

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2012
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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN 47031
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F0000	<p>This visit was for Investigation of Complaint IN00116087.</p> <p>Complaint IN00116087 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250, F279, F319 and F508.</p> <p>Survey dates: September 26 and 27, 2012</p> <p>Facility number: 000420 Provider number: 155730 AIM number: 100266230</p> <p>Survey team: Gloria J. Reisert MSW</p> <p>Census bed type SNF/NF: 94 Residential: 12 Total: 106</p> <p>Census payor type: Medicare: 12 Medicaid: 66 Other: 28 Total: 106</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. This plan of correction is filed as evidence of this facilities desire to comply with regulatory requirements and provide quality care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal law. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-22-12. I would like to request paper compliance for this survey.</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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	IAC 16.2. Quality review 10/03/12 by Suzanne Williams, RN				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to provide medically related social services to assist a resident who was having fluctuating cognitive and mood status with auditory/visual hallucinations and after an alleged attempt to jump out of a car.(Resident #A). This deficient practice affected 1 of 7 residents reviewed for Social Services in a sample of 7 residents.</p> <p>Findings include:</p> <p>Review of the closed clinical record for Resident #A on 9/27/2012 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus type 2, end stage renal failure with dialysis, hypertension and chronic pain.</p> <p>A 6/30/2012 nursing note at 6:20 p.m. indicated the resident's family member contacted the facility to let them know she was sitting on the side of the highway in her car trying to get the resident back into her car. She indicated she had pulled over as the</p>	F0250	<p>It is the intent of this facility is to provide medically related social services to assist all residents who are having fluctuations in cognitive and mood status with auditory/visual hallucinations.</p> <ol style="list-style-type: none"> 1. Corrective action for affected Resident – For Resident A psych services provided on 7-19-12. 2. Other Residents with the potential to be affected – Audit completed by Social Service 10-15-12 and residents with alterations in mood and behaviors referred to psych services. 3. Measures to prevent reoccurrence – In-service for Social Service Director and Designee on referring residents with fluctuating cognitive and mood status, auditory/visual hallucination,alleged attempt to harm self to psych services. Social Service Director and/or Designee will listen to report in daily am meeting, and review behavior management flow sheets daily 4. Monitoring of corrective action – Social Service Directive/Designee will monitor alterations in resident mood and behavior through reviewing the Behavior management program, clinical record review and 24 hour reports. Social Service 	10/22/2012	

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	<p>resident threatened to jump out of the car and now the resident would not get into the car as she did not recognize her family member nor the car.</p> <p>The note indicated the nurse could hear the resident screaming in the background and the family member was informed to call 911 for the safety of the resident. The family member indicated she would, but really did not want to do that to the resident.</p> <p>The note then indicated another family was called and informed the nurse he was aware of the situation and that if the other family member could not get her into the car after one more try, then he would go and get her. At 6:45 p.m., the resident and her daughter returned to the facility.</p> <p>A nursing note at 7:45 p.m. indicated the physician was notified of the situation who then ordered the resident be sent to the hospital emergency room for medical and psychiatric evaluations. At this time, the family member indicated there was something wrong with the resident and that she had given the resident some oranges, and the resident had eaten the peeling.</p>		<p>Director/Designee will report to QA&A Committee monthly on residents referred for psych services and with residents progress towards stabilization of mood and behavior. This will occur through the next 12 months. The QA&A Committee will review the progress October 2013. 5. Date systemic changes will be completed and who will be responsible – Social Services Director/Designee will be responsible for referring residents with fluctuating cognitive and mood, auditory/visual hallucinations, alleged attempt to self-harm to psych services.</p>		

