

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00166926.</p> <p>Complaint IN00166926-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F327, and F328.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: February 23 & 24, 2015</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF: 37 SNF/NF: 20 Residential: 59 Total: 116</p> <p>Census Payor type: Medicare: 29 Medicaid: 16 Other: 12 Total: 57</p>	F 000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies cited during the Complaint survey which was conducted on February 24, 2015 . Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective March 26, 2015.</p>	
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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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F 157 SS=D Bldg. 00	<p>Residential sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 1, 2015, by Janelyn Kulik, RN.</p> <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</p>			
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	<p>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 residents' Physician's were notified timely of signs and symptoms of fluid overload and a resident's high potassium level, which both residents required immediate medication interventions for treatment of the conditions, for 2 of 5 residents reviewed for quality of care in a sample of 5. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 02/23/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, advanced dementia, dysphagia, and acute kidney injury. The resident was 90 years old.</p> <p>The Annual Minimum Data Set Assessment, dated 11/27/14, indicated the resident was severely cognitively impaired, required extensive assistance of two for bed mobility and transfers, was extensive assistance for eating, had no shortness of breath, and weighed 147</p>	F 157	<p>1. Resident B is no longer in the facility. -Resident C no longer has high potassium level. 2. No other residents have signs or symptoms of fluid overload -No other residents have high potassium levels -DHS/Designee will in-service Licensed Nursing staff on timely physician notification of abnormal lab values and/or change of condition. 3. DHS/Designee will audit labs and change of condition documentation for timely physician notification 3 times weekly for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months and then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of compliance: March 26, 2015</p>	03/26/2015

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	<p>pounds.</p> <p>A Monthly Nursing Assessment & Data Collection, dated 01/07/15, indicated the resident was 65 inches and weighed 144 pounds and had no edema.</p> <p>A Change in Condition Form, dated 01/03/15 (Saturday), no time documented, indicated the resident had 1+ edema to both feet and ankles, and was receiving 0.45 % normal saline at 150 ml per hour for two more liters, had no history of renal failure or congestive heart failure. The form then indicated, "do you want to give the rest of the IV fluids". The form indicated it was faxed to the Physician's Office on the 11 p.m. to 7 a.m. shift (Saturday morning). The additional comments indicated the Day Shift Nurse would call the family and inform them.</p> <p>The follow up documentation on the back of the form, indicated: 01/03/15 7 a.m. to 3 p.m. shift- "BLE (bilateral lower extremities) remain c/ (with) 1+ edema. 0/ (no) resp (respiratory) distress apparent @ this time..."</p> <p>01/03/15 3 p.m. to 11 p.m. shift- "Resting quietly in bed c/ O2 (oxygen)/ 2 l (liter)/nc (nasal cannula) c/ O2 sat</p>						

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	<p>(saturation) 95-97%. BP (blood pressure) 98/60...Edema to ankles et feet 1+-2+ bilateral. (Physician's Name) notified c/ new orders received et noted. Family aware."</p> <p>A Change of Condition Form, dated 01/03/15 at 8:10 p.m., indicated, "...1+ to 2+ edema to ankles et feet bilaterally...Physician order/response to communication: Lasix (diuretic) 20 mg (milligrams) IVP (IV push) c/ 20 meq (milliequivalents) of KCL (potassium) oral then another 20 mg IVP lasix (sic) c/ 20 meq KCL oral in 6 hours...Notification:... (Physician's Name)...phone..."</p> <p>An interview on 02/24/15 at 9 a.m., LPN #1 indicated the resident's Physician had called in about another resident and the resident's daughter had wanted to talk to the Physician, so the daughter was given the phone and had spoke with the Physician regarding her concerns about the edema. LPN #1 indicated after the daughter had finished speaking by phone to the Physician, an update was given by the LPN, which was the resident was on oxygen and was stable and the resident had edema to the lower extremities. LPN #1 indicated this was when the Physician had ordered the Lasix and the potassium.</p>				

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	<p>The Change of Condition Form, dated 01/06/15 11 p.m.- 7 a.m., indicated the edema continued and the right lower extremity was now 3+ pitting and the left lower extremity was 1+ non-pitting edema. The notes indicated the edema was unchanged on the 7 a.m.- 3 p.m. and 3 p.m. to 11 p.m. shift.</p> <p>During an interview on 02/23/15 at 3:10 p.m., with the Executive Director and the DHS, the DHS indicated the information about the edema of the lower extremities should not have been faxed to the Physician's Office.</p> <p>During an interview on 02/24/15 at 8:30 a.m. with the Executive Director and the Director of Health Services (DHS), the DHS indicated the Nurse on the 11 p.m. to 7 a.m. shift had faxed the information to the Physician's Office as a FYI (for your information) only, since the resident was not in distress.</p> <p>2. Resident #C's record was reviewed on 02/24/15 at 10:35 a.m. The resident's diagnoses included, but were not limited to, hypertension and chronic kidney disease.</p> <p>A Basic Metabolic Profile (BMP) (laboratory test for electrolytes), dated 02/10/15 at 6 a.m., indicated the</p>			

