

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 06/28/2011
NAME OF PROVIDER OR SUPPLIER HILLCREST CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE JEFFERSONVILLE, IN47130		
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F0000	<p>This visit was for the Investigation of Complaint IN00091881.</p> <p>Complaint IN00091881 - Substantiated. Federal/state deficiencies related to the allegations are cited at F315, F323, and F328.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 6/27 and 6/28/11</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: 81 Total: 81</p> <p>Census payor type: Medicare: 6 Medicaid: 71 Other: 4 Total: 81</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings</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. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of 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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F0315 SS=D	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/30/11 Cathy Emswiller RN</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident was assisted to maintain urinary continence by implementing the plan for toileting for 1 of 1 resident reviewed related to toileting plans in a sample of 7. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 6/27/11 at 12:25 p.m.</p> <p>The most recent Minimum Data Set</p>	F0315	<p>The facility will ensure this requirement is met through the following corrective measures:1. Resident C was not harmed.2. All residents have the potential to be affected. All residents on a schedule toileting program was reviewed and revised as needed. The C.N.A assignment sheets were updated to reflect changes in the resident's toileting program. See below for corrective measures.3. The scheduled toileting procedure was reviewed with no changes made. (See attachment A) Nursing staff was inserviced on the above procedure. The DON</p>	07/01/2011	

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	<p>assessment, dated 4/5/11, indicated the resident was on a current toileting program or trial to manage the resident's urinary continence.</p> <p>The resident's Care Plan Worksheet for Restorative Toileting, with original date of 1/11/11 and most recently updated 5/10/11, indicated, "Problem: Resident is at risk for urinary incontinence/has incontinent episodes related to: cognitive deficit; decreased ability to get to and from toilet/commode/bedpan." Interventions included, but were not limited to, "Toilet resident before and after meals and prn [as needed] through the night; Toilet resident within a half an hour of these times: [no times listed]; Assist resident with getting to and from toilet/commode/bedpan in a timely manner; Assist with manipulation of clothing, pericare, and brief/pad changes as needed; [handwritten in:] Toilet res. [resident] q [every] 1 [symbol for hour]."</p> <p>The CNA Assignment Sheet, provided by RN #13 during Initial Tour started at 10:50 a.m., indicated, "Toilet plan before & after meals, res. may need to go more often, check q 1 hour."</p> <p>During interview on 6/27/11 at 2:55 p.m., CNA #14 indicated the first shift CNA had checked and changed Resident C for</p>		<p>or her designee will utilize the nursing monitoring tool (See attachment B) to ensure resident's toileting schedules are being maintained by staff by observing three resident's toileting schedules being followed as written daily for four weeks, then weekly for four weeks, then every two weeks for two months, then quarterly thereafter. 4. These audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before July 1, 2011.</p>		

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	<p>incontinence at 2:00 p.m., and she would be checking the resident again at 4:00 p.m.</p> <p>During interview on 6/27/11 at 4:15 p.m., CNA #14 indicated she and CNA #4 were ready to change Resident C. Resident C was in her room. During interview at that time, the resident was not offered toileting, but CNA # 4 told the resident she would be checking her and changing her, if needed. Resident C indicated she did not need to be changed as she was not wet. When the resident's brief was removed, CNA #4 indicated it was "soaked."</p> <p>During interview on 6/28/11 at 11:15 a.m., CNA #10 indicated she was caring for Resident C today. CNA #10 indicated she does not toilet Resident C but checks and changes her. She indicated she had changed Resident C after breakfast this morning, and had just offered to change the resident again. She indicated the resident refused to be changed, since she was in the dining room for an activity. She indicated usually if she could catch the resident in her room, she would agree to be changed, but the resident did not want to leave activities or the dining room to be changed.</p> <p>On 6/28/11 during the Exit Conference</p>				

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	<p>completed at 4:55 p.m., the facility's Nurse Consultant indicated would like to provide additional documentation. Provided was a document titled "Scheduled Toileting Program for [name of Resident C] Month/Year 6/2011." The document indicated on 6/27 and 6/28/11 the resident was incontinent at every hour, on the hour, from 12:00 a.m. through 11:00 p.m. on both dates. On 6/27/11, during the hours care was discussed and observed, the document indicated "void" at 1:00 p.m. and 4:00 p.m., and "no void" at 2:00 p.m. and 3:00 p.m. The document failed to indicate toileting was offered at these times. On 6/28/11, the document indicated "void" at 6:00 a.m., 8:00 a.m., 11:00 a.m., and 2:00 p.m., and "no void" each other hour during the first shift. The document failed to indicate toileting was offered at these times.</p> <p>This federal tag relates to Complaint IN00091881.</p> <p>3.1-41(a)(2)</p>				

