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S 000	Initial Comments Annual Health Survey Complaint Investigation 2341079/IL156189	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)1) 300.1210 d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to recognize a change in neurological condition, notify the physician/nurse practitioner (NP) of all pertinent information, and provide	S9999		

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S9999	Continued From page 2 service to address changes in condition for one of one resident (R324) reviewed for quality of care in the sample of 31. This resulted in R324 having a delay in treatment for a change in neurological condition. Findings include: R324's Face Sheet, undated, documents R324 was admitted on 7/21/15, and was discharged on 11/6/22. The Face Sheet documented R324 had the following diagnoses: Type 2 DM (Diabetes Mellitus), CHF (Congested Heart Failure), Obesity, Major Depressive Disorder, Anxiety Disorder, HTN (Hypertension), ASHD (Atherosclerotic Heart Disease), GERD (Gastric Esophageal Reflux Disease), Neuropathies, Osteoarthritis, Asthma, Hyperlipidemia, Disease of Liver, Chronic Pain, Unspecified Kidney Failure, and COVID-19. R324's Physician Order (PO), dated 1/13/21, documents "FULL CODE." R324's Minimum Data Set (MDS), dated 10/19/22, documents R324 had a BIMS (Brief Interview for Mental Status) Score of 10, indicating R324 had moderately impaired cognition. R324's MDS documents R324 had clear speech, usually could make herself understood, and usually understood others. R324's MDS documented R324 was totally dependent upon two staff members for transfers, toileting, personal hygiene, and bathing. R324's Care Plan, dated 10/27/22, documents, "(R324) is at risk for alteration in comfort related to impaired mobility/chronic pain." R324's Care Plan Interventions document "Administer pain meds per order	S9999		

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S9999	Continued From page 3 (Hydrocodone/Oxycontin/Morphine as needed) Mx (monitor) effectiveness of pain meds. Attempt to establish causative factors of pain in attempt to minimize discomfort for her, assess her for c/o (complaint of) pain on scale of 1-10 and how it affects her ability to participate in ADL's (Activities of Daily Living), If she continues to verbalize pain or discomfort with current interventions, update Physician." It continues "(R324) requires extensive-total staff assist with ADL's related to impaired mobility related to obesity/chronic pain." R324's Care Plan documents "(10/26/22) Activities: (R324) is alert and oriented, attends activities of choice. Interventions: (R324's) preferred preferences per interview: Receiving a bed bath, snacks available between meals, family involved in her care discussions, choosing her own bedtime. (R324) was admitted to facility on 7/21/15. (R324) is on 500-hall. (R324) eats all meals in resident's room. (R324) sister visits often. (R324) sister brings resident in groceries upon resident request. (R324) likes to listen to music, socialize with staff and residents, and watch/listen to TV." R324's Physician Order, dated 11/24/20, documents, "Naloxone (Narcan) 1 MG/ML (milligram/milliliter), Inject 2 MG/2 ML (2 syringes) SC/IM (subcutaneous/intramuscular injection) every two-three minutes PRN (as needed) for Opioid Overdose." R324's Nurse's Note, dated 11/2/22 at 5:22 PM, documented R324 was found on the floor and sustained an abrasion to her left knee. The Nurse's Note documented R324 had gross amounts of edema and discoloration to the left knee and shin and due to these injuries and complaints of pain, and she was sent to the Emergency Room (ER).	S9999		

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R324's Nurse's Note, dated 11/2/22 at 7:00 PM, documents R324 returned to the facility with a large hematoma/bruising to left lower extremities, and had negative results from all diagnostic tests performed at the ER for fractures.

R324's Nurse's Note, dated 11/3/22, documented R324 had bruises, black and blue in color, located to the left knee and lower leg which was grossly edematous with numerous large red and yellow fluid filled blisters.

R324's November 2022 Medication Administration Record (MAR) documented R324 had the following medications: Morphine 100mg/5ml give 1 ML (milliliters) every two hours PRN (as needed), Hydrocodone-Acetaminophen 5-325mg one tab Q (every) 6 hr. (hour) PRN, Naloxone Inject 1 MG/ML (milliliter) SC (subcutaneous)/IM (intramuscular) into thigh PRN for Opioid Overdose. May repeat two-three minutes PRN.