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	<p>resident's potassium was 5.7 (high) (normal 3.5-5). Written on the lab (laboratory) results was the potassium results from 02/09/15 of 5.2 and the resident had received 20 mg of Lasix once on 02/09/15. The lab result indicated the Physician had been notified of the results, but did not indicate the date and time nor the route of notification.</p> <p>A Nurses' Note, dated 02/11/15 at 11 a.m., indicated the facility had called the Physician's office, who was on call for the resident's Physician and spoke with someone at the office (name given, no title), related to the BMP result on 02/10/15. The office indicated she had presented the results to the Physician on 02/10/15 and would present it again to the Physician and fax the facility with orders.</p> <p>A Nurses' Note, dated 02/11/15 at 12:30 p.m., indicated the Director of Health Services (DHS) brought new orders from the Physician to the Unit in regards to the potassium level at 5.7.</p> <p>A Physician's Order, dated 02/11/15 at 12:30 p.m., indicated to administer Kayexalate (medicine to rid the body of potassium) 15 gm (grams) now and again at dinner, Lasix 40 mg now and obtain</p>			

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	<p>another BMP on 02/12/15 due to hyperkalemia (high potassium)</p> <p>During an interview on 02/24/15 at 11:30 a.m. with the Executive Director (ED) and the DHS, no further information was received from the ED and the DHS in regards to the timeliness of the follow up on the lab result for Resident #C.</p> <p>A facility policy, titled, "Physician Notification Guidelines", dated 12/06/07, and received as current from the ED, indicated, "...1. Resident assessments for change in condition...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known with a response received before the call is completed when possible...5. During non-office hour times the nurse should notify the physician by phone of abnormal lab results or the need for physician intervention..."</p> <p>This Federal Tag relates to complaint IN00166926.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F 282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 record review and interview, the facility failed to follow Physicians' Orders, related to vital signs to be taken every two hours, for 1 of 3 residents reviewed for Physicians' Orders, in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 02/23/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, advanced dementia, dysphagia, and acute kidney injury.</p> <p>A Physician's Order, dated 01/03/15 at 8:10 p.m., indicated, " (1) Lasix (diuretic) 20 mg (milligrams) IVP (IV push) now et Lasix 20 mg IV in 6 (hours) (2) KCL (potassium) 20 meq (milliequivalents) po (by mouth) now and KCL 20 mg po in 6 (3) Assess resident et monitor VS (vital signs) q/ (every) 2 (hours). If B/P (blood pressure) falls below 90/60 call (Physician Name)."</p>	F 282	<p>1. Resident B is no longer in facility 2. No other residents have orders for vital signs every two hours. -DHS/Designee will in-service Licensed nurses on following physicians orders relating to obtaining and documenting vital signs. 3. DHS/Designee will audit healthcare residents with physicians orders for: "vital signs every two hours", for proper documentation of those orders 3 times weekly for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months and then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of compliance March 26, 2015.</p>	03/26/2015

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	<p>A Physician's Order, dated 01/05/15 at 12 p.m., indicated to discontinue the assessment and vital signs every two hours.</p> <p>A Change in Condition Form, dated 01/03/15, indicated the resident's vital signs were obtained on 01/03/15 at 10:30 p.m.</p> <p>There was one set of vital signs and assessment completed on 01/04/15, no time documented.</p> <p>There was one assessment completed and no vital signs obtained on 01/04/15 during the 7 a.m. to 3 p.m. shift.</p> <p>The Nurses' Notes, indicated assessments and vital signs were obtained on 01/04/15 from 2:30 p.m. through 10:30 p.m.</p> <p>The follow up documentation, dated 01/05/14 (sic), indicated one assessment had been completed (no time was documented) and vital signs were obtained at 12 a.m., 2 a.m., 4 a.m., and 6 a.m.</p> <p>The follow up documentation, dated 01/05/14 (sic), no time documented, indicated there had been one assessment completed after the 6 a.m. vital signs.</p>			

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	<p>There were no further assessments and vital signs located in the Nurses' Notes.</p> <p>During an interview on 02/24/15 at 8:30 a.m. with the Executive Director and the Director of Health Services (DHS), the DHS indicated she was unable to locate documentation to indicate the resident was assessed and vital signs were obtained every two hours as ordered by the Physician.</p> <p>During an interview on 02/24/15 at 9 a.m., LPN #1 indicated the assessment and vital signs had been obtained on 01/03/15 as ordered until 10:30 p.m., then it was passed on to the next shift.</p> <p>This Federal Tag relates to complaint IN00166926.</p> <p>3.1-35(g)(2)</p>			

