

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130
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F0000	<p>This visit was for the Investigation of Complaint IN00111918.</p> <p>Complaint IN00111918 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F309, and 328.</p> <p>Unrelated deficiency is cited.</p> <p>Survey date: July 12 and 13, 2012</p> <p>Facility number: 000110 Provider number: 155203 AIM number: 100271120</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 0 SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 13 Medicaid: 56 Other: 3 Total: 72</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for survey ending July 13, 2012. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance.</p>	

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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	accordance with 410 IAC 16.2. Quality review completed 7/16/12 Cathy Emswiller RN				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified timely of an abnormal EKG (electrocardiogram) for 1 of 4 residents reviewed related to physician notification</p>	F0157	F157 It is the practice of this provider to immediately inform the resident, consult with the resident's physician; and if known, notify the residents legal representative or an interested	08/10/2012			

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	<p>in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/12/12 at 1:00 p.m. The record indicated the resident was admitted to the facility on 3/5/12 following discharge from the hospital.</p> <p>The Nurse Practitioner's Note, dated 4/2/12, indicated: O [observation] 90/52, 20, 92, 97.9 [blood pressure, respirations, pulse, temperature]; Neuro [neurological] - sitting in w/c [wheel chair], aphasic; Lungs CTA bil [clear to auscultation bilaterally]; Heart - HR [heart rate] rapid [symbol for about] 96 - 120, occ [occasional] skipped beats; Abd + BS [positive bowel sounds], soft & nontender; Ext [extremities] - [symbol for no] edema; A [assessment] Hypotension - [arrow pointing down - decrease Norvasc 2.5 mg qd [daily]; P [plan] Tachycardia - EKG [electrocardiogram] today; check CBC [complete blood count] BMP [basic metabolic profile]; TSH [thyroid stimulating hormone].</p> <p>Nurse's Notes for 4/2/12 at 2:15 p.m., indicated the resident returned to the facility from the hospital after the EKG and "Awaiting EKG results. [Symbol for no change] in condition. [Symbol for no</p>		<p>family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the residents physical, mental or psychosocial status a need to alter treatment significantly or a decision to transfer.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?The physician assessed resident B and reviewed the EKG on 4/4/12. Family and Physician were notified of results and transfer to the hospital.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?Residents who have diagnostics ordered have the potential to be affected by the alledged practice.Licensed staff will be re-educated on notification of diagnostics results to the physician and residents family by August 10,2012 by the Staff Development Coordinator and or Designee.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice dose not recur?The DNS and/or designee will conduct a audit of diagnostics will be conducted to ensure those residents with abnormal results were reviewed with the physician .The MD telephone order is utilized for physican orders of diagnositic</p>				

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	<p>new skin issues. BP 100/78, Pulse 118 [apical heart rate], Resp [respirations] 16, Temp [temperature] 97.5, O2 [oxygen saturation in the blood] 96%."</p> <p>Nurse's Notes, a late entry for 4/2/12 at 7:50 p.m., indicated the nurse tried multiple times to obtain results of the resident's labs and EKG report. Notes at 9:00 p.m. indicated, "EKG results rec'd [received] from House Supervisor at [name of hospital where EKG was completed]. Attempted to notify MD [physician] X 2 [twice]. LM [left message]. Faxed to [sic] results to office."</p> <p>Nurse's Notes for 4/2/12 at 10:00 p.m. indicated, "[Symbol for no] return phone call from MD at this time."</p> <p>Documentation in Nurse's Notes failed to indicate further contact with the physician related to the EKG report until 4/4/12 at 1:30 p.m. when the physician reviewed the clinical record, examined the resident and ordered direct admission to the hospital.</p> <p>During interview on 7/13/12 at 12:10 p.m., the Administrator indicated the hospital would also have notified the physician of the labs and abnormal EKG.</p>		<p>testing. The MD telephone order will be reviewed in the morning clinical meeting and notification of physician and resident family is recorded on this form.The Interdisciplinary Team(IDT)/House Supervisor and or designee will review the 24 hour report and MD telephone order forms for physician and family notification daily. Licensed staff will be re-educated on notification of diagnostics results to the physician and residents family by August 10,2012 by the Staff Development Coordinator and or Designee.The Director of Nursing is responsible to monitor compliance with resident diagnostics.How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The DNS/designee will conduct the Labs/Diagnostics CQI audit tool weekly for 4 weeks, monthly for 6 .The results of the audits will be presented to the CQI committee monthly for 3 months and quarterly thereafter.The CQI committee will review the data. If the threshold of 95% compliance is not met, an action plan will be developmentBy what date the systemic changes will be completed? August 10, 2012</p>		

