STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. BUILDING _____ B. WING _____	03/15/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHINLE NURSING HOME	PO BOX 910 CHINLE, AZ 86503

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 -** Actual harm **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 and record review the facility failed to notify and consult with a physician after a resident developed low oxygen levels in the blood approximately 4 hours after the resident complained of pain and immobility of his leg. In addition the facility did not notify the physician when there was an approximate 5 hour delay in Emergency Medical System (EMS) response for one resident (Resident 59). This deficient practice resulted in a delay in treatment and unnecessary suffering with pain and breathlessness for Resident 59. This finding is as a result of the investigation into a facility reported incident with intake number AZ 493 of reported fall with fracture that occurred on 1/5/2019. Findings include: 03/15/19 at 06:16 AM, the following was found in the medical record review: Resident 59 was a [AGE] year old male who was a long-time resident of the facility with [DIAGNOSES REDACTED]. The minimum data set (MDS-an assessment tool) dated 11/28/2018 indicated the resident needed limited assistance with most activities of daily living (ADLs), he had limited range of motion on one side of his body, needed human assistance to transfer from surface to surface. The resident used a wheel chair (w/c) for locomotion. He was able to propel himself. He had a history of [REDACTED]. The 12/31/2018 Morse Fall Scale (a fall risk assessment tool) had a fall risk score of 55. Scores over 45 are considered a high risk of falling. The 1/5/2019 (post fall) Morse Fall Scale score was 80. Continued record review on 3/15/2019 read as follows: Incident progress notes dated 1/5/2019 @ 3:45 PM, unwitnessed fall. Staff heard resident yelling from his room and found him lying on his back next to his w/c. Resident stated he was transferring from w/c to bed the w/c slipped out from under him. Stated he landed on his buttocks and laid back. He denied hitting his head. Two staff assisted him to his feet for a full body skin assessment. Skin intact over buttocks, back and posterior legs. Placed in wheel chair (w/c), resident taken to dining hall for evening meal. Vital signs were stable. Oxygen saturations (O2 sats) level on room air (RA) was 94%. (Oxygen saturation is a measurement of oxygen in the tissues of the body. This is measured with an instrument called a pulse oximeter. The device is clipped on a finger and quickly gives a percent of oxygen in the tissues. Normal O2 saturation levels are above 95% according to the National Institute of Health (NIH)). There was communication note to the physician (Staff 34) written on 1/5/2019 at 4:07 PM informing him of the resident's fall. The physician ordered the staff to continue to monitor resident often for skin assessment, mentation changes, and to call back with change in condition (e.g. bleeding, change in skin condition, change in mentation). Incident progress note dated 1/6/2019 @03:09 AM, Resident reported right leg pain with movement. He was unable to independently move around and required assist. There was no documentation that a physician was notified. Review the Medication Administration Record [REDACTED]. 1/6/2019 @ 06:55 AM, Resident remained in bed, O2 was given at 3 liters by nasal cannula (O2 @ 3L/nc) provided due to room air (RA) O2 sat at 63 -74%. (Resident)Denies SOB (shortness of breath) but continued to complain of pain right leg and low back with attempts to move. Tylenol given. Emergency Medical Services (EMS) notified of needed services. Currently on another call, but will be here to pick rsd (resident) as soon as possible (sic). Called emergency room (ER) with report that resident being sent over for evaluation. 1/6/2019 @07:01 AM, Report to ER nurse Anthony received report. No documentation was found or provided to indicate that the ER physician was consulted. 1/6/2019 @ 08:23 AM, resident was yelling in bed and taking off his oxygen (nasal cannula) .He reported difficulty breathing but wouldn't wear O2 cannula. (He is not) cooperative and moving arms a lot when taking vital signs. Called EMS three times but they are not answering the call. Awaiting EMS to pick him up. Resident still NPO (nothing by mouth). He is complaining pain to right leg with little movement. Oxygen saturation range on room air 75-89% fluctuating and resident is refusing to apply oxygen. Vital Signs (VS) @ 8 AM O2 sat 83% on room air, temperature 100.4 degrees Fahrenheit; Blood Pressure 78/50; respiratory rate 28 and Heart Rate 83. (Normal temperature range 97.6 - 99.6; normal blood pressure range 90/60 - 140/90; normal respiratory range 16-28) There was no documentation provided that a physician was notified of the resident's change of condition. After several attempts to get EMS to respond to the resident's need the staff called the police at 11 AM (four hours after his O2 sats were found to be 63-74%.) EMS arrived and the resident was sent to Chinle hospital ER at 11:47 AM. There was no documentation that a physician was notified of the delay in the EMS response. Review of the Medical records from the Chinle Comprehesive (sic) Health Care Facility (CCHCF) ER did not include in the chief complaint the resident's hypoxic and hypotensive episodes during the morning. The vital signs on 1/6/2019 at 01:53 PM; were Temp 100.1 degrees Fahrenheit; BP; 84/51; and O2 Sat 91%. Follow up with the ER doctor reported to the facility at 2:45 PM on 1/6/2019 the resident had a [MEDICAL CONDITION] and a fever. 03/15/19 at 07:47 AM, when asked about the incident, Staff 20 reported the following; It took a long to transfer him to the ER, the EMS is at the hospital. She called the hospital for EMS services. When asked if this delay in EMS response was a common problem Staff 20 said it depends. When asked if she had notified the physician of the low O2 Sat, she said she called the ER Nurse and reported to day shift at the facility to notify the attending physician. She stated, the attending (doctor) does not answer calls at night. She did not call the Medical Director at that time, because she stated she was told that staff were not to call him at night. Review of the No. NV-CA-18-0011 Collaborative Agreement Between Chinle Comprehesive (sic) Health Care Facility (CCHCF) Navajo Area Indian Health Service and Chinle Nursing Home (CNH): the following read in pertinent part: .1. CCHCF AGREES: B. These services shall fulfill the requirements of the Federal Regulations for Primary Medical Provider for IHS beneficiaries residing the in the home. These services include but are not limited to: .5. On-call after hours physician services are available to I.H.S. beneficiaries residing in the home for purposes of medical consultation, clarification of orders, and urgent queries .