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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were supervised to prevent falls for 2 of 3 residents reviewed related to falls in a sample of 7. (Resident F).</p> <p>Findings include:</p> <p>During Initial Tour on 6/27/11 at 10:50 a.m., Resident F was observed seated in a wheel chair in the dining/activity room of the secured unit. Her eyes were closed, her head was leaned back, and her mouth was open. The resident was wearing a seat belt, and the wheel chair was observed to have anti-tip devices to the front and back. During interview at this time, CNA #6 was at the resident's side and indicated the resident had just had her shower, and was tired. The resident awakened, and some slight pelvic thrusting was observed.</p> <p>The clinical record for Resident F was reviewed on 6/27/11 at 12:45 p.m. The resident's diagnoses included, but were not limited to, senile dementia with delusional features.</p> <p>The Interdisciplinary Care Plan</p>	F0323	<p>The facility will ensure this requirement is met through the following corrective measures:1. Resident E had front and rear anti-tippers to W/C placed and a new alarming seatbelt. The facility scheduled a family meeting for resident F, discussing fall interventions and the need for them to consistently follow the plan of care as well.2. All residents have the potential to be affected. All residents fall interventions were reviewed to ensure they were still appropriate. See below for corrective measures.3. The fall management procedure was reviewed with no changes made. (See attachment C) Nursing staff was inserviced on the above procedure. The DON or her designee will utilize the nursing monitoring tool to ensure resident's fall interventions are appropriate daily for four weeks, then weekly for four weeks, then every two weeks for two months, then quarterly thereafter. (See attachment D) 4. These audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. All residents who had a fall will have an immediate intervention initiated. The incident report will</p>	07/01/2011	

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	<p>Conference Record, dated 4/5/11, indicated the resident required maximum assistance for activities of daily living.</p> <p>The Weekly Summary Note, dated 5/29/11, indicated the resident had persistent confusion.</p> <p>The CNA Assignment Sheet provided by CNA #6 on 6/27/11 at 11:05 a.m., indicated Resident F required the assistance of two to transfer, and was incontinent of bowel and bladder.</p> <p>Nurse's Notes on 5/28/11 at 3:00 p.m., indicated, "U/A [urinalysis] results negative. MD aware. NNO [no new orders]."</p> <p>The next Nurse's Note was dated 5/29/11 at 6:45 a.m. and indicated, "Neuro [check mark] [neurological assessment] initiated @ this X [time]. [Name of Resident F's physician] paged et [and] left mess. [message] for [name of resident's son] on phone."</p> <p>Nurse's Notes on 5/29/11 indicated the physician was paged again at 7:30 and 8:30 a.m.</p> <p>A Nurse's Note for 5/29/11 at 10:00 a.m., indicated, "N.O. [new order] rec'd [received] and noted to send res to ER</p>		<p>be brought to morning meeting for review on the following business day and will be reviewed with the interdisciplinary team to ensure intervention to the fall is appropriate. If the intervention is not appropriate, then the interdisciplinary team will initiate a more appropriate intervention. The interdisciplinary team will track the fall with the intervention for four weeks to ensure that it is still appropriate. If, during this time, the intervention is deemed not effective, then the fall intervention will be discontinued and another put in place. See below for corrective measures.5. The above corrective measures will be completed on or before July 1, 2011.</p>		

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	<p>[emergency room] for eval [evaluation] et tx [treatment] as indicated [symbol for secondary to] fall, res [resident] [arrow pointing up] drowsy et hematoma L [left] forehead...."</p> <p>The Care Plan Worksheet for Falls Risk, with original date of 1/11/11 and most recent update of 4/5/11, indicated, "Problem: The resident has multiple risk factors for falls, such as wandering, impaired balance, hx [history] of falls, daily use of antianxiety, antidepressant, and antipsychotic medication." No other dates were indicated on the Care Plan Worksheet. Interventions included, but were not limited to, "...Monitor the resident frequently when the call lights are not available (i.e. dining room, activities, etc.)...Anti roll back brake system on w/c [wheel chair] to increase safety...anti-tippers to w/c at all times for safety...Front release velcro seatbelt with alarm...Allow to call son [name of son]; Anti-tippers to front & back of wheel chair, Dycem above and below wheelchair cushion...."</p> <p>A Rehabilitation Screening Form, dated 5/11/11, indicated, "Physical Therapy: Front release seat belt to help prevent scaral [sic] sitting/pelvic thrust [sic]. Able to release 3 X [times]."</p>				

