CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Mary Ann Chapman 2/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056322	A. BUILDING _____ B. WING _____	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERDUGO VALLEY SKILLED NURSING & WELLNESS CENTRE	2635 Honolulu Ave, Montrose, CA 91020-1706 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS AA CITATION -- PATIENT CARE 92-0539-0011832-F Complaint(s): CA00412160, CA00412160, CA00412160 Representing the Department of Public Health: Surveyor ID # 04945, RN, HFE III The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F 309 §483.25 Quality of Care Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. F328 §483.25(k) Special Needs The facility must ensure that residents receive proper treatment and care for the following special services; (6) Standard: Respiratory Care F279 § 483.20(k) (1) Comprehensive Care plans. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's		Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law. **F309 483.25 Quality of Care** **F328 483.25(k) Special Needs** **F279 483.20(k) Comprehensive Care Plans** **F157 483.10(b) Notification of Changes** **F224 483.13(c) Staff Treatment of Residents** **Corrective action for residents found to have been affected by this deficiency:** Resident 1 was no longer a resident at the facility.	

Event ID:52BA11 2/26/2016 8:29:51AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Narinderpal Gill | TITLE: Administrator | (X6) DATE: 2/29/16

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 16

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. Except for nursing homes, the findings 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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	medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: (i)The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under § 483.10 (b) (4). F157 §483.10(b) (11) Notification of Changes. (i) A facility must immediately inform: consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is— (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); F224 §483.13(c) Staff Treatment of Residents The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. "Neglect" means failure to provide goods and		**Corrective action for residents that may be affected by this deficiency:** a. ADON and/or RN supervisor will identify residents with respiratory problems; i.e. Pneumonia, CHF, COPD and residents on oxygen and inhalation therapy. The review will include care plan updates and documentation of signs and symptoms of respiratory distress. Completed on 11/15/2015. b. ADON and/or RN supervisor will identify all residents that are refusing care, eating, to be weighed and etc. Physicians will be notified and plan of care will be updated accordingly. Completed on 11/15/15.	

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	services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR 488.301). F385 §483.40 Physician Visits A physician must personally approve in writing a recommendation that an individual be admitted to the facility. Each resident must remain under the care of a physician. (a) Physician supervision. The facility must ensure that— (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable. (b) Physician visits. The physician must— (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. (c) Frequency of physician visits. (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (2) A physician visit is considered timely if it occurs		c. DON and/or ADON reviewed change of conditions. There were 5 changes of conditions from 11/4/2015 to 11/13/2015. 2 out of 5 were 911 was called promptly and timely. No other residents' change of conditions warranting 911 calls noted. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:** DON and/or QA Nurse consultant will re-educate licensed nurses by 12/4/2015 on the following areas:	

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	not later than 10 days after the date the visit was required. (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. The Department received a complaint on September 5, 2014, alleging a resident (Resident 1), was transferred to a general acute care hospital (GACH) via 911 paramedics on August 24, 2014 from a skilled nursing facility (SNF). The complaint indicated Resident 1 became unresponsive, lethargic (sleepiness or deep unresponsiveness and inactivity), and had labored breathing (airway obstruction; breathlessness; difficulty breathing). According to the complaint, Resident 1's family member (FM) stated the resident's condition had been declining, especially his respiratory condition, for a while. The FM had requested the facility to have Resident 1 seen by a lung specialist (pulmonologist); however, there was no documentation that the Resident was ever seen by a pulmonologist. The FM was also informed that Resident 1 had not been seen by a physician for months, and the facility told the FM that he needed to choose a physician to see the resident. Resident 1 expired on August 30, 2014 in the GACH. The facility failed to provide Resident 1 with the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, in accordance with comprehensive assessment and plan of care; to ensure that Resident 1 received proper treatment and care for respiratory problems; to develop a		a. Licensed Nurses will be provided education on appropriate documentation required with change of condition emphasis on respiratory changes. Completed on 11/15/15. b. A change of condition assessed by the RN and 911 is warranted; the RN will direct the charge nurse to immediately call 911 to provide timely interventions. The MD will be notified as well as the responsible party. c. Meal percentage will be reviewed on 7-3 and 3-11 shifts by charge nurse and resident refusing to eat meals will be reported to the DON/designee for further directions. If continue to refuse MD will be notified.	