R324's Nurse's Note, dated, 11/3/22 at 6:10 AM, documents, "Lying in bed, bed in low position, call light within reach. Moaning in pain, states that pain is severe. Left knee and lower leg bruised, black and blue in color, grossly edematous with numerous large red and yellow fluid filled blisters. States that any pressure applied to her leg hurts too much. Resident agreed to try an ice pack, ice pack from therapy applied to left lower leg at this time and tolerating well. Call placed to on call Dr regarding pain med d/t (due to) Tylenol Arthritis not helping severe pain. NP will be here this am and will see resident."

R324's Nurse's Note, dated 11/5/22 at 10:15 PM, written by V23, Licensed Practical Nurse/LPN,

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documents, "Resident moaning. flopping arms around. Resident shook head when asked if she was in pain. PRN Morphine given." There was no documentation V23 notified V25, Physician, or V27, Nurse Practitioner, that R324 was unable to verbalize.

R324's Nurse's Note, dated 11/6/22 at 03:00 AM, written by V23 documents, "[Recorded as Late Entry on 11/10/2022 21:38] Resident continues to be resting. No response to verbal or tactile stimuli. Narcan administered per nursing judgment." There was no documentation in R324's medical record V23 notified V25 or V27 that R324 was not responding to verbal/tactile stimuli, and she had administered Narcan

On 2/9/23 at 3:25 PM, V23, LPN, stated, "I worked that Friday and Saturday night (11/4/22-11/5/22). I started start my shift off at 6:00 PM. During the shift change on 11/5/22, I was told that they got a new order for liquid Morphine for (R324), and she had already received a couple of doses. I did my assessment and (R324) was lying in bed, not really alert but moaning when she was moved, but was not talking at all. Saturday night (11/5/22) I gave her one dose of Morphine around 10:30 PM because she was moaning and groaning loudly. She seemed to be resting quietly after that. I checked on her around 3:00 AM and there wasn't much changed. She was still lying there resting, her vital signs were stable, but she wasn't responding to me at all. I gave a dose of Narcan because I wanted to give myself peace of mind that (R324) did not get too much Morphine and I wanted to set my mind at ease. She seemed like she was resting well. After I gave the dose, nothing changed. There was no response to the Narcan, so I didn't think a second or third dose was

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necessary. She seemed to be getting her much needed sleep. I did not feel the need to call 911 or to even call the physician. I watched her for a good 30-45 minutes after and her BP (blood pressure) stayed the same and her breathing was same. At 6:00 AM, I gave report to (V24, LPN) and told her that (R324) had a restful night of sleep and that I gave Narcan once to make sure she did not get too much Morphine."

R324's Nurse's Note, dated 11/6/22 at 03:15 AM, written by V23 documents, "[Recorded as Late Entry on 11/10/2022 21:40] Resident continues to be resting. Resident did bite down on oral swab and held onto it for approximately 1 minute. VS (Vital Signs) WNL (within normal limits)."

R324's Nurse's Note, dated 11/6/22 at 6:10 AM, written by V23 documents, "[Recorded as Late Entry on 11/10/2022 21:43] Resident was assessed again by writer and day shift nurse (V24, LPN/Licensed Practical Nurse). Resident exhibited some mild moaning."

R324's Nurse's Note, dated 11/6/22 at 6:20 AM, written by V24, LPN, documents, "Resident resting in bed at this time, occasionally resident moans in pain. PERRLA (pupils equal round reactive light accommodation). Respirations even and unlabored. Incontinent care provided. Resident repositioned. Resident still not eating or drinking. Dressing CDI (clean dry intact) to LLE (left lower extremity) hematoma with open blisters."

There was no documentation in R324's medical record V24 notified V25 or V27 that R324 was not verbalizing her needs, or not eating/drinking.

