

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155070	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
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NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY RD NEW ALBANY, IN 47150
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F0000	<p>This visit was for Investigation of Complaint IN00117078.</p> <p>Complaint IN00117078 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309, and F514.</p> <p>Survey dates: 10/5 and 10/9/12</p> <p>Facility number: 000028 Provider number: 155070 AIM number: 100275370</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 10 Medicaid: 78 Other: 10 Total: 98</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/10/12</p>	F0000	<p><u>Allegation of Compliance</u> Please accept the following plan of correction for the abbreviated survey on October 9, 2012. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community.</p> <p>Green Valley Care Center respectfully requests consideration for a desk review and paper compliance for the abbreviated 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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	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 resident's attending physician was notified for follow-up to an episode of orthostatic hypotension. The deficient practice</p>	F0157	No harm was incurred by Resident B related to the alleged deficient practice. Additionally, given the date the incident allegedly occurred, documentation in the resident's	10/22/2012			

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	<p>affected 1 of 4 residents reviewed related to physician notification in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/5/12 at 11:00 a.m.</p> <p>Discharge Instructions from the Emergency Department at the local hospital, dated 9/14/12, indicated, "Custom Instructions: ...Notify primary care physician regarding pt [patient] status, bed rest today and increase oral fluids. Discharge Instructions: Orthostatic Hypotension (Low Blood Pressure on Arising)...." Handwritten next to the diagnosis was "Based on Report." The Discharge Instructions were printed on 9/14/12 at 11:07 a.m.</p> <p>The Emergency Department report indicated, "...Medical Decision Making: ...The patient had some mild ortho stasis on blood pressure testing. The patient will be allowed to return to the nursing home but will need to drink plenty of fluids today and stay in bed today and call her primary care provider in the morning for further instruction...."</p> <p>The only Progress Note Review for 9/14/12 was at 10:06 p.m. and indicated,</p>		<p>medical record could not be added. However, on 10/10/2012 the Director of Nursing spoke with the resident's physician regarding the alleged incident to evaluate if any additional follow-up was needed. The M.D. stated he was aware of the resident being sent to the hospital and the reasons why and stated no further follow-up is indicated at this time. All residents have the potential to be affected by the alleged deficient practice. An audit was completed by the Unit Managers on 10/17/2012 of residents that have been sent to the hospital in the last 30 days with return to the facility anticipated, to ensure that discharge instructions have been efficiently followed-up on as indicated. Additionally to ensure the resident's physician was notified and that documentation in the resident's medical record reflected the physician notification.</p> <p>On 10/19/2012, Licensed Nursing Staff will be re-inserviced by the Staff Development Coordinator on the importance of ensuring that they review and follow through on discharge instructions following the resident's return to the facility.</p> <p>Director of Nursing or designee will ensure that the medical record of residents who have been sent to the hospital with a return to facility anticipated is brought to the Mon-Fri Clinical meeting. The medical records will</p>		