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	This federal tag is related to Complaint IN00111918. 3.1-5(a)(3)				

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F0203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State</p>						

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	<p>long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure the Notice of Transfer and Discharge included all required information for 3 of 4 residents reviewed related to transfer and discharge in a sample of 4. (Residents A, B, and C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident A was reviewed on 7/12/12 at 2:25 p.m. The record indicated the resident was admitted on 4/27/12 and discharged to a behavior unit at a local hospital on 5/7/12.</p> <p>The All Staff Behavior Tracking Record, dated 5/6/12, indicated the resident was placed on every 15 minute checks related to the following: "Nurses Comments: Res [resident] became agitated, this nurse approached et [and] asked what was wrong, res began yelling et cursing,</p>	F0203	F203It is the practice of this provider to ensure that before a facility transfers or discharges a resident, the facility must notify the resident and if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move, in writing and in a language and in a manner they understand; record the reasons in the clinical record; and include; section (a)(4)-(6)i. The reason for the transfer or dischargeii. The effective date of the transfer or dischargeiii. The location to which the resident is transferred or dischargediv. A statement that the resident has the right to appeal the action to the state.v. The name, address, and telephone number of the state long term care Ombudsman.vi. For nursing facility residents with a developmental disabilities, the mailing address and telephone	08/10/2012

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	<p>removed res immed [immediately] et when I walked him back to his room res stated to me, 'If I had a gun I could make that room quiet.'"</p> <p>The Notice of Transfer and Discharge, dated 5/7/12, failed to indicate the address of the facility transferred to, the name, address, and phone number of the local Ombudsman and the Facility Contact Name, Facility Contact Title, and Facility Contact Phone Number related the facility's Bed Hold Policy on the Notice of Transfer or Discharge Request for Hearing section of the form.</p> <p>During interview on 7/12/12 at 4:30 p.m., the Director of Nursing indicated the resident was an emergency admission from home. She indicated before he was sent out, little things had begun to annoy him. During interview at this same time, the Administrator in Training indicated the resident "went off in the dining room" on a week-end when she was working. The Director of Nursing indicated the resident's family was not happy the resident was sent to a behavior unit. She indicated she thought the resident returned home after discharge from the behavior unit. The Administrator in Training indicated she understood the resident went to another facility for care.</p>		<p>number of the agency responsible for the protection and advocacy of the developmentally disabled individuals.vii. For nursing facility residents who are mentally ill the mailing address and telephone number of the agency responsible for the protection and advocacy of the mentally ill individual.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?2 of 3 residents no longer reside at the facility. The remaining resident was provided with the revised notice of transfer and discharge and bed hold policy on 7/13/12. This resident subsequently had no questions or concerns related to the bed hold policy and/or notice of transfer and discharge.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?Residents transferring or discharging from the facility have the potential to be affected by this practice.All licensed staff will be inserviced on the policy and procedure for transfer and/or discharge from the nursing facility on or before August 10, 2012 by the Staff Development Coordinator.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The Notice of Transfer and Discharge will be revised to include the</p>				