On 2/9/23 at 2:55 PM, V32, Certified Nurse's Aide

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(CNA), stated, "I took care of (R324) almost every day. She would complaint of pain off and on but was pretty easy to get along with. (R324) is normally alert and would talk to us and let us know her needs. I came in that morning of 11/6/22 at 5:00 AM. I got to her hall around 6:00 AM and was in her room between 6:00-6:30 AM to check for incontinence and turn and position her. (R324) was not talking or responding, was not moving, or helping at all. It seemed like her body was there, but she wasn't. She had a little moan when we moved her but that was it. I know (V31, CNA) was there too. We probably turned and positioned her about every two hours. When we went in some time after 10:00 AM to check and reposition her, she was breathing really weird. She would breathe fast, and then real slow, then would speed up again. She would not respond at all. We immediately called for the nurse (V24, LPN) who came in and assessed her. I took care of (R324) almost every time I worked and that was not (R324) that morning."

R324's Nurse's Note, dated 11/6/22 at 11:11 AM, written by V24 documents, "Writer called to residents' room at 10:55 AM. Resident noted to be unresponsive with bilateral wheezing throughout lung fields. Writer preformed sternal rub and resident still does not rouse. Writer placed call to (V27, Family Nurse Practitioner Certified/FNPC) at 11:00 AM and updated on condition, new orders received to send resident to nearest ER (Emergency Room). At 11:03 AM, call placed to 911. Call placed to (V28, R324's Sister) at 11:05 AM and updated on condition and transfer to hospital. 11:10 AM, call placed to (Local Hospital) ER and report given to nurse."

On 2/9/23 at 1:10 PM, V24 stated, "When I got report from (V23, LPN) didn't really tell me about

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any symptoms (R324) was having, she just said she gave a dose of Narcan to (R324) for her own peace of mind that (R324) was not overdosed. After report, I went and did my own assessment on (R324), and I thought she was just the same as she was at 6:00 PM the night before when I left. (R324's) pupils were reactive, lungs were CTA (clear to auscultation), respirations were unlabored. I said good morning to her, and she opened her eyes for me. I asked her if she was hurting, and she made a groaning sound that I took as no. I was the one who called 911 after the CNAs yelled for me to check on (R324). I told 911 that the resident did have a leg injury from a fall, but I believe I also told them that she was unresponsive."

R324's Nurse's Note, dated 11/6/22 at 11:18 AM, documents, "11:18 AM (Local Ambulance) here to transport resident to (Local Hospital) ER. Resident moved to stretcher with transfer sheet and six staff members. All paperwork sent with EMTs (Emergency Medical Technicians)."

R324's Nurse's Note, dated 11/6/22 at 1:00 PM, documents, "Call placed to (Local Hospital) at this time to check on resident, Nurse stated that resident went into full cardiac arrest in the ambulance, was coded for 25 minutes in the ER, and expired at 11:58 AM. (V28) at hospital with resident. (V27, FNPC) updated at 13:24 PM."

R324's Emergency Department Hospital Record, dated 11/6/22, documents, "History is provided by the EMS. EMS said the nursing home staff gave her a dose of "Narcan" at 3:00 AM with no response. It is uncertain what took place all the hours between 3:00 AM and the time the ambulance was called to bring her to the ED (Emergency Department)." It continues "The

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S9999	Continued From page 9 onset was unknown, the total time from the patient's arrest until ambulance arrival was unknown." On 2/8/23 at 12:15 PM, V26, Emergency Medical Technician Paramedic, EMTP, stated, "I was the one who was on the call to the facility. I believe the call came in right around 11:00 AM. We were paged out for a female who was having Left Lower Leg pain from a fall days prior. When we arrived to the facility, we found the resident with snoring respirations, and unconscious. The nurse had told me that the resident had been receiving a lot of Morphine the day prior and had her last dose of Morphine 20 MG was given at 10:00 PM the night prior. The nurse stated that she had given one dose of Narcan at 3:00 AM. After that, I am not sure what they did for the resident until we got the call eight hours later. Once we got her into the ambulance, we started assisting her airway and we gave one dose of Narcan. I was working on getting an IV (intravenous catheter) in but because of her size, I ended up putting an IO (interosseous) in her and one dose of Epinephrine was given and then a second dose of Narcan. We couldn't get a BP (blood pressure) on her and had no pulse, so we started CPR (Cardiopulmonary Resuscitation) and started to transport to the hospital. I knew the events leading up to this day for this resident. (R324) fell and was taken to the hospital, was given pain medications and sent back to another hospital. She was returned to the facility with more pain medications. I would have assumed that after a first dose of Narcan, that the nurse would have either called 911 immediately, or at least administer another dose of Narcan as it was ordered." On 2/8/23 at 10:10 AM, V2, Director of Nursing,	S9999		