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	<p>"Resident remains on bed rest per MD orders. No further signs of weakness noted this shift....This nurse also placed call to [name of cardiology provider group] with apt [sic] [appointment] made for pacemaker to be checked 9/21/12 @ 10:00 a.m."</p> <p>Documentation failed to indicate contact for follow-up with the primary care physician, as instructed by the Emergency Department physician.</p> <p>During interview on 10/9/12 at 1:55 p.m., the Director of Nursing indicated he was unable to locate information to indicate the attending physician was notified following the resident's episode of orthostatic hypotension.</p> <p>This federal tag is related to Complaint IN00117078.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>		<p>then be reviewed to ensure documentation of physician notification and that discharge instructions have been reviewed and followed through on. These audits will be completed 5x's/week for 4 weeks and then weekly for no less than 2 additional months.</p> <p>The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; the facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the physician's order and the resident's care plan were followed for assessment of the resident's cardiac pacemaker. The deficient practice affected 1 of 3 residents reviewed related to cardiac pacemakers in a sample of 4 residents. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/5/12 at 11:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, atrial fibrillation, unspecified essential hypertension, fitting and adjustment of cardiac pacemaker, chronic ischemic heart disease, and heart valve replaced by other means.</p> <p>Physician's orders for the month of September 2012 included, but were not limited to an order, originally dated 11/29/11, for "Pacemaker Check Monthly."</p> <p>The Cardiac Care Plan, with Onset Date</p>	F0282	<p>No harm was incurred by the resident related to the alleged deficient practice. According to Resident B's medical record her pacemaker monitoring check had been last completed on 9/24/2012 and received further evaluation of her pacemaker by Commonwealth Cardiology on 9/28/2012.</p> <p>Residents with pacemaker devices have the potential to be affected by the alleged deficient practice. An audit was completed on 10/10/2012 by the Unit Managers of residents with pacemakers to ensure their devices were being monitored in accordance to the physician's order and the comprehensive care plan.</p> <p>On 10/10/2012, Licensed Nursing Staff were re-inserviced by the Staff Development Coordinator on the facilities policy and procedure for pacemaker monitoring.</p> <p>Director of Nursing or designee will complete a monthly audit of residents with pacemaker devices to ensure the devices are being monitored in accordance to the physician's order and the resident's careplan. These audits will be conducted monthly for no</p>	10/22/2012			

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	<p>5/25/2009, indicated, "Problems: Resident has a potential for cardiac complications related to diagnosis of...Pacemaker..." Approaches included, but were not limited to, "Schedule and perform pacemaker checks as ordered."</p> <p>Review of Treatment Flow Sheets for March, April, May, July, August, and September 2012 failed to indicate a nurse's initials next to the entry for "Pacemaker Check Monthly" until 9/21/12.</p> <p>An Operative Report, dated 9/27/12, indicated, "Indications: This is an...nursing home resident. She has apparently been lost to follow-up for pacemaker interrogation. She originally had a device placed in 1997. Attempts were made to interrogate her device over the telephone recently and her device was found to be at end of life..."</p> <p>During interview on 10/5/12 at 3:15 p.m., the Director of Nursing indicated on 9/17/12 the facility realized Resident B's pacemaker checks were not being completed as ordered.</p> <p>During interview on 10/9/12 at 11:10 a.m., the Unit Manager for Resident B's unit indicated Resident B's last pacemaker check was completed in January 2012.</p>		<p>less than 3 months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; the facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>		

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	<p>The Unit Manger indicated the pacemaker checks were changed from every three months to monthly in December [sic] 2011.</p> <p>This federal tag is related to Complaint IN00117078.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>                      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 observation, interview, and record review, the facility failed to ensure assessment, planning, and implementation of the care plan to ensure effective care of the resident with cardiovascular disease. The deficient practice affected 1 of 3 residents reviewed related to cardiac pacemakers in a sample of 4 residents. (Resident B) Checks of Resident B's pacemaker were not implemented as ordered by the physician. When Resident B experienced an episode of orthostatic hypotension, she was not consistently assessed and monitored. When the resident was readmitted to the facility after pacemaker surgery, the surgical site was not assessed, and care was not provided in accordance with physician's instruction.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/5/12 at 11:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, atrial</p>	F0309	<p>No harm was incurred by the resident related to the alleged deficient practice. According to Resident B's medical record her pacemaker monitoring check had been last completed on 9/24/2012 and received further evaluation of her pacemaker by Commonwealth Cardiology on 9/28/2012. In relation to the date the incident allegedly occurred, documentation in the resident's medical record could not be added related to physician notification, and completion of vital signs. On 10/10/2012, the Director of Nursing spoke with the resident's physician regarding the alleged incident to evaluate if any additional follow-up was needed. The M.D. stated he was aware of the resident being sent to the hospital and the reasons why and stated no further follow-up is indicated at this time. Additionally, the post-op incision site was assessed by the Unit Manager and was found to be free of any signs or symptoms of infection. All residents have the potential to be affected by the alleged deficient practice. An audit was</p>	10/22/2012