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	<p>Physician's orders for May 2011 included, but were not limited to, "Ask res to unlease [sic] the self-releasing seat belt 3 X in a row once a day." The Medication Record for May 2011 indicated the resident performed the release on the 7:00 a.m. to 7:00 p.m. shift on all dates in May 2011.</p> <p>During interview on 6/27/11 at 12:50 p.m., in regard to the fall on 5/29/11, LPN #9, who was caring for Resident F, indicated the resident had fallen about a month earlier, but she was not working that day, and was uncertain what happened.</p> <p>During interview on 6/27/11 at 1:00 p.m., the Physical Therapy Assistant (PTA) indicated Resident F was no longer on a walking program, because she was unable to walk now. She indicated the resident is now on a transfers program. In regard to the fall on 5/29/11, the PTA indicated the resident fell forward from her wheel chair, when she was asleep in her chair. She indicated the resident now has anti-tippers on the front of the chair.</p> <p>During interview on 6/27/11 at 1:10 p.m., CNA #6 indicated on the morning Resident F fell, the nurse had asked her to take another resident outside to smoke, and that's when the fall happened. CNA</p>				

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	<p>#6 indicated the resident was bad to tip the wheel chair back and forth, but now she has front and back anti-tippers on the wheel chair, and that has helped. CNA #6 indicated the seat belt was connected when the resident fell, and the wheel chair tipped over on top of her. CNA #6 indicated the fall happened in the dining/activity room.</p> <p>During interview completed at 11:00 a.m. on 6/28/11, in regard to the circumstances of Resident F's fall on 5/29/11, and the assessment of the resident after the fall, the Director of Nursing indicated the information may be on an incident report which she would provide. The Director of Nursing provided an "Incident & Accident Report" from the fall on 5/29/11 and two "Post Fall Investigation Worksheets" - one from the fall on 5/29/11 and one from a previous fall on 4/28/11.</p> <p>The "Post Fall Investigation Worksheet," dated 4/28/11, indicated, "...What was resident attempting to do at the time of the fall? [handwritten response:] get out of chair looking for son, lunged forward....Were previously planned intervention in place at the time of the fall and, if so, were they effective or not and, in not, why? [handwritten response:] seat belt (alarm)...What does the</p>						

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	<p>interdisciplinary team determine the cause of the fall to be? [handwritten response:] agitated resident wanting son...." The document indicated new intervention of: "IDT [Interdisciplinary Team], let res call family."</p> <p>The Incident and Accident Report, dated 5/29/11 at 6:30 a.m., indicated,: "Res. was sleeping upright in W/C @ 6:30 a.m. et started leaning forward. (Res. seat belt alarm in place & working). Res hit forehead on floor & W/C tipped over on top of her - seatbelt was still attached & in place. Res. assessed & assisted [arrow pointing up] per ii [two] assist et tol [tolerated] well. Res. noted [symbol for with] drowsiness, R [right] eye constricted to 1 mm, L [left] eye [symbol for with] slower response than R eye." The document indicated neurochecks were started at 6:45 a.m. The answer "yes" was checked for the question, "Any change in cognition noted?" with the explanation, "Res looking for baby [name of son]." The document indicated "Hematoma to L side of forehead measuring 4.2 cm X 4.1 cm X 0.4 cm."</p> <p>The "Post Fall Investigation Worksheet," dated 5/29/11 @ 6:30 a.m., indicated, "...What was resident attempting to do at the time of the fall? [handwritten response:] Sleep in wheelchair....If</p>				