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	comprehensive care plan for services to attain or maintain the resident's highest practicable physical well-being; to immediately inform and consult with the resident's physician when there was a change in the resident's physical health status; to ensure that each resident remains under the continuing care of a physician and the medical care of each resident is supervised by a physician; and to develop and implement written policies and procedures that prohibited mistreatment, neglect, and abuse of residents, including but not limited to: Failure to ensure Resident 1, who had a history of respiratory problems, was assessed for signs and symptoms of respiratory distress daily, as indicated in the resident's plan of care. Failure to notify a physician immediately, as stipulated in Resident 1's plan of care, when the resident exhibited respiratory signs and symptoms. Failure to ensure Resident 1 had a primary care physician for supervision and management of the resident's care and services. Failure to ensure physician's orders were obtained before the staff provided care and services to Resident 1. Failure to call 911 paramedics promptly when Resident 1 had a significant change of condition, as ordered by the physician, and as stipulated in the facility's policy and procedures, regarding emergency situations.		d. Medical records department will audit the ADL sheets for meal percentage daily Monday to Friday and provide the DON/RN supervisor and Administrator a copy of audit. e. Licensed Nurse will call the MD for further orders in event of COC. f. The SBAR communication tool will be used to guide the nurse during his/her assessment. g. COC's will be documented on the 24 hour report, will be reviewed by the DON/IDT next day, except for COC identified on Friday and weekends will be reviewed on Monday. h. RN supervisor will review any COC with nursing staff during shift change report.	

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	These deficient practices resulted in a delay in a medical assessment, care, and treatment for Resident 1, who was transported to a GACH. According to the GACH records, the resident was diagnosed with sepsis (infection that is potentially life-threatening), had an extensive right lobe pneumonia (infection of the lung), requiring intravenous ([IV] into the vein) antibiotics and fluids. The resident was in acute respiratory failure, requiring an oral intubation (insertion of a tube into the trachea [a large membranous tube, extending from the larynx to the bronchial tubes and conveying air to and from the lungs (the windpipe) for purposes of airway maintenance and lung ventilation) and was placed on a ventilator (a breathing machine designed to mechanically move breathable air into and out of the lungs), due to the resident exhibiting respiratory failure. Resident 1 was admitted to the intensive care unit (ICU) and expired six days later (August 30, 2014), after being placed on hospice care (end of life care) the day prior. The GACH listed Resident 1's cause of death as being acute respiratory failure. A review of a Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated June 9, 2014, indicated Resident 1's cognition was intact, but was non-ambulatory and was totally dependent in most of all his care needs, except eating, where he only required limited assistance and set-up. A review of an unsigned physician's order, dated April 8, 2014, indicated to administer oxygen at 2 liters per minute (PM) via nasal cannula ([N/C] tube		**Measures that will be put into place to ensure that this deficiency does not reoccur:** The above POC will be reviewed in the QAA committee for further review and recommendations monthly for 3 months and quarterly thereafter and as needed. Administrator and/or DON will report trends. **F385 483.40 Physician Visits** **Corrective action for residents found to have been affected by this deficiency:** Resident 1 was no longer a resident at the facility. **Corrective action for residents that may be affected by this deficiency:**	

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	in the nose) as needed to keep the resident's oxygen saturation greater than 92 percent (%). A review of unsigned recapped-orders (orders previously written and carried forward) physician's orders for the month of August 2014, indicated to administer oxygen to Resident 1 at 2 to 4 liters PM via N/C "continuously" for chronic obstructive pulmonary disease ([COPD] a chronic lung disease). A review of Resident 1's Admission Face Sheet, indicated the resident was a 58 year-old male, who was initially admitted to the facility on June 3, 2013, and last readmitted on April 8, 2014. Resident 1's diagnoses included pneumonia (an infection of the lungs caused by fungi, bacteria, or viruses), chronic airway obstruction ([COPD] persistent or recurring condition impedes normal breathing), asthma (common chronic inflammatory disease of the airways), and a history of extensive burns over 90 percent (%) of his body that occurred in 1990. A further review of Resident 1's clinical records indicated there was no documented evidence the resident was physically seen by a physician from June 4, 2014 through August 11, 2014. There were no documented physician's progress notes in Resident 1's chart from June 4, 2014 through August 11, 2014. On October 2, 2015, at 11:20 a.m., during a review of Resident 1's clinical record and an interview with Licensed Vocational Nurse (LVN) 1, LVN1 stated that initial treatment orders were written by a		a. Medical record designee conducted an audit and review of residents and their attending physician on 11/9 and 11/10/2015. New admissions from 11/4 to 11/13/2015 have their designated attending physicians and approved admissions to skilled nursing facility. No other residents were affected by the deficient practice. b. Medical record designee conducted an audit and review of telephone and physicians' orders and physicians' visits on 11/9 and 11/10/2015. There were 2 attending physicians that were not in compliant. 1 physician needed to signed telephone orders and physician's orders and the other physician was not timely on his visits. Corrections were addressed on both concerns.	