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	<p>2. The clinical record for Resident B was reviewed on 7/12/12 at 1:00 p.m. The record indicated the resident was admitted to the facility on 3/5/12 and discharged to the hospital on 4/4/12.</p> <p>The Notice of Transfer and Discharge, dated 4/3/12 [sic], failed to indicate the name, address, and phone number of the local Ombudsman and the Facility Contact Name, Facility Contact Title, and Facility Contact Phone Number related the facility's Bed Hold Policy on the Notice of transfer or Discharge Request for Hearing section of the form.</p> <p>3. The clinical record for Resident C was reviewed on 7/12/12 at 3:00 p.m. The record indicated the resident was admitted to the facility on 6/11/12 and transferred to the hospital on 7/2/12.</p> <p>The Notice of Transfer and Discharge, dated 7/2/12, failed to indicate the Date Issued, the Transfer or Discharge Effective Date, the address of the facility the resident was transferred to, and the Reason for Transfer or Discharge.</p> <p>During interview on 7/13/12 at 12:10 p.m., the Administrator indicated the facility had recently revised the Notice of Transfer and Discharge form to include the pre-printed address of the local</p>		<p>appropriate information as described 483.12 (a)(4)-(6) Notice Requirements Before Transfer/Discharge. All licensed staff will be inserviced on the proper completion of the Notice of Transfer/Discharge form. The medical record of the resident(s) who transferred or discharged from the facility will be reviewed by the IDT. The IDT will ensure the transfer and discharge notification is completed properly and proper notifications completed. If non-compliance is identified the employee will receive further disciplinary action. All licensed staff will be in-serviced on the policy and procedure for transfer and/or discharge from the nursing facility on or before August 10, 2012 by the Staff Development Coordinator. The Director of Nursing is responsible to monitor compliance of proper completion of the transfer and discharge notification. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The DNS and/or designee will complete the Hospital Transfer and Discharge CQI tool weekly for 4 weeks, monthly for 6 months. The results of the audits will be presented to the CQI committee monthly for 6 and or until compliance is achieved. The CQI committee will determine the need for further</p>		

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	<p>Ombudsman and contact information for the facility's Bed Hold Policy. She indicated someone had apparently used the unrevised form when the information was not included.</p> <p>3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(F)</p>		<p>review. The CQI committee will review the data. If a threshold of 95% compliance is not met, an action plan will be developed. By what date the systemic changes will be completed? August 10, 2012</p>		

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.</p> <p>Based on record review and interview, the facility failed to ensure the resident was thoroughly and consistently assessed, including vital signs, when the resident experienced a decline in condition, including increased heart rate and decreased blood pressure, abnormal labs, abnormal EKG [electrocardiogram], and need for intravenous fluids. The deficient practice affected 1 of 3 residents reviewed related to discharge to the hospital in a sample of 4 residents. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/12/12 at 1:00 p.m. The record indicated the resident was admitted to the facility on 3/5/12 following discharge from the hospital.</p> <p>The Nurse Practitioner's Note, dated 4/2/12, indicated: O [observation] 90/52, 20, 92, 97.9 [blood pressure, respirations, pulse, temperature]; Neuro [neurological] - sitting in w/c [wheel chair], aphasic;</p>	F0309	F309It is the practice of the provider to 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 care plan.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides at the facility.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?Residents with change in condition have the potential to be affected by this practice.All Licensed staff will be inserviced on or before 8/10/12 on the policy for assessing change in condition, appropriate notification and the required documentation.The staff Development Director and/or designee will conduct the inservice education. What measures will be put into place or what systemic changes will be made to ensure that the deficient	08/10/2012			

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	<p>Lungs CTA bil [clear to auscultation bilaterally]; Heart - HR [heart rate] rapid [symbol for about] 96 - 120, occ [occasional] skipped beats; Abd [abdominal] - + BS [positive bowel sounds], soft & nontender; Ext [extremities] - [symbol for no] edema; A [assessment] Hypotension [low blood pressure] - [arrow pointing down - decrease Norvasc 2.5 mg qd [daily]; P [plan] Tachycardia [rapid heart rate] - EKG [electrocardiogram] today; check CBC [complete blood count] BMP [basic metabolic profile]; TSH [thyroid stimulating hormone]."</p> <p>The Nurse's Notes for 4/2/12 indicated the following:</p> <p>At 2:15 p.m., indicated the resident returned to the facility from the hospital after the EKG and "Awaiting EKG results. [Symbol for no change] in condition. [Symbol for no] new skin issues. BP 100/78, Pulse 118 [apical heart rate], Resp [respirations] 16, Temp [temperature] 97.5, O2 [oxygen saturation in the blood] 96%."</p> <p>At 7:30 p.m., "Late entry. Lab results rec'd [received]. N.P. [name of Nurse Practitioner] notified. N.O. [new order] D5 1/2 NS [dextrose 5% with 1/2 normal saline intravenous solution]. Give 1 liter</p>		<p>practice does not recur? Charge nurses will be responsible for assessing resident status each shift. If a change in the resident condition is identified, the physician and family will be notified. The change in condition will be recorded on the 24 hour reporting sheet. The charge nurses will be responsible for assessing and documenting change in condition in the residents medical record each shift for 72 hours or until the residents condition stabilizes. All Licensed staff will be inserviced on or before 8/10/12 on the policy for assessing change in condition, appropriate notification and the required documentation. The staff Development Director and/or designee will conduct the inservice education. The IDT team will review the 24 hour report each day M-F. The Weekend Supervisor or designee will review on weekends to ensure notification and 72 hour follow-up is completed. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The DNS will complete the Change in Condition CQI tool weekly for 4 weeks, monthly for 6 months.. The results of the audits will be presented to the CQI committee monthly for 6 months and the CQI team will determine need for further</p>				