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DON, stated, "It all started when (R324) fell on 11/2/22 and was sent to (Local ER) for evaluation and was told there was nothing fractured and that she just had a deep tissue ecchymosis. (R324) continued to complain of pain and we were having a pain control issue with her, so we decided to send her out to another hospital for evaluation. (R324) had a history of not tolerating pain medications well, causing her to have altered mental status with pain meds. What we were giving her wasn't working, so we discussed with her family, and they wanted us to do anything we can to control her pain. Early morning on 11/6/22 around 3:00 AM, (V23, LPN) found (R324) lethargic with no response to verbal or tactile stimuli. (V23) gave Narcan and watched her for fifteen minutes and she didn't see any changes other than (R324) bit down on an oral swab while swabbing her mouth. I know that (V23) did not call 911 or the Physician after administering Narcan and she should have done that. (V23) was disciplined for that and I have in serviced all nurses since then. I had a meeting with our Medical Director (V25, Physician) and we now have a Narcan order for all residents who have Narcotics ordered along with the nurse to Call 911, Call the Physician, Call the DON after administering the Narcan."

On 2/8/23 at 12:15 PM, V26, EMTP (Emergency Medical Technician Paramedic), stated, "I was the one who was on the call to the facility. I believe the call came in right around 11:00 AM. We were paged out for a female who was having Left Lower Leg pain from a fall days prior. When we arrived to the facility, we found the resident with snoring respirations, and unconscious. The nurse had told me that the resident had been receiving a lot of Morphine the day prior and had her last dose of Morphine 20 MG was given at 10:00 PM

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the night prior. The nurse stated that she had given one dose of Narcan at 3:00 AM. After that, I am not sure what they did for the resident until we got the call eight hours later." V26 stated, "I knew the events leading up to this day for this resident. (R324) fell and was taken to the hospital, was given pain medications, and sent back to another hospital. She was returned to the facility with more pain medications. I would have assumed that after a first dose of Narcan, that the nurse would have either called 911 immediately, or at least administer another dose of Narcan as it was ordered."

On 2/8/23 at 1:30 PM, V25, Physician, stated, "I was notified of this incident regarding (R324) and I was told that the first dose of Narcan did not do anything for the resident. I would have expected the nurse to call the physician on call, and that physician would have made the decision to send the resident to the hospital or not. I know we have a Narcan Administration Policy that should tell them what to do. Another dose of Narcan could definitely have been given, it would not have hurt her at all. We give Morphine for patients with cardiac problems, such as chest pain, all the time because it could make it better. So, there is no way to know if Morphine caused a cardiac event or not. It is impossible to determine if sending her to the ER initially would have helped, that is a tough one and I wish I had an answer for you. The Morphine dose really depends on how much pain a patient is having. (R324) is getting 2 MG isn't she. Oh, she's getting 20 MG, but is it every two hours. So, she is getting 20 MG PRN and not every two hours. I know the nurse called my Nurse Practitioner (NP) at one point and I believe the NP is the one who decided to send her out to the hospital. What I think should have happened is the nurse who gave the Narcan, should have

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called the physician and most likely the physician would have sent the resident out to the hospital at that time. I do think it was a delay, and a long-time frame from when the first dose of Narcan was given until the Nurse Practitioner was called, and the resident was sent to the hospital."