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	<p>fibrillation, unspecified essential hypertension, fitting and adjustment of cardiac pacemaker, chronic ischemic heart disease, and heart valve replaced by other means.</p> <p>A. Physician's orders for the month of September 2012 included, but were not limited to an order, originally dated 11/29/11, for "Pacemaker Check Monthly."</p> <p>The Cardiac Care Plan, with Onset Date 5/25/2009, indicated, "Problems: Resident has a potential for cardiac complications related to diagnosis of...Pacemaker..." Approaches included, but were not limited to, "Schedule and perform pacemaker checks as ordered."</p> <p>Treatment Flow Sheets for March, April, May, July, August, and September 2012 failed to indicate a nurse's initials next to the entry for "Pacemaker Check Monthly" until 9/21/12.</p> <p>A nursing Progress Note Review, dated 9/21/12 at 10:02 a.m., indicated, "This nurse called [name of resident's cardiology provider] for pacemaker check at 10:00 a.m., and receptionist informed nurse that the lady that does the checks is out sick and to call back Monday [9/24/12]...."</p>		<p>completed on 10/17/2012 by the Unit Managers of residents that have been sent to the hospital in the last 30 days with return to the facility anticipated, to ensure that discharge instructions have been efficiently followed-up on as indicated to include assessment of vital signs or other clinical assessment needs as indicated. Additionally to ensure the resident's physician was notified and that documentation in the resident's medical record reflected the physician notification. An audit was completed on 10/10/2012 by the unit managers of residents with pacemakers to ensure their devices were being monitored in accordance to the physician's order and the comprehensive care plan.</p> <p>On 10/10/2012 Licensed Nursing Staff were re-inserviced by the Staff Development Coordinator on the facilities policy and procedure for pacemaker monitoring. On 10/19/2012, Licensed Nursing Staff will be re-inserviced by the Staff Development Coordinator on the importance of ensuring that they review and follow through on discharge instructions following the resident's return to the facility, adequately assessing and documenting a resident's change of condition, to include vital signs or other clinical assessment need as indicated.</p> <p>The Director of Nursing or</p>		

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	<p>A nursing Progress Note Review, dated 9/24/12 at 11:15 a.m., indicated, "Cardiologist office called back and informed nurse that pacemaker was not working and that it would be possible that she could be admitted to hospital for replacement..."</p> <p>A nursing Progress Note Review, dated 9/24/12 at 10:37 p.m., indicated, "Resident direct admit at [name of hospital]. Picked up by ambulance at 3:15 p.m...."</p> <p>An Operative Report, dated 9/27/12, indicated, "Indications: This is an...nursing home resident. She has apparently been lost to follow-up for pacemaker interrogation. She originally had a device placed in 1997. Attempts were made to interrogate her device over the telephone recently and her device was found to be at end of life..."</p> <p>During interview on 10/5/12 at 3:15 p.m., the Director of Nursing indicated on 9/17/12 the facility realized Resident B's pacemaker checks were not being completed as ordered.</p> <p>During interview on 10/9/12 at 11:10 a.m., the Unit Manager for Resident B's unit indicated Resident B's last pacemaker</p>		<p>designee will ensure that the medical record of residents who have been sent to the hospital with a return to facility anticipated is brought to the Mon-Fri Clinical meeting. The medical records will then be reviewed to ensure documentation of physician notification and that discharge instructions have been reviewed and followed through on, clinical assessment is completed and documented in accordance to the type of assessment indicated. Audits of physician notification and clinical assessment will be completed 5x's/week for 4 weeks and then weekly for no less than 2 additional months. Audits of pacemaker monitoring checks will be completed monthly by the Director of Nursing or designee for no less than 3 months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; the facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>				