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	<p>via IV over 6 hours then D5 NS [dextrose 5% with normal saline intravenous solution] 100 cc/hr [cubic centimeters/hour]. Recheck CBC, BMP on Wednesday [4/4/12]...."</p> <p>At 7:50 p.m., "Late entry. This nurse has called [name of local hospital] multiple times trying to get lab results. House supervisor attempting to retrieve results & fax to us."</p> <p>At 8:30 p.m., "#22 gauge [brand name of intravenous catheter] inserted in (L) [left] forearm X 1 [one time] attempt D5 1/2 NS infusing [symbol for without] diff [difficulty]. Res [resident] tol [tolerated] well."</p> <p>At 9:00 p.m., "EKG results rec'd [received] from House Supervisor at [name of hospital where EKG was completed] Attempted to notify MD [physician] X 2 [twice]. LM [left message]. Faxed to [sic] results to office."</p> <p>At 10:00 p.m. indicated, "Cont. [continue] IV [intravenous] fluids to LFA [left forearm] Res in bed. Skin W & D [warm and dry]. Resp [respirations] even and unlabored. [symbol for no] S&S [signs and symptoms] of distress. [Symbol for no] return phone call from</p>		<p>review. The CQI committee will review the data. If the threshold of 95% compliance is not met, an action plan will be developed. By what date will the systemic changes will be completed? August 10, 2012</p>				

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	<p>MD at this time."</p> <p>Documentation in Nurse's Notes failed to indicate further contact with the physician related to the EKG report until 4/4/12 at 1:30 p.m. when the physician visited the resident and ordered direct admission to the hospital.</p> <p>Documentation in Nurse's Notes failed to indicate further assessment of the resident, including vital signs between the resident's return from the EKG test p.m. on 4/2/12 at 2:15 p.m. and 4/3/12 at 2:00 p.m. Documentation also failed to indicate information about care related to the intravenous fluids, including rate per hour of the infusion, and the time of the change of IV fluid types and bags of IV fluids, from the start of IV fluids on 4/2/12 at 8:30 p.m. until 4/3/12 at 2:00 p.m., when the next Nurse's Notes indicated, "BP 100/64, P 98, R 18, T 97.6; IV infusing to LFA [symbol for without] difficulty. Resident resting abed. Skin warm, dry, Resp. unlabored. O2 [oxygen] @ 3 l/m [liters per minute]. Appetite remains very poor. D5 1/2 N/S infusing @ 100 cc/hr. IV site free of S/S infiltration. Incont [incontinent] care provided. Remains very weak."</p> <p>The next Nurse's Note, dated 4/3/12 at 10:00 p.m., indicated, "IV fluids infused.</p>						

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	<p>IV flushed [symbol for without] diff [symbol for no] S/S of infiltration."</p> <p>The next Nurse's Note, dated 4/4/12 at 2:00 a.m., indicated the next assessment of the resident, indicating, "Res. quiet - resp [respiration] easy, non-labored. Lungs CTA [clear to auscultation]. Grimaces at times when moved. Inc. B & B [bowel and bladder] [symbol for with] peri-care prn [as needed]. 84/61, 11, 18, T 100.9 ax [axillary] Tylenol 650 mg given. Will monitor."</p> <p>The Medication Administration Record for April 2012 indicated a transcribed physician's order for "O2 sats [oxygen saturation in the blood] q [every] S [shift] & prn." Documentation for the 4/3/12 for 7:00 p.m. to 7:00 a.m. shift failed to indicate the oxygen saturation was measured that shift.</p> <p>The next Nurse's Note, dated 4/4/12 at 4:30 a.m., indicated the resident's temperature was 99.1 axillary, and blood was drawn and sent to the lab for CBC and BMP.</p> <p>The next Nurse's Note, dated 4/4/12 at 9:00 a.m., indicated, "Call from [name of local hospital] r/t [related to] PH [panic high] of chloride of 129. Will fax results when finished."</p>			