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	<p>The physician orders for June 2012 indicated the resident was on a renal diet due to dialysis and on a 1200 cc [cubic centimeter] fluid restriction - oranges were not allowed on this diet.</p> <p>Review of the 6/30/2012 Resident Transfer notice which accompanied the resident to the hospital indicated: "Condition & Reason for Transfer - [change] in mental status . Repeated verbalizations of 'I want to kill myself.'" "Orders for Medications, Treatments, Therapy:...Sent to [name of hospital] ER [emergency room] 6/30/12 @ [at] 12 A r/t [related to] agitation & mental status [changes]."</p> <p>A nursing note dated 7/1/2012 at 0250 [2:50 a.m.] indicated the hospital called the facility and indicated the resident was without agitation during the assessment and family member who accompanied her to the ER was now claiming that the previous episode involving the car was misunderstood and did not happen. The hospital indicated they did not do a psychiatric evaluation and were returning the resident to the facility as soon as transportation could be arranged.</p> <p>At 5:15 a.m., the resident returned to the facility and asked the nurse if she</p>				

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	<p>was tired because "you drove me all around in the van."</p> <p>During an interview with Social Worker #3 on 9/27/2012 at 4:20 p.m., she indicated Social Worker #1 and #2, who were initially assigned to the resident for the provision of Social Services, should have made a referral at that time to the psychiatric group who consulted with the facility, as well as the resident having been seen prior to this incident due to the resident had a long history of non-compliance with care and following fluid/diet restrictions and fluctuating mood status.</p> <p>A psychiatric referral was made by Social Worker #3 on 7/19/2012 for the resident to be seen as soon as possible, and the resident was seen on 7/30/2012.</p> <p>Review of the Social Service notes indicated a note dated 7/2/2012 by Social Worker #1 in which she made reference to the incident on 6/30/2012 and indicated the facility was to have a meeting with the family the next day to discuss restricting visitation outside of facility, call resident on more frequent basis and to reinforce resident's living situation in a positive manner.</p>						

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	<p>Documentation was lacking of Social Service interventions with the resident to address her mood issues and the incident on 6/30/2012 in which the resident allegedly threatened to jump out of the car while it was moving.</p> <p>Review of the 8/3/2012 MDS [Minimum data Set] 3.0 Social Service Progress Note: Resident Interview, indicated Social Worker #2 referenced several nursing notes in which the resident had displayed behavioral issues:</p> <p>- "8/1/2012 - res. disruptive & attention-seeking since writer arrived @ 1800 (6:00 p.m.). Resident pounding on tables & windows. Res. [resident] talking to empty w/c [wheelchair] saying 'your mommy doesn't take very good care of you.' Resident with confusion upon talking to objects as if they were people."</p> <p>- "8/1/2012 - Res. in common area yelling 'please please take me to my son's house. I'll give you whatever you want, don't you care about me?'" Refused offers of snacks stating 'I don't want your damn food.' Res yelling 'open this door for me. I'm going to my sister's, I'm trying to leave, no body will help me.'"</p>						

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	<p>- "8/3/2012 - Res in common area yelling that she wanted to go home."</p> <p>Under "Change of Behavior/Other Symptoms," Social Worker #2 indicated there was no change in the resident's behaviors, and there were no concerns.</p> <p>Review of the nursing notes for 8/10/12, 8/13/2012, 8/16/12, 8/17/12 and 8/20/2012, indicated the following entries were made:</p> <p>- "8/10/2012 - 9p : resident arrives back to facility via [ambulance company] @ this time. resident yelling 'Help me, Help me'. She conts [continues] 'They kidnapped me.' Writer explained to resident that the ambulance took her to get a chest X-ray and she states 'I didn't get an X-ray'. She adds 'They had a gun pointed @ me.' Resident grabbing @ writer's wrist and yelling 'Don't leave me alone. They will kidnap me again.'" Writer got resident transferred to w/c [wheelchair] @ this time. [Ambulance] medics reported to writer that resident's SpO2 [O2 saturation]. dropped down into the the 80's during the transport back from [hospital]. Medics added that resident's HR [heart rate] [increased] above the 100's. Medics reported increasing O2 to 4 L. Medics reported to writer that</p>						