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0580 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) 03/15/19 at 08:40 AM, when asked to speak with the attending physician. Staff 2 stated she received notice that Resident 59's attending physician would not be available to talk with surveyors, until after the survey was completed. 03/15/19 at 12:20 PM, on a phone interview: When asked if he was aware of the delay in EMS response for Resident 59; The Medical Director stated he was not aware of the extent of the delay of services for this resident; however he was aware that the Chinle EMS system sometimes responded late. He stated that the facility did not know what else they could do about it. In regards to Resident 59's situation; he stated the night shift nurse should have notified the physician when the resident had pain and couldn't move his leg on 1/6/2019 at 03:09 AM. They should have called the CCHCF emergency room and spoke with the doctor at the hospital for direction. When informed that Staff 20 informed the surveyor that she was told they were told not to call the attending physician or the medical director at night; he stated that the Chinle hospital (CCHCF) ER doctors cover for night shift and weekends and they do speak directly to the facility nurses. When informed of the resident's 02 sat levels at 6:55 AM of 63-74% he stated they should have taken the resident directly to the ER when EMS was not available. He said that they should have put the resident in a wheelchair and taken him across the parking lot to the ER. When asked if the facility had discussed the EMS slow response time in QAPI he stated he did not think so. 03/15/19 at 02:15 PM during an interview when asked how often the EMS is late responding to their calls, Staff 5 stated it happens pretty often; however it usually was not this bad. When asked if they had included this issue in their QAPI, she said everyone is aware of the problem; however we did not discuss it because we didn't think we could do anything about it. She said that she will make sure it is addressed ASAP. Requested a list of calls made to the EMS and their response time. Staff 5 stated the facility did not keep track of that information. However she said she would call the EMS to obtain the information. According to an article about complications of [MEDICAL CONDITION] in the elderly the following Webster https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 33/ read in part as follows: .Mortality incidence due to fat embolism syndrome (FES) varies among varied studies, probably because of its underdiagnosis.(27) Acute fulminant FES may lead to death due to right heart failure, while majority of deaths are usually due to [MEDICAL CONDITION]. Though prognosis for neurological defects is good, deaths have also been reported. Incidents of acute coronary syndrome, probably due to circulating fat globules have also been reported.(57) Overall, the mortality is estimated to be 5-15%.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on document review and staff interview, the facility failed to provide notification to the Ombudsman of the resident's admission to the hospital for three sampled residents (R)16 who was admitted to the hospital on 3 separate occasions, R59 and R159. This failure had the potential for the ombudsman not being able to track and investigate concerns related to hospital transfers. Finding Include: Review of the clinical record for R16 revealed the resident was transferred to the hospital on [DATE], 01/09/19 and 02/23/19.Review of the facility's Bed Hold policy revised 01/2019 failed to identify instruction to the staff to inform the Ombudsman of a resident's admission to the hospital. Interview with Social Services 4 on 3/13/19 at 12:36 PM confirmed R16's transfer to the hospital on 01/2019, 01/09/19, and 02/23/19 were not reported to the Ombudsman. Social Services 4 stated the facility lacked a process to notify the Ombudsman of a resident's admission to the hospital. Review of Resident 59 and Resident 159 medical record revealed the following: Resident 59 was admitted to the hospital on [DATE] for [MEDICAL CONDITION]. During an interview with Staff 13 on 3/15/2019 in the afternoon, when asked for documentation that the ombudsman had been notified R59, she stated she did not realize she had to notify the ombudsman of transfers to the hospital. Resident 159 had been sent to the hospital on [DATE] for a gastrointestinal condition and urinary tract infection. During an interview on 3/15/2019 at 1:32 PM, when asked for the documentation that the ombudsman had been notified of R159's transfer to the hospital and subsequent discharge, Staff 4 stated she was not aware that they had to notify the ombudsman of hospitalization s.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > The facility failed to complete a discharge summary for one resident (Resident 59). Findings; 03/15/19 at 06:16 AM, the following was found in Residetn 59's medical record review: Resident 59 was a [AGE] year old male who was a long-time resident with [DIAGNOSES REDACTED]. On 1/5/2019 at 3:45 PM the resident fell in his room. On 1/6/2019 at 11:47 AM the resident was taken to the emergency room at Chinle Comprehesive (sic) Health Care Facility (CCHCF). By the time of the survey the resident had not returned to the facility. On 3/14/2019 in the afternoon when asked for a copy of Resident 59's discharge summary, Staff 36 stated she was not able to find one in the medical records for the 1/6/2019 discharge.