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	<p>applicable, were staff assisting the resident according to the plan of care? [handwritten response:] No, unsupervised... Were previously planned intervention in place at the time of the fall and, if so, were they effective or not and, in not, why? [handwritten response:] seat belt, supervision... What does the interdisciplinary team determine the cause of the fall to be? [handwritten response:] resident sleeping in chair and fell forward..." The document indicated new intervention of: "IDT [Interdisciplinary Team], let res call family." The document indicated new interventions of "Sent to ER, IDT; never unsupervised in dining room; W/C replaced, anti-tippers, front/back."</p> <p>During interview on 6/28/11 at 12:05 p.m., in regard to the circumstances of Resident F's fall on 5/29/11, the Director of Nursing (DON) indicated the resident was found by a CNA. The DON indicated the CNA no longer works at the facility. The DON indicated the nurse on duty at the time of the fall no longer works at the facility. The DON indicated the fall happened at the time of shift change, and the off-going and on-coming nurses were getting ready to give report. The DON indicated it was fortunate the on-coming nurse realized what needed to be done and assessed and provided care</p>						

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F0328 SS=D	<p>for the resident.</p> <p>This federal tag relates to Complaint IN00091881.</p> <p>3.1-45(a)(2)</p> <p>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 observation, interview, and record review, the facility failed to ensure respiratory services, including measurement of blood levels of oxygen saturation and administration of oxygen provided for 3 of 5 residents reviewed related to respiratory care in a sample of 7. (Residents D, G, and H)</p> <p>Findings include:</p> <p>During interview on 6/27/11 at 10:50 a.m., the Manager of Respiratory Therapy</p>	F0328	<p>The facility will ensure this requirement is met through the following corrective measures: 1. Resident D, G and H were not harmed.2. All residents have the potential to be affected. All oxygen orders were clarified and if oxygen saturations are needed then they will be obtained. See below for corrective measures.3. The oxygen administration procedure was reviewed with no changes made. (See attachment E) Nursing staff was inserviced on the above procedure. The DON or her designee will utilize</p>	07/01/2011	

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	<p>indicated her company was contracted by the facility to provide respiratory services to residents on oxygen and respiratory treatments. The Manager indicated her staff is in the facility seven days a week from 6:00 a.m. to 6:30 p.m. and set up all oxygen and do respiratory treatments during those hours. She indicated nursing staff provides oxygen services and respiratory treatments scheduled at other times.</p> <p>1. The clinical record for Resident D was reviewed on 6/27/11 at 12:10 p.m.</p> <p>A physician's order, dated 5/4/11, indicated, "D/C [discontinue] routine O2 [oxygen] in day. Continue O2 @ 2 LPM [liters per minute] per N/C [nasal canula] q [every] HS [bed time] & prn [as needed] in day. Monitor & record O2 sat [saturation] q shift X 7 days then PRN SOB [shortness of breath]."</p> <p>Physician's orders for June 2011 included, but were not limited to, "O2 @ 2 LPM per N/C q HS & prn in day" and "Monitor O2 sats daily per shift."</p> <p>The Medication Administration Record (MAR) for June 1, 2011 through 6/27/11 indicated the resident's oxygen saturation was measured daily on the 7:00 a.m. to 7:00 p.m. shift and ranged between 94 and</p>		<p>the nursing monitoring tool to ensure resident's oxygen orders are wrote correctly and followed correctly plus oxygen saturation are obtained as needed daily for four weeks, then weekly for four weeks, then every two weeks for two months, then quarterly thereafter. The DON or her designee will review the order and ensure the resident is receiving oxygen per order by doing rounds per schedule above. If oxygen saturation is needed the DON will ensure the saturation is obtained and documented. (See attachment A) 4. These audits will be reviewed during the facility' s quarterly quality assurance meetings and the plan of action adjusted accordingly . 5. The above corrective measures will be completed on or before July 1, 2011.</p>		

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	<p>100%. Documentation on the MAR failed to indicate another measurement during the day. In the entry line for oxygen saturation from 7:00 p.m. to 7:00 a.m. indicated, "Nursing MAR." Dated but untimed Medicare Documentation Worksheets for 6/1 through 6/26/11 indicated the resident's oxygen saturation was measured daily, and that the resident was on oxygen at 2 LPM by nasal canula.</p> <p>The MAR for June 1 through 27, 2011, indicated oxygen was administered daily at 2 LPM by nasal canula from 7:00 a.m. to 7:00 p.m. The entry line for oxygen from 7:00 p.m. to 7:00 a.m. indicated "Nursing MAR." No other documentation related to oxygen administration was on the Medication Administration Record.</p> <p>During observation on 6/27/11 at 2:00 p.m., Resident D was observed seated in a chair in her room with oxygen by nasal canula with the oxygen concentrator set at 2 LPM.</p> <p>During observation on 6/27/11 at 5:15 p.m., Resident D was observed seated in a chair in her room with a visitor in a chair next to her. A nasal canula with tubing was on the resident's nose.</p> <p>On 6/27/11 at the Daily Exit Conference ending at 5:30 p.m., clarification was</p>				