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	<p>check was completed in January 2012. The Unit Manger indicated the pacemaker checks were changed from every three months to monthly in December [sic]2011. She indicated she did not know why the change to monthly checks was made.</p> <p>B. Discharge Instructions from the Emergency Department at the local hospital, dated 9/14/12, indicated, "Custom Instructions: ...Notify primary care physician regarding pt [patient] status, bed rest today and increase oral fluids. Discharge Instructions: Orthostatic Hypotension (Low Blood Pressure on Arising)..." Handwritten next to the diagnosis was "Based on Report." The Discharge Instructions were printed on 9/14/12 at 11:07 a.m.</p> <p>The Emergency Department report indicated, "...Medical Decision Making: ...The patient had some mild ortho stasis on blood pressure testing. The patient will be allowed to return to the nursing home but will need to drink plenty of fluids today and stay in bed today and call her primary care provider in the morning for further instruction...."</p> <p>Documentation in the clinical record failed to indicate what happened prior to the resident's transfer to the Emergency</p>						

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	<p>Department on 9/14/12.</p> <p>During interview on 10/5/12 at 4:30 p.m., the Unit Manager for Resident B's unit indicated the nurse, LPN #16, caring for Resident B at the time of transfer no longer was employed at the facility. The Unit Manager indicated LPN #16 phoned her about 7:00 a.m. on the morning of 9/14/12, before the Unit Manager arrived on duty at the facility. The Unit Manager indicated LPN #16 was notifying her of the need to transfer the resident to the emergency room. The Unit Manager indicated LPN #16 informed her the resident attempted to stand, and LPN #16 was able to assist the resident into a chair to prevent her falling to the floor. The Unit Manager indicated the nurse did not document the information about the event in the clinical record.</p> <p>The Falls Care Plan, with Onset Date 5/26/2009, indicated, "Problems: Resident has a potential for falls related to a hx [history] of falls and gait. Resident has a shuffling gait. She ambulates on the unit ad lib [at will]." Approaches for care included, but were not limited to, "Assess resident's balance, VS [vital signs B/P [blood pressure] (lying down and standing), prn [as needed] Document results and report abnormalities to physician."</p>						

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NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY RD NEW ALBANY, IN 47150
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	<p>The nursing Progress Note Reviews did not indicate the time of the resident's return to the facility.</p> <p>The only Progress Note Review for 9/14/12 was at 10:06 p.m. and indicated, "Resident remains on bed rest per MD orders. No further signs of weakness noted this shift....This nurse also placed call to [name of cardiology provider group] with apt [sic] [appointment] made for pacemaker to be checked 9/21/12 @ 10:00 a.m."</p> <p>The resident's vital signs were measured on 9/15/12 at 10:00 a.m. and 9:39 p.m. and 9/16/12 at 7:48 p.m. Vital signs were not measured again until the resident's return to the facility from the hospital on 9/28/12. Documentation failed to indicate vital signs were measured lying and standing. Documentation failed to indicate further assessment of the resident's vital signs between 9/16/12 and 9/21/12 when the pacemaker check was scheduled.</p> <p>Documentation failed to indicate contact with the primary care physician as instructed by the Emergency Department physician, other than to set up an appointment for the pacemaker check on 9/21/12.</p>			

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	<p>During interview on 10/9/12 at 1:55 p.m., the Director of Nursing indicated he was unable to locate information to indicate the attending physician was notified following the resident's episode of orthostatic hypotension.</p> <p>C. On 10/5/12 at 5:00 p.m., Resident B was observed lying in her low bed while LPN #8 prepared to perform a requested assessment of the surgical site of Resident B's pacemaker implant. During interview at this time, LPN #8 indicated the resident had a dressing to the site a few days ago, the last time she worked. The resident was observed to have a gauze pad under a transparent dressing on the left upper chest wall. The Director of Nursing entered the room and observed the dressing also.</p> <p>Hospital orders, dated 9/27/12, included, "Send copy of office pacer instruction sheet [symbol for with] F/U [follow up] appt [appointment] to nursing home [symbol for with] pt [patient]."</p> <p>The instruction sheet with Resident B's name in the "Patient Name" blank included, "...Remove the bandage over the incision 2 days after the procedure. The steri-strips (paper strips) under the bandage should not be removed. These</p>						