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	<p>The next Nurse's Note, dated 4/4/12 at 10:15 a.m., indicated the lab results were faxed and called to the physician's office, and the nurse was advised the physician would visit that day and review the labs at that time.</p> <p>Documentation in Nurse's Notes for 4/4/12 at 1:30 p.m. indicated the physician reviewed the clinical record, examined the resident and ordered direct admission to the hospital .</p> <p>The hospital History and Physician, dated 4/4/12, indicated, "...admitted with marked hypernatremia secondary to severe dehydration, due to the fact that she has been eating and drinking little, if anything, for the last several days, if not weeks...."</p> <p>During interview on 7/13/12 at 12:10 p.m., the Director of Nursing indicated vital signs should be measured "every shift," which at the time of the resident's change in condition, was every twelve hours. She indicated she might find more information related to the resident's care between 4/2 and 4/4/12 on the 24 Hour Reports for the resident's unit, and provided the reports. She also indicated the Monthly Vital Sign Monitoring Log in the resident's record might indicate vital</p>				

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	<p>signs taken on the "night shift" during this period. Review of the Monthly Vital Sign Monitoring Log indicated vital signs were measured on 4/2/12; however, documentation did not indicate a time the assessment was completed. Review of the 24 Hour Report provided no further information related to the assessments and care of the resident.</p> <p>This federal tag is related to Complaint IN00111918.</p> <p>3.1-37(a)</p>				

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure intravenous therapy included ongoing assessment of the resident's care for 1 of 1 resident reviewed related to intravenous therapy in a sample of 4 residents. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/12/12 at 1:00 p.m. The record indicated the resident was admitted to the facility on 3/5/12 following discharge from the hospital.</p> <p>The Nurse Practitioner's Note, dated 4/2/12, indicated: O [observation] 90/52, 20, 92, 97.9 [blood pressure, respirations, pulse, temperature]; Neuro [neurological] - sitting in w/c [wheel chair], aphasic; Lungs CTA bil [clear to auscultation bilaterally]; Heart - HR [heart rate] rapid [symbol for about] 96 - 120, occ</p>	F0328	<p>F328 It is the practice of the provider to ensure that residents receive the proper treatment and care for the following special services;injections, Parenteral and entereral fluids, colostomy, urostomy, or ileostomy care. Tracheostomy care, tracheal care, suctioning, respiratory care, foot care, prostheses.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?Resident B no longer resides at the facility.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?Residents with physician orders for IV therapy have the potential to be affected by this alledged practice.All Licensed staff will be inserviced on or before 8/10/12 on the IV assessment criteria, frequency of the assessment and documentation guidelines for this</p>	08/10/2012			

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	<p>[occasional] skipped beats; Abd [abdominal] + BS [positive bowel sounds], soft & nontender; Ext [extremities] - [symbol for no] edema; A [assessment] Hypotension [low blood pressure] - [arrow pointing down - decrease Norvasc 2.5 mg qd [daily]; P [plan] Tachycardia [rapid heart rate] - EKG [electrocardiogram] today; check CBC [complete blood count] BMP [basic metabolic profile]; TSH [thyroid stimulating hormone]."</p> <p>The Nurse's Notes for 4/2/12 indicated the following:</p> <p>7:30 p.m., "Late entry. Lab results rec'd [received]. N.P. [name of Nurse Practitioner] notified. N.O. [new order] D5 1/2 NS [dextrose 5% with 1/2 normal saline intravenous solution]. Give 1 liter via IV over 6 hours then D5 NS [dextrose 5% with normal saline intravenous solution] 100 cc/hr [cubic centimeters/hour]. Recheck CBC, BMP on Wednesday [4/4/12]...."</p> <p>At 8:30 p.m., "#22 gauge [brand name of intravenous catheter] inserted in (L) [left] forearm X 1 [one time] attempt D5 1/2 NS infusing [symbol for without] diff [difficulty]. Res [resident] tol [tolerated] well."</p>		<p>service. The Staff Development Coordinator and or designee will conduct the in-service education. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Charge nurses will be responsible for assessing, providing treatment for IV therapy per physician orders and ongoing assessment of resident change in condition. The charge nurse will address the change in condition on each shift to include but not limited to IV therapy. The charge nurse identifying the order for IV therapy will address the change on the 24-hour condition report, in the nurses notes and add it to the Hot Charting list in the 24 hour book. The charge nurses will be responsible for assessing and documenting the on going assessment in the nurses note each shift until residents condition stabilizes. The IDT team will review the Hot Charting report each day M-F. The Weekend Supervisor or designee will review on weekends to ensure appropriate follow-up is completed and an on- going assessment is completed and documented as deemed appropriate. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The DNS will complete</p>				