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	<p>requested of the Administrator, Director of Nursing, Assistant Director of Nursing, and Unit Manager related to Resident D's use of oxygen.</p> <p>During interview completed on 6/28/11 at 11:00 a.m., the Nurse Consultant, Director of Nursing, and Unit Manager indicated the physician's orders for oxygen and measurement of oxygen saturation had been clarified with the physician. Copy of a physician's order was provided, and the order indicated, "6/27/11 D/C [discontinue] previous oxygen orders. Start O2 @ 2 LPM per N/C SOB cont [continuous]...Monitor O2 sat q shift."</p> <p>2. During observation on 6/27/11 at 12:05 p.m., Resident G was not in her room. An oxygen concentrator was observed in the room, and a portable oxygen tank was on the resident's wheel chair. During interview at this time, LPN #11 indicated the resident used oxygen, but she was at the dialysis center, and the ambulance providing transportation provided the resident's oxygen for the trip to dialysis.</p> <p>On 6/27/11 at 5:20 p.m., Resident G was observed in bed with the head of the bed raised slightly. Oxygen tubing was observed to run from the oxygen concentrator, which was set at "3" liters per minute, to the resident by nasal</p>						

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	<p>canula.</p> <p>During observation on 6/28/11 at 11:20 a.m., Resident G was observed in her room seated in her wheel chair. A portable oxygen tank was on the back of the resident's wheel chair. Upon request, LPN #7 checked the tank, and during interview at this time, indicated the tank was set on "3." The tank was connected by oxygen tubing with nasal canula to the resident.</p> <p>The clinical record fro Resident G was reviewed on 6/27/11 at 2:30 p.m. The record indicated physician's orders for June 2011 included, but were not limited to, "O2 at 2 L/M [liters per minute] PNC [per nasal canula] continuous."</p> <p>3. During observation on 6/27/11 at 4:00 p.m., Resident H was observed in bed with her eyes closed and oxygen tubing to her nose by nasal canula. The oxygen concentrator was turned on, and the setting was on "2." During interview at this time, LPN #9 indicated she thought the physician's order for oxygen was for 2 to 5 liters per minute to keep the resident's oxygen saturation above 95%.</p> <p>On 6/28/11 at 10:20 a.m., Resident H was observed in bed with her eyes open and oxygen tubing to her nose by nasal canula.</p>						

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	<p>The oxygen concentrator was turned on, and the setting was on "2."</p> <p>The clinical record for Resident H was reviewed on 6/27/11 at 4:00 p.m.</p> <p>The record indicated a physician's order received 6/1/11 for "O2 at 3 L/NC PRN R/T [related to] SOA [shortness of air] - Duonebs [nebulizer treatments] BID [two times daily] O2 at 3 L/NC continuous."</p> <p>Handwritten entries on the rewrites of physician orders for June 2011 included two entries as follows: "O2 @ 3 L/min per NC PRN r/t SOA PRN" and "O2 at 3 L/min per N/C continuously."</p> <p>The Medication Record for June 2011 indicated oxygen was administered from 7:00 p.m. to 7:00 a.m. at 3 LPM. Documentation for the 7:00 a.m. to 7:00 p.m. time frame was not indicated on this Medication Record.</p> <p>During interview on 6/27/11 at 2:10 p.m., LPN #15 indicated if oxygen administration was not recorded on the Medication Record at the nurse's medication cart, it would be on documentation in the respiratory book that the respiratory therapists keep.</p> <p>An interview was completed on 6/28/11 at</p>				

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F0514 SS=D	<p>11:00 a.m. with the facility's Nurse Consultant, Director of Nursing, and Unit Manager in regard to Resident H's oxygen orders and oxygen administration. When interviewed in regard to Resident H's current orders for oxygen therapy, the Unit Manager indicated the order "can't be both" for as needed and continuous oxygen, and she would check on the correct order. Subsequently copy of a clarified physician's order obtained on 6/28/11 at 2:00 p.m. indicated, "O2 at 3L continuous per nasal canula."</p> <p>This federal tag relates to Complaint IN00091881.</p> <p>3.1-47(a)(6)</p> <p>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 documentation in the clinical record was complete and</p>	F0514	The facility will ensure this requirement is met through the following corrective measures:1. Resident D and F were not	07/01/2011	