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	<p>will fall off in two to three weeks....Report any signs of infection, fever, pain, swelling, redness, oozing or heat at the site especially if these symptoms increase after the first 3 to 4 days....You have an appointment on 10/8/12 at 11:30 a.m. to allow the wound to be examined for proper healing...."</p> <p>Physician's orders upon readmission after the pacemaker placement, dated 9/28/12, included, but were not limited to, "Keep incision dry X 5 days. Do not remove steri-strips - allow to fall off."</p> <p>Nursing Progress Note Review indicated the following related to the surgical incision and care:</p> <p>9/28/12 at 5:41 p.m., "Resident readmitted....Surgical incision without signs or symptoms of infection noted. Steri-strips in place and intact...."</p> <p>9/29/12 at 5:58 a.m., "...dressing intact on left upper chest, clean and dry."</p> <p>9/29/12 at 12:03 p.m., "...Dressing clean, dry and intact...."</p> <p>10/7/12 at 11:57 a.m., "Resident has not complaint of pain/discomfort voiced related to pacemaker site...."</p>			

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	<p>The Treatment Flow Sheets for September and October 2012 failed to indicate assessment of the wound.</p> <p>Documentation failed to indicate a dressing was removed two days after the surgery or the condition of the wound, other than as indicated above.</p> <p>Documentation failed to indicate a physician's order for the gauze and transparent dressing observed on the wound on 10/5/12.</p> <p>This federal tag is related to Complaint IN00117078.</p> <p>3.1-37(a)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure complete documentation related to the transfer of a resident to the emergency room for care. The deficient practice affected 1 of 4 residents reviewed related to accuracy of documentation in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/5/12 at 11:00 a.m.</p> <p>Discharge Instructions from the Emergency Department at the local hospital, dated 9/14/12, indicated, "Custom Instructions: ...Notify primary care physician regarding pt [patient] status, bed rest today and increase oral</p>	F0514	<p>No harm was incurred by Resident B related to the alleged deficient practice. Additionally, given the date the incident allegedly occurred, documentation in the resident's medical record could not be added.</p> <p>All residents have the potential to be affected by the alleged deficient practice. An audit was completed by the Unit Managers on 10/17/2012 of residents that have been sent to the hospital in the last 30 days to ensure that documentation in the medical record indicated what happened prior to the resident being transferred to the hospital. On 10/19/2012, Licensed Nursing Staff will be re-inserviced by the Staff Development Coordinator on the importance of ensuring that documentation in the medical record provides the indication for</p>	10/22/2012			

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	<p>fluids. Discharge Instructions: Orthostatic Hypotension (Low Blood Pressure on Arising)..." Handwritten next to the diagnosis was "Based on Report."</p> <p>Documentation in the clinical record failed to indicate what happened prior to the resident's transfer to the Emergency Department on 9/14/12.</p> <p>During interview on 10/5/12 at 4:30 p.m., the Unit Manager for Resident B's unit indicated the nurse, LPN #16, caring for Resident B at the time of transfer was no longer was employed at the facility. The Unit Manager indicated LPN #16 phoned her about 7:00 a.m. on the morning of 9/14/12, before the Unit Manager arrived on duty at the facility. The Unit Manager indicated LPN #16 was notifying her of the need to transfer the resident to the emergency room. The Unit Manager indicated LPN #16 informed her the resident attempted to stand, and LPN #16 was able to assist the resident into a chair to prevent her falling to the floor. The Unit Manager indicated the nurse did not document the information about the event in the clinical record.</p> <p>This federal tag is related to Complaint IN00117078.</p>		<p>transfer when a resident is transferred out of the facility. Director of Nursing or designee will ensure that the medical record of residents who have been transferred out of the facility is brought to the Mon-Fri Clinical meeting. The medical records will then be reviewed to ensure that documentation in the medical record provides the indication for transfer. These audits will be completed 5x's/week for 4 weeks and then weekly for no less than 2 additional months.</p> <p>The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; the facility will achieve 95% compliance threshold prior to discontinuing audits, if 95% threshold is not met an action plan will be developed to accompany the performance improvement plan. Plan to be updated as indicated.</p>				

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