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	<p>they had to pull over @ one point D/T [due to] resident's unbuckling self from stretcher and attempting to crawl down..."</p> <p>- "8/13/2012 - 9:30 pm : Res sitting in recliner @ this time... SpO2 75% RA [room air], 2 L of O2 via NC [nasal cannula] applied @ this time per order - 95% @ 2 L via NC. Rhonchi noted t/o all lobes. res voice remains hoarse. resident noted to be talking to people much of night that were not present. Redirection attempted X 5 [with] [no] success. Resident cont'd [continued] speaking to people that were [not] there."</p> <p>- "8/16/2012 - 2 pm (late entry for 12 pm): Res requested to call her children X [times] 4...Resident stated [with] tearfulness 'I'm not going to make it another day. My children need to take me home.' Asked nurse to borrow vehicle & drive her and drop her off @ [family member's name] house. Unable to re-direct anxiety..."</p> <p>- "8/17/2012 - 3:40 pm: Returned from dialysis tearful & requesting to call children stating 'let me leave', 'I need to get out of here.'...Placed in recliner, requested to get back in w/c d/t [due to] she had to leave now. Resident confused - unable to reason</p>			

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	<p>with..."</p> <p>- "8/20/2012 - [11:30 p.m.]: ...Res repeatedly saying t/o [throughout] evening that a big fat man sat on her bed earlier & ate 2 bags of her bananas & oranges..."</p> <p>Further review of the nursing notes between 8/21 and 9/4/2012 indicated the resident was experiencing more and more episodes of attention-seeking behaviors in which she wanted staff with her all the time, changing her mind or refusing care when staff attempt to fulfill her requests, non-compliance with fluid/food restrictions, and requests to call her family.</p> <p>Documentation was lacking in the Social Service notes by Social Worker #2 of having addressed these episodes of increased confusion and anxiety nor having reported them to the psychiatrist.</p> <p>During an interview with Social Worker #3 on 9/27/2012 at 4:20 p.m., she indicated she or the psychiatrist should have been made aware by Social Worker #2 of these episodes.</p> <p>This Federal tag is related to Complaint IN00116087.</p>						

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 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).</p> <p>Based on record review and interview, the facility failed to develop care plans which addressed a resident's fluctuating cognitive and mood status with auditory/visual hallucinations and after an alleged episode of attempting to jump out of a car. This deficient practice affected 1 of 7 residents reviewed for Social Service care plans in a sample of 7 residents. (Resident #A)</p> <p>Finding includes: Review of the closed clinical record</p>	F0279	<p>It is the intent of this facility to develop care plans which address residents fluctuating cognitive and mood status, auditory/visual hallucinations, alleged attempt to self-harm. 1. Corrective action taken for affected Resident – The facility is unable to correct Resident A care plan. 2. Corrective action for other Residents potentially affected – Audit was completed and Residents identified without a care plan addressing Residents mood and behavior, auditory/visual hallucinations a care plan was provided. 3. Systematic changes to ensure</p>	10/22/2012	

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	<p>for Resident #A on 9/27/2012 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to, diabetes mellitus type 2, end stage renal failure with dialysis, hypertension and chronic pain.</p> <p>The 6/8/2012 Quarterly Mnimum Data Set [MDS] Assessment indicated the resident had a slight decline in cognitive status with some impairments in long and short memory; and was experiencing hallucinations with occasional disruptive behavior not directed towards others.</p> <p>A 6/30/2012 nursing note at 6:20 p.m. indicated the resident's family member contacted the facility to let them know she was sitting on the side of the highway in her car trying to get the resident back into her car. She indicated she had pulled over as the resident threatened to jump out of the car and now the resident would not get into the car as she did not recognize her family member nor the car.</p> <p>The note indicated the nurse could hear the resident screaming in the background and the family member was informed to call 911 for the safety</p>		<p>deficient practice does not reoccur - In-service for Social Service Director and Designee completed on 10-17-12 for care planning Residents mood and behavior, auditory/visual hallucination. During care plan meetings, Social Service Director/Designee/IDT will review Resident care plans addressing mood and behavior, auditory/visual hallucinations.</p> <p>4. Monitoring of corrective action to ensure deficient practice does not reoccur – Social Service Director/Designee will review each residents care plan related to mood and behavior, visual/auditory hallucinations with each MDS assessment and with every episode of resident escalation of behaviors. Social Services Director/Designee will report to QA&A Committee monthly results of audits of care plans related to residents mood and behavior, auditory/visual hallucinations for six months. The QA&A Committee will review progress in April 2013. 5. Date systematic changes will be completed and who will be responsible – Social Services Director/Designee will be responsible for compliance of care planning Residents mood and behavior, auditory/visual hallucinations.</p>		