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	<p>accurate for 2 of 7 residents whose records were reviewed in a sample of 7. (Residents F and D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 6/27/11 at 12:45 p.m.</p> <p>A. Nurse's Notes on 5/28/11 at 3:00 p.m., indicated, "U/A [urinalysis] results negative. MD aware. NNO [no new orders]."</p> <p>The next Nurse's Note was dated 5/29/11 at 6:45 a.m. and indicated, "Neuro [check mark] [neurological assessment] initiated @ this X [time]. [Name of Resident F's physician] paged et [and] left mess. [message] for [name of resident's son] on phone."</p> <p>Nurse's Notes on 5/29/11 indicated the physician was paged again at 7:30 and 8:30 a.m.</p> <p>A Nurse's Note for 5/29/11 at 10:00 a.m., indicated, "N.O. [new order] rec'd [received] and noted to send res to ER [emergency room] for eval [evaluation] et tx [treatment] as indicated [symbol for secondary to] fall, res [resident] [arrow pointing up] drowsy et hematoma L [left] forehead...."</p>		<p>harmed.2. All residents have the potential to be affected. All physicians' orders were reviewed to ensure accuracy. See below for corrective measures.3. The documentation policy including how to complete an assessment and how to transcribe an order was reviewed with no changes made. (See attachments F and G) Nursing staff was inserviced on the above procedure. The DON or her designee will utilize the nursing monitoring tool to ensure resident's oxygen saturations are initialed, that accurate assessments are completed until issue is resolved and the all medications on the MAR are given per order and initialed daily for four weeks, then weekly for four weeks, then every two weeks for two months, then quarterly thereafter. (See attachment A) 4. These audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before July 1, 2011.</p>		

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	<p>Documentation in Nurse's Notes failed to indicate any information related to the resident's fall.</p> <p>During interview completed at 11:00 a.m. on 6/28/11, in regard to the circumstances of Resident F's fall on 5/29/11, and the assessment of the resident after the fall, the Director of Nursing indicated the information may be on an incident report which she would provide. During interview at this same time, the facility's Nurse Consultant indicated the incident report is part of the Quality Assurance program, but a copy could be provided. The Director of Nursing provided an "Incident & Accident Report" from the fall on 5/29/11.</p> <p>The Incident and Accident Report, dated 5/29/11 at 6:30 a.m., indicated, "Res. was sleeping upright in W/C @ 6:30 a.m. et started leaning forward. (Res. seat belt alarm in place & working). Res hit forehead on floor & W/C tipped over on top of her - seatbelt was still attached & in place. Res. assessed & assisted [arrow pointing up] per ii [two] assist et tol [tolerated] well. Res. noted [symbol for with] drowsiness, R [right] eye constricted to 1 mm, L [left] eye [symbol for with] slower response than R eye." The document indicated neurochecks</p>				

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	<p>were started at 6:45 a.m. The answer "yes" was checked for the question, "Any change in cognition noted?" with the explanation, "Res looking for baby [name of son]." The document indicated "Hematoma to L side of forehead measuring 4.2 cm X 4.1 cm X 0.4 cm." Documentation in the clinical record failed to indicate this information.</p> <p>B. Nurse's Notes for 5/27/11 at 9:00 p.m., indicated Resident F was started on the antibiotic, Levaquin, for seven days related to infiltrates of the left lower lobe of the lung.</p> <p>Nurse's Notes for 5/27/11 at 9:00 p.m. and Nurse's Notes for 5/28/11 at 10:00 a.m. included an assessment of the resident's respiratory status. The next Nurse's Notes indicating assessment of the resident were on 5/29/11 at 6:45 a.m., when neurological checks were started related to the resident hitting her head during a fall, and the resident was transferred to the emergency room. Documentation failed to indicate a respiratory assessment from 5/28/11 at 10:00 a.m. to 5/29/11 at 6:45 a.m. when neurological checks were started and included some respiratory information. Respiratory assessment was not indicated until after the resident returned from the emergency room on 5/29/11 at 3:30 p.m.</p>				