On 2/9/23 at 11:13 AM, V27, Nurse Practitioner (NP), stated, "I document my assessments in the electronic medical record. I was aware of (R324's) fall on 11/2/22. I'm usually at the facility on Mondays and Thursdays. That week, I came in on Thursday (11/3/22) and was told of (R324's) fall the day before (11/2/22). I went and assessed her and her leg and from the knee down was a deep dark purple with blisters. I have never seen anything like that before. I decided to send her to back to the ER because she was in extreme pain and her leg looked bad. I gave an order for a one-time liquid Morphine 20mg PO order to hold her over until she gets to the ER. She came back some time after I left and was contacted several times about her pain not in control. They called me on Friday (11/4/22) and said she was in extreme pain. I ordered Oxycontin 10mg. I know that the Oxycontin is basically an extended-release Morphine, and I was thinking that she needed something like that to maintain her pain control. I am not sure if there is a max dose of Morphine per 24 hours. Typically, we only use Morphine in Nursing Homes for Hospice residents, but I thought this would help her. When she came back from the ER, I don't think she came back with anything new so that is why I gave her those drugs. On Saturday (11/5/22) they called me again and I ordered the liquid Morphine at that time to be every two hours PRN. Yes, I think having all three drugs at once (Oxycontin, Hydrocodone, Morphine) would be too much, but I told them to discontinue the Oxycontin and

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Hydrocodone when they start the liquid Morphine. This was all a verbal order, so I assumed this was done. I felt like giving (R324) 20mg dose was sufficient because she was a very big lady. Then on Sunday (11/6/22) (V24, LPN) called me around 11:00 AM and told me that (R324) was not doing well. I don't recall her telling me she was unresponsive, but that she just wasn't doing well. I was told about her receiving Narcan but not sure who told me that. It may have been the next day (Monday 11/7/22) when I came in. Narcan is supposed to be given for a suspected overdose. They should have given it and immediately notified the Physician. They can give up to three doses and honestly, they should have called 911 if they had to give Narcan. I would have expected that nurse to give another dose of Narcan and/or call 911. Anytime they give Narcan, they should be sending the resident out. I can't predict if sending (R324) out when they gave the Narcan at 3:00 AM would have changed anything, but yes, more than likely it would have."

On 2/14/23 at 8:39 AM V14, Restorative Aide, stated she was very familiar with R324. V14 stated prior to her fall on 11/2/22, R324 would have her good days and bad days, physically, with bad days being when she was more sleepy and not able to participate in her own ADLs (Activities of Daily Living) as much. V14 gave the example that on "bad days" R324 would not help roll herself over in bed during turning and repositioning or incontinent care, but on good days R324 could roll herself onto her side and grasp the handrail to help with her ADLs. V14 stated R324 was able to feed herself after set-up by staff, and stated R324's appetite was very good, and R324 would often ask for seconds and sometimes thirds at meals. V14 stated R324 was alert and oriented and like to talk to staff about

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what was going on in their lives. V14 stated she did work the midnight shift for several months and did take care of R324 on that shift. V14 stated R324 would be awake a lot on midnight shift normally, and if she was asleep when they were doing rounds, R324 would wake easily and respond appropriately to staff who were performing her care. V14 stated R324 was mostly in bed, except when she got up for appointments, because it was very uncomfortable for R324 to be gotten up with the full body mechanical lift due to her size, and she preferred to stay in her bed. V14 stated if she would have gone into R324's room at night and R324 didn't speak to her, or wake up while she was providing care, she would have considered that a big change from R324's norm.

On 2/14/23 at 8:47 AM V2 stated, "Prior to her fall on 11/2/22, (R324) did have pain. She would put a washcloth in her mouth and moan in pain when we had to move her during care. (R324) had a history of mental status changes related to narcotic medications; her lactic acid would increase and cause the mental changes. Her doctor and nurse practitioner weighed the risks and benefits of this and decided to order narcotic medication to try to get (R324's) pain under control. She did not eat much after the fall; on 11/3/22, she ate 50-75% at breakfast and lunch, and 26-50% at dinner; on 11/4/22 and 11/5/22, the staff did not document any intake at meals for (R324)." V2 stated R324 was able to communicate that she was in pain to the nurse practitioner when she saw her after her fall, and she was sent to the hospital twice due to the fall and her pain. V2 stated the staff did update the nurse practitioner on R324's increased restlessness and attempts to roll herself out of bed. V2 stated the goal was to get R324's pain

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under control, which they were able to do with the Morphine that was ordered. V2 stated prior to her fall on 11/2/22, R324 was alert and oriented time 2-3 with some occasional confusion on the time of day, but R324 was confused after the fall and V2 stated she attributed that to R324's pain medication. V2 stated she recognizes the failure by the nurse on 11/6/22 at 3:00 AM when she gave Narcan but did not notify the physician or call 911, and that nurse has been disciplined and educated to notify the physician and call 911 if administering Narcan.