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	treatment nurse or a charge nurse, and then communicated to the assigned physician. LVN 1 stated he had written treatment orders for Resident 1. LVN 1 stated he left a message for Physician 3, but did not remember talking to a physician. LVN 1 further stated since it's a treatment, he would go ahead and do the treatment without talking to the physician. A review of the Physician and Telephone Orders with LVN 1 revealed three treatment orders for Resident 1 dated April 8, 2014, written by LVN 1 but not signed by a physician. A review of the facility's policy, with a revised date of January 1, 2012, and titled, "Physician Supervision of Resident Care and Alternative Visit Schedules," stipulated each resident admitted to the facility must be under the continuing supervision of an attending physician. The policy further stipulated an attending physician would evaluate a resident as needed and at least every 30 days, unless there was an alternate schedule. Another facility's policy, dated January 2004 and titled, "Physician Documentation," indicated part of the physician's responsibilities included writing and/or giving orders and reviewing a resident's total program of care. A review of a Resident 1's care plan, titled, "Respiratory," dated April 8, 2014, and revised and updated, on July 20, 2014, indicated Resident 1 was at risk for respiratory distress due to his diagnoses of COPD and asthma with shortness of breath (SOB). The goal was to minimize the resident's signs and symptoms of respiratory distress on a daily basis. The staff's approaches		a. Telephone orders and physician's orders were hand delivered to one physician on 11/11/2015 b. Two resident changed attending physician per the approval of the responsible parties. Both previous and new attending physicians agreed on the changed per responsible parties request on 11/11/2015 **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:**	

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	included assessing the resident for indications of respiratory distress such as SOB, wheezing (high-pitched whistling sound made when breathing), rhonchi (rattling lung sounds usually caused by secretions), and coughing, if present, and to notify the physician immediately. The staff's approaches also included monitoring the sputum's (mixture of saliva and mucus coughed up from the respiratory tract, typically as a result of infection or other disease) consistency, color, odor, and amount. However, a review of the Licensed Nurses Record forms, dated from April 8, 2014 to August 23, 2014, indicated there was no daily documentation of Resident 1's respiratory assessment, as stipulated in the resident's plan of care as follows: For nine of the 22 days for the month of April 2014 (post readmission). For 27 of the 31 days for the month of May 2014 For 22 of the 30 days for the month of June 2014 For 29 of the 31 days for the month of July 2014 For 13 of the 24 days for the month of August 2014, this included six days prior to Resident 1's documented change in condition (COC) with respiratory problems. In addition, a review of the record revealed no documented nursing notes, from August 19 through August 24, 2014, to indicate the resident's status prior to the resident's COC on August 24, 2014. According to the nursing note dated August 24, 2014, Resident 1 had a change in condition (COC). A review of the COC document, an Interact		The administrator will review and re-educate the process with the admission team (admission coordinator, DON and Medical record director), by 12/4/2015 on the following areas: a. During inquiry intake and after the DON approved the admission. The admission coordinator will verify from discharge planner the name of the attending physician that will follow-up resident at the skilled nursing facility. If there is no physician assigned. The admission coordinator will call family/responsible party if they have a preferred physician that could follow-up the resident. If there is none facility will give at least 3 physician names to the responsible party or family to choose from. Once the physician was chosen. The	

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	Assessment Form ([SBAR] an inter-facility communication record), dated August 24, 2014, and timed at 6:20 a.m., indicated Resident 1 had an acute change in level of consciousness (LOC) and lung congestion (abnormal accumulation of fluid). Resident 1 was assessed and had labored breathing, was lethargic, verbally unresponsive, congested, had an increased heart rate, and a weak pulse. The resident's vital signs were documented as blood pressure of 146/72 (normal reference range [NRR] is 120/80), pulse was 116 beats per minute (NRR is 60 to 100), respirations of 25 per minute (NRR is 16 to 20), and a temperature of 98.4 Fahrenheit [F] (NRR is 98.6). Resident 1's oxygen saturation level (referring to the percentage of oxygen-saturated hemoglobin ([transport oxygen]/ unsaturated + saturated] in the blood), while receiving oxygen at 2-4 liters per minute (PM) via N/C was 95-96%. According to the Medication Administration Record (MAR) for the month of August 2014, Resident 1's oxygen saturation levels generally were documented as 96-97%, while receiving 2-4 liters of oxygen PM via N/C. A review of a charge nurse's narrative note, dated August 24, 2014, indicated at 6:20 a.m., the charge nurse reported to the registered nurse (RN) supervisor that Resident 1 had a change in LOC, had limited verbal response, was lethargic, but was able to state his name. According to the note, a breathing treatment was given to Resident 1 and both Physicians 1 and 2 were paged. At 6:30 a.m., on August 24, 2014, Physician 1 (the resident's physician since June 3, 2014) called back and was informed of Resident 1's status. Physician 1 gave a		admission coordinator will verify with the physician that he/she approves to be the attending physician and approves the admission to the SNF. b. Once the resident is admitted to the facility. Medical record designee will conduct a chart audit review of the required physician visits o Initial visits o Content of visits o Frequency of visits The process will be validated during scheduled IDT admission meeting within 72 hours from admissions. Findings will be reported to the administrator for review and follow-up.	

