diarrhea, vomiting, decreased urine output and a blood pressure of 57/36. A hospital record present in his chart states that he presented with among other things, hypovolemia and acute chronic renal failure, both of which are indicative of dehydration. Review of the nursing notes for the days prior to his transfer shows no evidence that nurses were monitoring his intake of fluids or conducting hydration assessments. There appears to have been a delay in recognizing how ill Resident 4 was becoming until his condition had become critical on 1/11/12.

IV. Inadequate fall prevention.

The size and physical layout of the facility is such that careful planning is needed for residents at risk for falling: staff may be at some physical distance when they are needed to supervise the resident at risk. This means that careful attention to planning for fall prevention is essential. However, in the case of at least one resident reviewed, Resident 1, the facility failed to plan and implement planned interventions to prevent her from falling. She fell and broke her right ankle on 1/15/12.

As of her comprehensive assessment (Minimum Data Set) dated 8/28/11, Resident 1 was nonambulatory but required only supervision for transfers from bed to chair. She fell for the first time on 10/16, while attempting to transfer herself. According to an interdisciplinary fall review on 10/17, the plan was to advise the resident to use her call light for assistance when she desired to transfer, and to have physical therapy evaluate her for "proper transfer technique". I did not find any physical therapy notes or evaluations in her chart thereafter.

She fell again on 12/24, and again was reviewed by the interdisciplinary team; however, it was not noted that the plan after the last fall for a physical therapy evaluation was not carried out, and again the IDT recommended reminding her to use the call light for assistance. The third fall occurred on 12/31; again the IDT recommended a physical therapy evaluation ("screen") but no physical therapy notes are found for this time frame. The fourth fall which resulted in the ankle fracture, like the preceding falls, occurred when the resident was attempting a self-transfer. After the application of a splint and later a cast, the resident was not to bear weight on the right foot, and she developed a pressure ulcer of the left heel. Her current care plan says she is independent with transfers, whereas she clearly is more dependent now than she was before she broke the ankle.

I asked the physical therapist about whether Resident 1 had in fact been "screened" after the earlier falls since no documentation was present in her chart. The therapist told me that she would "get them in there," meaning her chart, but was unable to produce the documentation for me to review. It seems unlikely that any such screening did take place, as there were no changes to her plan of care and no evidence that her abilities to

self-transfer changed. This resident continues to be at high risk for falling and suffering further avoidable injuries from falling.

Resident 3 was admitted to the facility on 2/15, with diagnoses including stroke and a wrist fracture from falling. Two days after admission, Resident 3 fell to the floor from her bed. She was known to be at high risk, but the care plan addressing her risk did not include basic interventions such as the provision of toileting services, personal alarms or reinforcing her safety awareness. The IDT review after Resident 3's fall indicates that the plan was to place half-rails on her bed and that "alarms [were] working" at the time of her fall. Without additional efforts to ensure that planned interventions are carried out, and to devise additional interventions to protect Resident 3's safety, the resident remains at very high risk for falling and becoming injured.

V. Poor nursing monitoring.

As noted above, there were instances when residents in need of frequent monitoring by licensed nurses did not receive it as evidenced by gaps in the narrative nursing notes. In some cases reviewed, although nurses wrote narrative entries, frequently the entries were devoid of meaningful information and constituted rote charting. Rote charting, the practice of entering stock phrases that do not speak to the individual resident's condition or care needs, gives the impression that nurses are assessing the resident while soon-to-become obvious changes in resident status are not documented and it turns out that the resident was in need of medical attention. For example, the nurse who documented that Resident 8's oral intake was adequate did not document an assessment of her hydration status; she turned out to have become dehydrated during the time frame covered by the nurse's charting. Rote charting is also indicative of poor supervision, since most supervisory nurses will agree that entries without meaningful information about the resident do not constitute evidence that the resident was actually assessed and monitored.

When rote charting takes the place of meaningful entries, nurses may mistakenly rely on it and fail to follow up with careful clinical observation. Then, the decline in the resident's condition goes unnoticed until the deterioration is severe. The failure to carefully observe and monitor residents whose conditions were changing was noted in several residents reviewed. The end result, as in the cases of Residents 4, 6, 7, 8, 9 and 12, is that action is delayed and residents are harmed.

VI. Discharge planning.

I did not find evidence in many of the residents reviewed that efforts are made toward planning for the resident's discharge. This was especially the case for residents admitted for Medicare-paid skilled nursing, many of whom lived independently in the community prior to needing hospitalization. The standard for such residents is that discharge planning begins on admission to the nursing home, with frequent updating of plans, based on the resident's progress with therapy and nursing care. For example, there were no entries concerning Resident 3's discharge plan beyond an assessment stating that it was "uncertain at this time". Resident 10, who has been living at the facility for many

months, is fully oriented ("x 4"), independent in all of her activities of daily living and does not appear to be in need of nursing facility care. According to a team member's interview with her daughter, Resident 10 was at the facility to "make sure she takes her meds". There was no plan for discharge found in the record.

In summary, conditions at this home at the present time are concerning, with poor nursing monitoring that has resulted in residents experiencing avoidable falls, dehydration, clinical deterioration and poor end-of-life care. Disorganization has led to inaccurate and missing diagnoses listed in resident charts.