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview and record review the facility failed ensure that a resident received timely treatment and care for a resident who fell and approximately eleven (11) hours later complained of pain and immobility of his leg. No pain medication was given. Four hours after the pain the resident then developed low oxygen levels in the blood, and low blood pressure although the EMS was called, the facility did not notify the physician when there was an approximate 5 hour delay in Emergency Medical System (EMS) response for one resident (Resident 59). This deficient practice resulted in a delay in treatment and unnecessary suffering with pain and breathlessness for Resident 59. This finding is as a result of the investigation into a facility reported incident with intake number AZ 493 of reported fall with fracture that occurred on 1/5/2019. Findings include: 03/15/19 at 06:16 AM, the following was found in the medical record review: Resident 59 was a [AGE] year old male who was a long-time resident of the facility with [DIAGNOSES REDACTED]. The minimum data set (MDS-an assessment tool) dated 11/28/2018 indicated the resident needed limited assistance with most activities of daily living (ADLs), he had limited range of motion on one side of his body, needed human assistance to transfer from surface to surface. The resident used a wheel chair (w/c) for locomotion. He was able to propel himself. He had a history of [REDACTED]. The 12/31/2018 Morse Fall Scale (a fall risk assessment tool) had a fall risk score of 55. Scores over 45 are considered a high risk of falling.

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F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) The 1/5/2019 (post fall) Morse Fall Scale score was 80. Continued record review on 3/15/2019 read as follows: Incident progress notes dated 1/5/2019 @ 3:45 PM, unwitnessed fall. Staff heard resident yelling from his room and found him lying on his back next to his w/c. Resident stated he was transferring from w/c to bed the w/c slipped out from under him. Stated he landed on his buttocks and laid back. He denied hitting his head. Two staff assisted him to his feet for a full body skin assessment. Skin intact over buttocks, back and posterior legs. Placed in wheel chair (w/c), resident taken to dining hall for evening meal. Vital signs were stable. Oxygen saturations (O2 sats) level on room air (RA) was 94%. (Oxygen saturation is a measurement of oxygen in the tissues of the body. This is measured with an instrument called a pulse oximeter. The device is clipped on a finger and quickly gives a percent of oxygen in the tissues. Normal O2 saturation levels are above 95% according to the National Institute of Health (NIH)). There was communication note to the physician (Staff 34) written on 1/5/2019 at 4:07 PM informing him of the resident's fall. The physician ordered the staff to continue to monitor resident often for skin assessment, mentation changes, and to call back with change in condition (e.g. bleeding, change in skin condition, change in mentation). Incident progress note dated 1/6/2019 @03:09 AM, Resident reported right leg pain with movement. He was unable to independently move around and required assist. There was no documentation that a physician was notified. Review the Medication Administration Record [REDACTED]. Record review continued: on 1/6/2019 @ 06:55 AM, Resident remained in bed, O2 was given at 3 liters by nasal cannula (O2 @ 3L/nc) provided due to room air (RA) O2 sat at 63 -74%. (Resident)Denies SOB (shortness of breath) but continued to complain of pain right leg and low back with attempts to move. Tylenol given. Emergency Medical Services (EMS) notified of needed services. Currently on another call, but will be here to pick rsd (resident) as soon as possible (sic). Called emergency room (ER) with report that resident being sent over for evaluation. 1/6/2019 @07:01 AM, Report to ER nurse Anthony received report. No documentation was found or provided to indicate that the ER physician was consulted for treatment or what to do when the EMS had not arrived. 1/6/2019 @ 08:23 AM, resident was yelling in bed and taking off his oxygen (nasal cannula) .He reported difficulty breathing but wouldn't wear O2 cannula. (He is not) cooperative and moving arms a lot when taking vital signs. Called EMS three times but they are not answering the call. Awaiting EMS to pick him up. Resident still NPO (nothing by mouth). He is complaining pain to right leg with little movement. Oxygen saturation range on room air 75-89% fluctuating and resident is refusing to apply oxygen. Vital Signs (VS) @ 8 AM O2 sat 83% on room air, temperature 100.4 degrees Fahrenheit; Blood Pressure 78/50; respiratory rate 28 and Heart Rate 83. (Normal temperature range 97.6 - 99.6; normal blood pressure range 90/60 - 140/90; normal respiratory range 16-28) There was no documentation provided that a physician was notified of the resident's change of condition or request for consultation on what to do for the resident. After several attempts to get EMS to respond to the resident's needs the staff called the police at 11 AM (four hours after his O2 sats were found to be 63-74%.) EMS arrived and the resident was sent to Chinle hospital ER at 11:47 AM. There was no documentation that a physician was notified of the delay in the EMS response. 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