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	<p>During interview on 6/28/11 at 12:05 p.m., in regard to assessments of a resident on an antibiotic for left lower lobe infiltrate, the facility's Nurse Consultant indicated she would expect a respiratory assessment every shift. When interviewed in regard to a record of oxygen saturation levels possibly measured during antibiotic therapy for respiratory infection, the Nurse Consultant indicated that may be on the Medication Record for May 2011, which she indicated was not yet filed in the clinical record.</p> <p>During interview on 6/28/11 at 12:20 p.m., a copy of the May 2011 Medication Record was provided by the Nurse Consultant. Next to an entry indicating "Nrsng [nursing] Measure: Pulse Ox [oximeter] q [every] shift" was a number indicating a oxygen saturation level for two shifts on all dates from 5/27 through 5/31/11. No nurse's initials were indicated next to the number to indicate who measured the oxygen saturation level. The Nurse Consultant indicated since this was a "nursing measure" the nurse might "just put the sat [saturation]" and not include her initials.</p> <p>During interview on 6/28/11 at 3:00 p.m., LPN #3 indicated when she measures a</p>						

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	<p>resident's oxygen saturation, she initials the entry, showing that she took the measurement.</p> <p>C. A Radiology Report, dated 5/27/11, indicated, "Conclusion: Modest left lower lobe infiltrates."</p> <p>A physician's order, dated 5/27/11, indicated, "Levaquin [antibiotic] 750 mg po [by mouth] qd [every day] X [times] 7 days."</p> <p>The Medication Record for May 2011 indicated Levaquin was administered as ordered on 5/27/11 at 9:00 p.m. and 5/30/11 at 9:00 p.m. Documentation on the Medication Record failed to indicate the medication was administered on 5/28, 5/29, and 5/31/11.</p> <p>Nurse's Notes indicated the resident continued on the antibiotic, but not that the medication was administered, on the following dates and times: 5/28/11 at 10:00 a.m. and 5/31/11 at 1:00 p.m. and 11:10 p.m.</p> <p>During interview on 6/28/11 at 4:00 p.m., the Unit Manager reviewed the Medication Record for May 2011 and indicated she was unsure whether the antibiotic was administered as ordered. She indicated the first dose was</p>				

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	<p>administered from the EDK [Emergency Drug Kit], and the drug should have been ordered Friday [5/27/11] and delivered Saturday [5/28/11]." The Unit Manager then provided a copy of a pharmacy delivery ticket indicating seven doses of medication were received on 5/27/11.</p> <p>2. The clinical record for Resident D was reviewed on 6/27/11 at 2:10 p.m.</p> <p>Physician's orders for June 2011 indicated orders including, but not limited to, "Advair 250/50 inhalation - BID [two times a day].</p> <p>The Medication Record for June 2011, from the Medication Administration binder at the nurse's medication cart, indicated a nurse's initials next to the entry for "Advair 250/50 inhalation BID" each day at 9:00 a.m., except on 6/6/11, for 6/1 through 6/27/11.</p> <p>The Medication Record for June 2011, from the Respiratory Therapy binder, indicated a Respiratory Therapist's initials next to the entry for "Advair 250/50 inhalation BID" each day at 9:00 a.m., for 6/1 through 6/27/11.</p> <p>During interview on 6/28/11 at 2:40 p.m., Respiratory Therapist [RT] #17 indicated the "M" on the Medication Record on</p>				

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	<p>dates in June 2011 was her initial. She indicated her co-worker, not her supervisor, told her to initial the medication as administered, although nursing was actually administering the medication. When interviewed as to whether she administered the medication as indicated by her initials on dates in June 2011, RT #17 indicated she had obtained the Advair from nursing and administered it herself.</p> <p>During interview on 6/28/11 at 3:00 p.m., LPN #19 indicated he sometimes works as a Respiratory Therapist at the facility. He indicated the initials on the Medication Record from Respiratory Department indicate nursing was administering the medication, and the RT was just initialing that the medication was given. LPN #19 indicated that was not clear on the documentation. LPN #19 indicated an initial on a Medication Record means the medication was administered by the person whose initials appear on the Medication Record.</p> <p>During interview on 6/28/11 at 3:00 p.m., LPN #3 indicated nursing, including she herself, had been administering the 9:00 a.m. dose of Resident D's Advair in June, until a recent change. LPN #3 indicated initials on a Medication Record mean the medication was administered by the</p>				

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	<p>person whose initials appear on the Medication Record. She indicated she was certain the resident had not received two doses of Advair at 9:00 a.m. on the dates in June 2011, since the pharmacy would not send extra medication.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				