On 2/14/23 at 10:00 AM V9, Activity Director, stated R324 was alert times 2-3. She stated R324 always recognized her by her voice and her southern accent because R324 could not see very well. V9 stated R324 was able to carry on a conversation about what was going on that day and let her know if she wanted a snack. V9 stated if she did not go into R324's room, R324 would send a CNA down to the activity room to get her a snack. V9 stated before R324's fall on 11/2/22, V9 would sometimes walk past her room and hear her moaning and sounding like she was in pain. V9 stated after R324 fell on 11/2/22, she was usually sleeping whenever V9 went into her room to take her snacks or to talk to her about activities that were held that day. V9 stated she would leave the snack on R324's table and instruct the CNAs to help R324 with it when she woke up. V9 stated she really didn't have any more conversations with R324 after her fall.

On 2/14/23 at 1:10 PM, V27, Nurse Practitioner, stated, "(R324) was always alert and oriented and able to carry on a conversation with me. There are times when (R324) would chew on a washcloth or the bed linen when she was in pain, but I am not sure if it was a habit or what,

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because sometimes it would not correlate with her pain. I never got multiple calls about (R324) having a change in condition. The one call I remember was (R324) spitting out her medications and that is when I transitioned to the liquid Morphine. Any time a resident has a change in condition, they should be notifying the provider on call. Yes, I would have sent (R324) out to the hospital if they would have called me with her change in mental status. I don't mess around with anyone, especially a full code, having mental status changes. I would definitely give them the order to send the resident out. I would consider if you had to use tactile stimulation to arouse someone when they normally respond to verbal, that should be considered a change in condition. It sounds like there should have been more done for (R324) that what was done."

The Facility's "Administration of Narcan", dated 9/2022, documents "Assess: Assess for signs of Opioid overdose (shallow breathing, decreased heart rate, pinpoint pupils, blue lips/nail beds, skin cool/clammy, confusion, or loss of consciousness. Verify Order. Activate EMS. Gather supplies, prepare syringe to withdraw dose (0.4 MG). Administer intramuscularly in thigh or upper arm (may be administered subcutaneously). Reassess: assess resident's response. May repeat dose every two-three minutes as needed. Closely monitor resident for several hours for symptom recurrence."

The Facility's Change in Condition Policy, dated 2/2012, documents "It is the policy of (This Company) that resident change in condition will be assessed promptly and follow up activity will occur as appropriate and in a timely manner. Definition: Change in condition is defined as an improvement or decline in the resident's physical,

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mental or psychosocial status that effects less than two areas of activities of daily living. Significant change is defined as an improvement or decline in the resident's physical, mental or psychosocial status that effects two or more areas of activities of daily living. Procedure: 1. The staff person who first notices the change reports resident change in condition immediately to the licensed nurse. 2. The licensed nurse assesses the resident including vital signs and notes signs and symptoms, regarding physical and mental changes in condition. 3. The results of the assessment, including the vital signs, signs, symptoms and any physical and/or mental changes in condition are documented in the resident's medical record. 4. The resident's primary physician or designated alternate will be notified immediately of any change in resident's physical or medical condition, this includes: a. accident involving the resident. b. Deterioration in health, mental, or psychosocial status. c. Need to alter treatment (i.e., Need to discontinue an existing form of treatment due to adverse consequences or to commence new form of treatment). d. A decision to transfer or discharge from the facility. 5. The resident's designated medical contact or guardian will also be notified. In certain circumstances, the change may warrant contacting clergy or other significant persons. Nursing judgement should be used given the time of day and the severity of the resident change. 6. Notification of physician and/or responsible parties shall be documented in the clinical record as well as on the 24-hour report form. Status changes, which are not significant enough to be reported, must also be documented in the medical record. 7. Significant change in condition requires a comprehensive resident reassessment (MDS) with associated documentation in the clinical record and care

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