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	<p>of the resident. The family member indicated she would, but really did not want to do that to the resident.</p> <p>The note then indicated another family was called and informed the nurse he was aware of the situation and that if the other family member could not get her into the car after one more try, then he would go and get her. At 6:45 p.m., the resident and her daughter returned to the facility.</p> <p>A nursing note at 7:45 p.m. indicated the physician was notified of the situation who then ordered the resident be sent to the hospital emergency room for medical and psychiatric evaluations. At this time, the family member indicated there was something wrong with the resident and that she had given the resident some oranges and the resident had eaten the peeling.</p> <p>The physician orders for June 2012 indicated the resident was on a renal diet due to dialysis and on a 1200 cc [cubic centimeter] fluid restriction - oranges were not allowed on this diet.</p> <p>Review of the 6/30/2012 Resident Transfer notice which accompanied the resident to the hospital indicated: "Condition & Reason for Transfer -</p>						

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	<p>[change] in mental status . Repeated verbalizations of "I want to kill myself." "Orders for Medications, Treatments, Therapy:...Sent to [name of hospital] ER [emergency room] 6/30/12 @ [at] 12 A r/t [related to] agitation & mental status [changes]."</p> <p>A nursing note dated 7/1/2012 at 0250 [2:50 a.m.] indicated the hospital called the facility and indicated the resident was without agitation during the assessment and family member who accompanied her to the ER was now claiming that the previous episode involving the car was misunderstood and did not happen. The hospital indicated they did not do a psychiatric evaluation and were returning the resident to the facility as soon as transportation could be arranged.</p> <p>At 5:15 a.m., the resident returned to the facility and asked the nurse if she was tired because "you drove me all around in the van."</p> <p>Review of the Social Service notes indicated a note dated 7/2/2012 by Social Worker #1 in which she made reference to the incident on 6/30/2012 and indicated the facility was to have a meeting with the family the next day to discuss restricting</p>			

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	<p>visitation outside of facility, call resident on more frequent basis and to reinforce resident's living situation in a positive manner.</p> <p>Documentation was lacking of Social Service care plans which addressed the resident's mood and behavior issues, including the incident on 6/30/2012 in which the resident allegedly threatened to jump out of the car while it was moving.</p> <p>During an interview with Social Worker #3 on 9/27/2012 at 4:20 p.m., she indicated she or the psychiatrist should have been made aware by Social Worker #2 of these episodes.</p> <p>This Federal tag is related to Complaint IN00116087.</p> <p>3.1-35(a)</p>						

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F0319 SS=D	<p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>Based on record review and interview, the facility failed to ensure a resident who was experiencing fluctuations in cognitive and mood status with auditory/visual hallucinations and after an alleged attempt to jump out of a car, received appropriate treatment and services to attain and maintain the highest level of mental and psychosocial functioning when away from family members (Resident #A). This deficient practice affected 1 of 7 residents reviewed for overall changes in physical and mental health in a sample of 7 residents.</p> <p>Finding includes:</p> <p>Review of the closed clinical record for Resident #A on 9/27/2012 at 10:00 a.m., indicated the resident was recently re-admitted after an acute hospital stay between 3/16 and 3/18/2012, and had diagnoses which included, but were not limited to, diabetes mellitus type 2, end stage</p>	F0319	<p>It is the intent of this facility to ensure all Residents who are experiencing fluctuations in cognitive and mood status with auditory/visual hallucinations and after an alleged attempt to self-harm to receive appropriate treatment and services to attain and maintain the highest mental and psychosocial well-being,</p> <ol style="list-style-type: none"> 1. Corrective action for affected Resident – For Resident A psych services provided on 7-19-12. 2. Other Residents with the potential to be affected – Audit completed by Social Services on 10-03-12 and residents with alteration in mood and behaviors referred to psych services as needed. 3. Measures to prevent reoccurrence – In-service for Social Service Director and Designee on referring residents with fluctuating cognitive and mood status, auditory/visual hallucinations, alleged attempt to harm self to psych services. Social Service Director and Designee will listen to report in daily am meeting, review behavior management flow sheets monthly. 4. Monitoring of corrective action – Social Service 	10/22/2012	