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	<p>At 10:00 p.m. indicated, "Cont. [continue] IV [intravenous] fluids to LFA [left forearm] Res in bed. Skin W & D [warm and dry]. Resp [respirations] equal and unlabored. [symbol for no] S&S [signs and symptoms] of distress. [Symbol for no] return phone call from MD at this time."</p> <p>Documentation in Nurse's Notes failed to indicate other information in regard to care related to the intravenous fluids, including rate per hour, and the time of the change of IV fluid types, and bags of IV fluids, from the start of IV fluids on 4/2/12 at 8:30 p.m. until 4/3/12 at 2:00 p.m., when the next Nurse's Notes indicated, "BP 100/64, P 98, R 18, T 97.6; IV infusing to LFA [symbol for without] difficulty. Resident resting abed. Skin warm, dry, Resp. unlabored. O2 [oxygen] @ 3 l/m [liters per minute]. Appetite remains very poor. D5 1/2 N/S infusing @ 100 cc/hr. IV site free of S/S infiltration. Incont [incontinent] care provided. Remains very weak."</p> <p>The next Nurse's Note, dated 4/3/12 at 10:00 p.m., indicated, "IV fluids infused. IV flushed [symbol for without] diff [symbol for no] S/S of infiltration."</p> <p>During interview on 7/12/12 at 3:45 p.m., the Medical Records Nurse indicated the</p>		<p>the Parenteral Therapy CQI tool weekly for 4 weeks, monthly for 6months.The results of the audits will be presented to the CQI committee monthly for 6 months and the CQI committee will determine need for further review.The CQI committee will review the data. If the threshold of 95% compliance is not met, an action plan will be developed.By what date the systemic changes will be completed? August 10, 2012</p>		

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	<p>facility did not maintain a separate flow sheet when intravenous fluids were administered. She indicated all information related to the fluid administration is on the Medication Administration Record.</p> <p>Resident B's Medication Administration Record for April 2012 indicated two entries for IV fluids, as follows: "D5 1/2 NS. Give 1 liter via IV over 6 hours then [arrow pointing down to next entry] D5 NS 100 cc/hr for 2 liters IV." Nurse's initials were indicated as follows: 4/2/12 from 7:00 p.m. to 7:00 a.m. 4/3/12 from 7:00 p.m. to 7:00 a.m. and 7:00 p.m. Documentation failed to indicate flow rates for the first six hours. Documentation failed to indicate the changes in types of fluids, or any change of bags of fluids.</p> <p>The facility's pharmacy policies and procedures manual, including IV policies, was provided by the Medical Records Nurse on 7/13/12 at 11:05 a.m. Review of the policy indicated, "A. Intravenous Administration Policy, Adults; ...4. a. Assessment Criteria for a patient with an IV infusion must include: 1) Verification that the patient, the fluid and the drip rate are correct. 2) Expiration date of solution and tubing. 3) Examination of the area proximal to insertion site for signs of</p>				

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	<p>redness, swelling, pain (persistent) leakage, infiltration, phlebitis or purulence. 4) Condition of dressing must also be assessed....b. Frequency of Assessment includes: 1) Every 4 hours while fluids are infusing....4) When changing IV fluids (i.e., new or same solution).... B. Insertion of a Peripheral IV; Documentation: Initial Documentation: Includes...type of solution, flow rate, and type of infusion control.... Every Shift Documentation: ...Condition of catheter and dressing; patency of catheter...flow rate...."</p> <p>This federal tag is related to Complaint IN00111918.</p> <p>3.1-37(a)(2)</p>				