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	verbal order to transfer Resident 1 to the GACH via 911 paramedics. According to the nurse's narrative, at 7 a.m., on August 24, 2014, Resident 1 was picked up by the paramedics in "fair condition," was non-verbal, but was able to turn his head when his name was called. A review of the Physician and Telephone Orders form, dated August 24, 2014, timed at 6:30 a.m., indicated to transfer Resident 1 to the GACH for medical evaluation due to an acute (sudden) change in LOC and congestion. This order had a line drawn across it with "error" written on it. Another Physician and Telephone Orders form with the same date and time, indicated to transfer Resident 1 to the GACH via 911 paramedics. On September 4, 2014, at 11:30 p.m., there was a clarification of Physician and Telephone Orders of transfer for August 24, 2014, indicating "around" 7:35 a.m., to transfer Resident 1 to the GACH via 911 paramedics due to a change in level of consciousness (LOC) and congestion. A review of the charge nurse's narrative note, dated August 24, 2014, indicated Resident 1 was picked up by 911 paramedics in "fair condition at 7 a.m." However, a review of the paramedics report indicated they were not dispatched until 7:40 a.m., on August 24, 2014, which was over an hour after the physician ordered the 911 transfer. According to the paramedics report, dated August 24, 2014, paramedics were dispatched to the SNF facility at 7:43 a.m., and arrived at 7:45 a.m. The paramedics' report indicated Resident 1 had SOB		Medical records consultant provided training per regulations to the medical records director audit and reviews of the charts on 11/9 and 11/10 on the following areas: • Time of initial visits and frequency of visits of the attending physician o Resident evaluations including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission o The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A	

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	with ALOC (altered level of consciousness) since 6 a.m. that morning, almost two hours prior to the paramedics being dispatched. Resident 1's heart rate was documented by the paramedics at 126 beats per minute (bpm), and had an elevated respiratory rate at 30, and the resident's blood pressure was 128/76. According to the paramedics' report, Resident 1's LOC was altered with a Glasgow Coma Score ([GCS] a neurological scale) of 9 (4=eye; 4=motor; 1=verbal). The resident was not verbally responsive. The paramedics documented rales (rattling in the chest caused by congestion) were heard after Resident 1 was moved to the gurney. A review of the facility's policy, with a revision date of January 1, 2012, and titled, "Change of Condition Notification," stipulated that in an emergency situation the licensed nurse will do the following: "If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to the hospital." The policy's list of emergency situations included a resident experiencing shortness of breath. Resident 1 was documented as experiencing shortness of breath on August 24, 2014 at 6:20 a.m. A review of the GACH's emergency room (ER) note, dated August 24, 2014, indicated at approximately 10 a.m., Resident 1's vital signs were: blood pressure was 135/100, heart rate was 128, respirations were 30 bpm, and the resident's temperature was 97.5 F. The oxygen saturation was 94% while receiving oxygen. A review of the		physician visit is considered timely if it occurs not later than 10 days after the date the visit was required • Content of physician's visits o Review the resident's total program care, including medications and treatments o Write, sign and date progress notes at each visit o Sign and date all orders • Delegation of visits o At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the	

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	056322	A. BUILDING _____ B. WING _____	11/04/2015