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	<p>renal failure with dialysis, hypertension and chronic pain.</p> <p>The 6/8/2012 Quarterly Minimum Data Set [MDS] Assessment indicated the resident had a slight decline in cognitive status with some impairments in long and short memory; and was experiencing hallucinations with occasional disruptive behavior not directed towards others.</p> <p>A 6/30/2012 nursing note at 6:20 p.m. indicated the resident's family member contacted the facility to let them know she was sitting on the side of the highway in her car trying to get the resident back into her car. She indicated she had pulled over as the resident threatened to jump out of the car and now the resident would not get into the car as she did not recognize her family member nor the car.</p> <p>The note indicated the nurse could hear the resident screaming in the background and the family member was informed to call 911 for the safety of the resident. The family member indicated she would, but really did not want to do that to the resident.</p> <p>The note then indicated another</p>		<p>Directive/Designee will monitor alterations in resident mood and behavior through reviewing the Behavior Management Program, clinical record review and 24 hour reports. Social Service Director/Designee will report to QA&A Committee monthly on residents referred for psych services and with residents progress towards stabilization of mood and behavior through October 2013. QA&A Committee will review the progress at this time. 5. Date systemic changes will be completed and who will be responsible – Social Services Director/Designee will be responsible for referring residents with fluctuating cognitive and mood, auditory/visual hallucinations, alleged attempt to self-harm to psych services.</p>		

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	<p>family was called and informed the nurse he was aware of the situation and that if the other family member could not get her into the car after one more try, then he would go and get her. At 6:45 p.m., the resident and her daughter returned to the facility.</p> <p>A nursing note at 7:45 p.m. indicated the physician was notified of the situation who then ordered the resident be sent to the hospital emergency room for medical and psychiatric evaluations. At this time, the family member indicated there was something wrong with the resident and that she had given the resident some oranges, and the resident had eaten the peeling.</p> <p>The physician orders for June 2012 indicated the resident was on a renal diet due to dialysis and on a 1200 cc [cubic centimeter] fluid restriction - oranges were not allowed on this diet.</p> <p>Review of the 6/30/2012 Resident Transfer notice which accompanied the resident to the hospital indicated: "Condition & Reason for Transfer - [change] in mental status . Repeated verbalizations of 'I want to kill myself.'" "Orders for Medications, Treatments, Therapy:...Sent to [name of hospital] ER [emergency room]</p>						

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	<p>6/30/12 @ [at] 12 A r/t [related to] agitation & mental status [changes]."</p> <p>A nursing note dated 7/1/2012 at 0250 [2:50 a.m.] indicated the hospital called the facility and indicated the resident was without agitation during the assessment and family member who accompanied her to the ER was now claiming that the previous episode involving the car was misunderstood and did not happen. The hospital indicated they did not do a psychiatric evaluation and were returning the resident to the facility as soon as transportation could be arranged.</p> <p>At 5:15 a.m., the resident returned to the facility and asked the nurse if she was tired because "you drove me all around in the van."</p> <p>During an interview with Social Worker #3 on 9/27/2012 at 4:20 p.m., she indicated Social Worker #1 and #2, who were initially assigned to the resident for the provision of Social Services, should have made a referral at that time to the psychiatric group who consulted with the facility, as well as the resident having been seen prior to this incident due to the resident had a long history of non-compliance with care and</p>						

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	<p>following fluid/diet restrictions and fluctuating mood status.</p> <p>A psychiatric referral was made by Social Worker #3 on 7/19/2012 for the resident to be seen as soon as possible, and the resident was seen on 7/30/2012.</p> <p>Review of the Social Service notes indicated a note dated 7/2/2012 by Social Worker #1 in which she made reference to the incident on 6/30/2012 and indicated the facility was to have a meeting with the family the next day to discuss restricting visitation outside of facility, call resident on more frequent basis and to reinforce resident's living situation in a positive manner.</p> <p>Documentation was lacking of Social Service interventions with the resident to address her mood issues and the incident on 6/30/2012 in which the resident allegedly threatened to jump out of the car while it was moving.</p> <p>Review of the 8/3/2012 MDS [Minimum data Set] 3.0 Social Service Progress Note: Resident Interview, indicated Social Worker #2 referenced several nursing notes in which the resident had displayed behavioral issues:</p>						

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	<p>- "8/1/2012 - res. disruptive & attention-seeking since writer arrived @ 1800 (6:00 p.m.). Resident pounding on tables & windows. Res. [resident] talking to empty w/c [wheelchair] saying 'your mommy doesn't take very good care of you.' Resident with confusion upon talking to objects as if they were people."</p> <p>- "8/1/2012 - Res. in common area yelling 'please please take me to my son's house. I'll give you whatever you want, don't you care about me?' Refused offers of snacks stating 'I don't want your damn food.' Res yelling 'open this door for me. I'm going to my sister's, I'm trying to leave, no body will help me.'"</p> <p>- "8/3/2012 - Res in common area yelling that she wanted to go home."</p> <p>Under "Change of Behavior/Other Symptoms," Social Worker #2 indicated there was no change in the resident's behaviors, and there were no concerns.</p> <p>Review of the nursing notes for 8/10/12, 8/13/2012, 8/16/12, 8/17/12 and 8/20/2012, indicated the following entries were made: - "8/10/2012 - 9p : resident arrives back to facility via [ambulance</p>						

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	<p>company] @ this time. resident yelling 'Help me, Help me'. She conts [continues] 'They kidnapped me.' Writer explained to resident that the ambulance took her to get a chest X-ray and she states 'I didn't get an X-ray'. She adds 'They had a gun pointed @ me.' Resident grabbing @ writer's wrist and yelling 'Don't leave me alone. They will kidnap me again.'" Writer got resident transferred to w/c [wheelchair] @ this time. [Ambulance] medics reported to writer that resident's SpO2 [O2 saturation]. dropped down into the the 80's during the transport back from [hospital]. Medics added that resident's HR [heart rate] [increased] above the 100's. Medics reported increasing O2 to 4 L. Medics reported to writer that they had to pull over @ one point D/T [due to] resident's unbuckling self from stretcher and attempting to crawl down..."</p> <p>- "8/13/2012 - 9:30 pm : Res sitting in recliner @ this time... SpO2 75% RA [room air], 2 L of O2 via NC [nasal cannula] applied @ this time per order - 95% @ 2 L via NC. Rhonchi noted t/o all lobes. res voice remains hoarse. resident noted to be talking to people much of night that were not present. Redirection attempted X 5 [with] [no] success. Resident cont'd</p>			

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	<p>[continued] speaking to people that were [not] there."</p> <p>- "8/16/2012 - 2 pm (late entry for 12 pm): Res requested to call her children X [times] 4...Resident stated [with] tearfulness 'I'm not going to make it another day. My children need to take me home.' Asked nurse to borrow vehicle & drive her and drop her off @ [family member's name] house. Unable to re-direct anxiety..."</p> <p>- "8/17/2012 - 3:40 pm: Returned from dialysis tearful & requesting to call children stating 'let me leave', 'I need to get out of here.'...Placed in recliner, requested to get back in w/c d/t [due to] she had to leave now. Resident confused - unable to reason with..."</p> <p>- "8/20/2012 - [11:30 p.m.]: ...Res repeatedly saying t/o [throughout] evening that a big fat man sat on her bed earlier & ate 2 bags of her bananas & oranges..."</p> <p>Further review of the nursing notes between 8/21 and 9/4/2012 indicated the resident was experiencing more and more episodes of attention-seeking behaviors in which she wanted staff with her all the time, changing her mind or refusing care</p>			