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	ER physician's order, dated August 24, 2014, and timed at "1730" (5:30 p.m.), indicated an order to intubate Resident 1 and place him on a ventilator, due to the resident's increase in respiratory distress. The ER physician's admission assessment, dated August 24, 2014, and timed at 2 p.m., indicated Resident 1 was admitted to the GACH with diagnoses that included acute respiratory failure , pneumonia with sepsis, COPD with pulmonary fibrosis [literally "scarring of the lungs"] a respiratory disease in which scars are formed in the lung tissues, leading to serious breathing problems), acute renal failure ([ARF] kidney failure), and multiple decubitus wounds (injuries to skin and underlying tissue resulting from prolonged pressure on the skin). A review of Resident 1's GACH's history and physical (H/P), dated August 24, 2014, indicated the resident was brought to the GACH due to an altered mental status and SOB while in the SNF. According to the H/P, Resident 1 had been coughing, was congested, and had SOB for several days while in the SNF, per the resident's family member (FM). Resident 1 was examined in the ER and was in respiratory distress, with increase in his respiratory and heart rate since arrival, was septic ([infection] with bacteria in the blood), had an acute renal (kidney) failure, and his x-ray indicated the resident had a large right-sided pneumonia (lung infection). A review of the GACH physician's order, dated August 30, 2014, indicated Resident 1 was put on hospice care and expired the same day.		physician and visits by physician assistant, nurse practitioner or clinical nurse specialist Facility administrator and medical director will send letters to physicians of residents at the facility, which includes a copy of regulations and requirements by 11/15/2015. Medical records designee will continue to conduct an audit of required physicians documentations and if not in compliance. The administrator will conduct a follow-up call to the resident's attending physicians and after 2 calls were made and no response. Medical director will be notified and contact the attending physicians.	

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	A review of Department Justice (DOJ) Bureau of Medical Fraud & Elder Abuse Unit's Report of Investigation dated July 8, 2015, which was shared with the Department of Public Health, indicated Investigator 1 had conducted interviews with Resident 1's documented Physician (Physician 3) on June 18, 2015. Investigator 1 asked Physician 3 if he was Resident 1's primary care physician (PCP). Physician 3 indicated that he had never been Resident 1's physician, nor was he associated with the facility, because he has never been to the facility and should have not been listed as the PCP for Resident 1. On September 28, 2015, at 4 p.m., during a telephone interview, Physician 3 stated Resident 1 was not his patient. Physician 3 stated he had never cared for Resident 1 or been to the facility or corresponded with anyone at the facility regarding Resident 1. On November 5, 2015, at 1:50 p.m., during a telephone interview, Physician 1 (who was the facility's Medical Director) stated when he was informed about Resident 1's request to change physicians; he visited the resident the next day, on June 3, 2014. Physician 1 stated he was not aware that Resident 1 did not have a PCP and was not being seen and followed by a physician, until the facility's staff informed him in June 2014. He stated the facility only called him once, on August 24, 2014, regarding Resident 1's change of condition. Physician 1 stated he ordered for the resident to be transferred to the GACH on August 24, 2014.		The administrator will review and validate the medical records audits weekly for follow-up and corrections. **Measures that will be put into place to ensure that this deficiency does not reoccur:** The above POC will be reviewed in the QAA committee for further review and recommendations monthly for 3 months and quarterly thereafter and as needed. Administrator and/or Designee will report trends.	

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	A review of Resident 1's death certificate, indicated the resident expired on August 30, 2014, at 3:08 p.m., and the primary cause of death was bronchopneumonia (inflammation of the lungs, arising in the bronchi or bronchioles [passageways by which air passes through the nose or mouth to the alveoli of the lungs]). A review of an autopsy report, dated September 16, 2014, indicated Resident 1's primary cause of death was bronchopneumonia. The autopsy concluded with the medical examiner-coroner's opinion that after a review of the case circumstances, the resident's medical records, and a complete autopsy, Resident 1's "cause of death is attributed to complications of bronchopneumonia." The facility failed to provide Resident 1 with the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, in accordance with comprehensive assessment and plan of care; to ensure that Resident 1 received proper treatment and care for respiratory problems; to develop a comprehensive care plan for services to attain or maintain the resident's highest practicable physical well-being; to immediately inform and consult with the resident's physician when there was a change in the resident's physical health status; to ensure that each resident remains under the continuing care of a physician and the medical care of each resident is supervised by a physician; and to			

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	develop and implement written policies and procedures that prohibited mistreatment, neglect, and abuse of residents, including but not limited to: Failure to ensure Resident 1, who had a history of respiratory problems, was assessed for signs and symptoms of respiratory distress daily, as indicated in the resident's plan of care. Failure to notify a physician immediately, as stipulated in Resident 1's plan of care, when the resident exhibited respiratory signs and symptoms. Failure to ensure Resident 1 had a primary care physician for supervision and management of the resident's care and services. Failure to ensure physician's orders were obtained before the staff provided care and services to Resident 1. Failure to call 911 paramedics promptly when Resident 1 had a significant change of condition, as ordered by the physician, and as stipulated in the facility's policy and procedures, regarding emergency situations. The above violations either jointly, separately, or in any combination presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of death of Resident 1.			