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	<p>when staff attempt to fulfill her requests, non-compliance with fluid/food restrictions, and requests to call her family.</p> <p>Documentation was lacking in the Social Service notes by Social Worker #2 of having addressed these episodes of increased confusion and anxiety nor having reported them to the psychiatrist.</p> <p>During an interview with Social Worker #3 on 9/27/2012 at 4:20 p.m., she indicated she or the psychiatrist should have been made aware by Social Worker #2 of these episodes.</p> <p>This Federal tag is related to Complaint IN00116087.</p> <p>3.1-43(a)(1)</p>						

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F0508 SS=D	<p>483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to obtain chest x-ray results in a timely manner for a resident who had been displaying increasing signs/symptoms of an upper respiratory infection in order to determine need for continuing or changing course of treatment. This deficient practice affected 1 of 6 residents reviewed for timeliness of X-ray results in a sample of 7 residents. (Resident #A)</p> <p>Findings include:</p> <p>Review of the closed clinical record for Resident #A on 9/27/2012 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to, diabetes mellitus type 2, end stage renal failure with dialysis, hypertension and chronic pain.</p> <p>Review of the nursing notes between 8/8/2012 and 8/14/2012, included the following entries: - "8/8/2012 - 3:45 [p.m.]: Res [resident] noted [with] an occ</p>	F0508	<p>It is the intent of this facility to obtain chest x-ray results in a timely manner. 1. Corrective Action to affective Resident – The vendor informed this facility a directive was initiated on 8-6-12 to only fax/send results of chest x-rays to physicians only and not to facilities. This facility notified vendor that this facility is required to have results of chest x-rays in a timely manner. Vendor informed facility directive has been stopped. 2. Corrective action taken for other Residents – An audit was completed and no other Residents identified. 3. Measure to ensure deficient practice does not recur – In-service for licensed nurses completed on 10-18-12 to inform licensed nurses track chest x-ray results by writing chest x-ray on 24 hour report and if facility has not received chest x-ray results within 24 hours licensed nurse to call vendor for results. DON/Designee to review 24 hour reports and the clinical daily to ensure chest x-ray results are received timely. 4. Monitoring to ensure the practice will not recur – The DON/Designee will report to monthly QA&A</p>	10/22/2012

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	<p>[occasional] [non] productive cough. [No] SOB [shortness of breath] Temp [temperature] 98.0. O2 94% RA [room air] . LS [lung sounds] [with] exp [expiratory] [upper] lobe wheezes. Res c/o [complains] a sore throat. MD [medical doctor] updated."</p> <p>- "8/8/2012 - 4 pm: Res noted to have hoarse voice starting and c/o 'lungs hurt when I cough.' Denies pain only 'when coughing it hurts.'"</p> <p>- "8/8/2012 - 1900 [7:00 p.m.]: Res in sun room, stating she doesn't feel well. Mod [moderate] amt [amount] yellow-tan emesis earlier in shift...O2 SAT [saturation] 87%, O2 applied @ [at] 2 L/NC [liters per nasal cannula], sats [up] to 93%..."</p> <p>- "8/10/2012 - 3 pm: Returned to facility (from dialysis). O2 @ 2.5 L/min. Stated she felt better."</p> <p>- "8/10/2012 - 6 pm: N.O. [new order] received for CXR [chest x-ray], Avelox (an antibiotic) 400 mg [milligrams] PO [by mouth] QD [daily] X [times] 7 days."</p> <p>- "8/10/2012 - 6:50 pm: Left [with] [name of ambulance company] for CXR..."</p>		<p>committee results of audits related to receiving chest x-ray results timely. 5. Date systematic changes will be completed and who will be responsible – DON/Designee will be responsible for compliance ensuring chest x-ray results are received timely.</p>				

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	<p>- "8/10/2012 - 9p: Resident arrives back to facility via [ambulance company] @ this time. Resident yelling 'Help me, Help me.' She conts [continues] 'They kidnapped me.' Writer explained to resident that the ambulance took her to get a chest X-ray and she states 'I didn't get an X-ray.' She adds 'They had a gun pointed @ me.' Resident grabbing @ writer's wrist and yelling 'Don't leave me alone. They will kidnap me again.' Writer got resident transferred to w/c [wheelchair] @ this time. [Ambulance] medics reported to writer that resident's SpO2 [O2 Saturation] dropped down into the the 80's during the transport back from [hospital]. Medics added that resident's HR [heart rate] [increased] above the 100's. Medics reported increasing O2 to 4 L. Medics reported to writer that they had to pull over @ one point D/T [due to] resident's unbuckling self from stretcher and attempting to crawl down...SpO2 95% @ 2 L. LS [lung sounds] rhonchi [throughout] all fields. Resident conts [with] hoarseness...."</p> <p>- "8/13/2012 - 3:30 pm: ...O2 91% RA [room air]. Occ moist [non] productive cough. LS [with] rhonchi throughout. Cont [with] ATB/URI [antibiotic/upper respiratory infection]."</p>			

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	<p>- "8/13/2012 - 4:20 pm: Res c/o S.O.B. [shortness of breath] O2 95% on RA. Res [with] LS rhonchi throughout all lobes. Res c/o pain to chest when coughs. Res voice hoarse...N/O to have PICC [IV] placed. After PICC placed, Zosyn [antibiotic] via PICC line Pharm [pharmacy] to dose...Cath lab called, closed at this time. Will call 8-14-2012 a.m."</p> <p>- "8/13/2012 - 9:30 pm: Res sitting in recliner @ this time... SpO2 75% RA 2 L of O2 via NC applied @ this time per order - 95% @ 2 L via NC. Rhonchi noted t/o all lobes. Res voice remains hoarse. Resident noted to be talking to people much of night that were not present. Redirection attempted X 5 [with] [no] success. Resident cont'd [continued] speaking to people that were [not] there."</p> <p>- "8/14/2012 - 0820 [8:00 a.m.]: [Ambulance] company in to transport to [name of hospital] for PICC line. Chest x-ray results in. Sent to MD."</p> <p>- "8/14/2012 - 1400 [2:00 p.m.] - [no] N.O. [new orders] R/T chest X-ray."</p> <p>- "8/14/2012 - 5 pm: Clarification: D/C [discontinue] Avelox 400 mg. Start</p>						

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	<p>Zosyn [antibiotic] 2.25 grams Q [every] 8 hrs [hours] via PICC over 30 mins X 1 week."</p> <p>The chest X-ray completed on 8/10/2012 gave the following as the impression: "PERSISTENT BASILAR DENSITY PERHAPS WORSE THAN THE PREVIOUS EXAMINATION. FINDINGS MAY REPRESENT PROGRESSIVE ATELECTASIS OR UNIMPROVED PNEUMONIA."</p> <p>Documentation was lacking in the nursing notes between 8/10/2012 evening and 8:00 a.m. on 8/14/2012 of nursing making attempts to obtain the chest X-ray results in order to notify the physician for new orders or whether to continue the same course of treatment initially implemented. The resident was displaying respiratory symptoms of infection during this time.</p> <p>During an interview on 9/27/2012 at 2:10 p.m., the DoN [Director of Nursing] and ADON [Assistant Director of Nursing] indicated the usual turn around time was 24 hours in getting labs and X-ray reports back, and a copy used to come to the facility and to the physician. They indicated [name of hospital] had put into place on 8/6/2012 a new</p>			

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	<p>format for notification of labs and x-rays results and did not tell the nursing facilities that only the physicians would be receiving a copy of the reports. And, it would be up to the physicians' offices to notify the nursing facilities if new orders were needed based on the results. They also indicated the physicians were also not aware of the new format until they had started receiving the report from another company instead of the nursing homes, and orders were either not given or were delayed. They indicated the new format did not last long, but that this chest X-ray fell into that time frame when reports were no longer coming to the facility. The DoN also indicated that unless the resident was displaying increased signs and symptoms of distress, nursing would just wait on the physician to call with the results if he/she wanted to change or give new orders.</p> <p>This Federal tag is related to Complaint IN00116087.</p> <p>3.1-49(g)</p>				