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F 327 SS=G Bldg. 00	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure a resident received adequate fluids orally and assessments were completed to ensure a resident did not exhibit clinical signs of possible dehydration, which resulted in one resident requiring intravenous (IV) fluid to be given for hydration (Resident #B), for 2 of 3 residents reviewed for dehydration risks, in a total sample of 5. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 02/23/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, advanced dementia, dysphagia, and acute kidney injury. The resident was 90 years old.</p> <p>The Annual Minimum Data Set Assessment, dated 11/27/14, indicated the resident was severely cognitively impaired, required extensive assistance of two for bed mobility and transfers, and required extensive assistance for eating.</p> <p>A Monthly Nursing Assessment & Data</p>	F 327	<p>1. Resident B is no longer in the facility. -Resident C has fluid intake documented in caretracker. 2. Other residents at high risk for dehydration were assessed for signs and symptoms of dehydration. No issues were noted with these residents. -DHS/Designee will in-service Licensed nurses on assessment and documentation for residents at high risk for dehydration, and documenting fluid intake. -DHS/Designee will in-service nursing staff on importance of offering fluids and documenting intake in Care tracker. 3. DHS/Designee to audit for signs and symptoms of dehydration of healthcare residents at high risk for dehydration 3x weekly for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months and then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of compliance: March 26, 2015.</p>	03/26/2015	

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	<p>Collection, dated 01/07/15, indicated the resident was 65 inches and weighed 144 pounds, mucous membranes were pink and moist, and skin turgor had been left blank.</p> <p>A Professional Resource, titled, "Indiana Diet Manual 6th Edition", indicated the resident's fluid intake should be approximately 1963 ml (milliliter)/ 24 hours. (allow 30 ml per kilogram of actual body weight per day for resident's over 55 years of age with no history of congestive heart failure or edema)</p> <p>The resident's care plan, dated 12/08/14, indicated the following problems and interventions:</p> <p>The resident required assistance with care. The interventions included to provide set up for meals and encourage independent eating.</p> <p>The resident had dysphagia and was a risk for choking and aspiration. The interventions included to provide the resident with diet as recommended by Speech Therapy.</p> <p>The resident had nausea at times. The interventions included to encourage to drink plenty of fluids, provide with ordered diet and fluids and document my</p>			

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	<p>consumption.</p> <p>There was no care plan to indicate the resident was a risk for hydration.</p> <p>A Physician's Order, dated 12/22/14 at 8 p.m., indicated an order to obtain a BMP (Basic Metabolic Profile) (Electrolytes) on 12/23/14 related to diagnosis of dehydration.</p> <p>The Nurses' Note, dated 12/22/14 at 8 p.m., indicated the facility received an order from the Physician for a BMP and an urinalyses to be completed on 12/23/14, related to possible dehydration.</p> <p>There was no assessment of the resident's hydration status (oral mucosa color and moisture, skin turgor, fluid intake) completed to and no documentation oral fluids had been encouraged.</p> <p>The Nurses' Notes, dated 12/22/14 at 11 p.m. and 12/23/14 at 12:30 a.m., indicated an assessment for the resident's hydration status had not been completed and oral fluids had not been encouraged. The noted indicate an external catheter had been applied to assist in obtaining an urine specimen.</p> <p>The Nurses' Notes, dated 12/23/14 at 4 a.m., indicated the resident consumed 60</p>			

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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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	<p>ml of thickened water and a scant amount of urine was present in the external catheter.</p> <p>A Nurses' Note, dated 12/23/14 at 5:30 a.m., indicated the urine specimen could not be obtained due to no urine in the external catheter.</p> <p>The BMP results were received on 12/23/14 at 2:14 p.m., the sodium was 142 (normal 135-147), potassium 3.9 (3.5-5.0), BUN (kidney function) 21 (normal 7-22), and creatinine (kidney function) 0.7 (0.4-1.5). The Physician documented on the results the resident was well hydrated.</p> <p>The next Nurses' Notes were dated 12/24/14 at 10 a.m. and 12/24/14 at 8 p.m. The Nurses' Notes indicated an assessment of the resident's hydration status had not been completed and extra oral fluids had not been offered to the resident.</p> <p>The next Nurses' Notes, dated 12/26/14 at 5 p.m., indicated an assessment of the resident's hydration status had not been completed and extra oral fluids had not been offered to the resident.</p> <p>The next Nurses' Notes, dated 12/28/14 at 6 p.m., indicated an assessment of the</p>			

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	<p>resident's hydration status had not been completed and extra oral fluids had not been offered to the resident.</p> <p>A Resident First Conference Notes form, dated 12/29/14, indicated the nutritional status and hydration concerns was left blank, the residents overall status had declined due to exacerbation of a medical condition and natural aging process, the areas of decline included ADL's (activities of daily living) and cognition. The Care giver comments, indicated, "From therapy-his eating has been poor...expecting his eating behavior to decline further...If we are able to see if hydration changes condition to see if his intake improves..." The Resident/responsible party comments indicated, "... (Daughter's Name) 'I want him hydrated w/ (with) IV hydration with (Resident) is an issue; someone has to offer him water constantly every couple of hours offer him a few sips."</p> <p>A Physician's Order, dated 12/29/14 at 1 p.m., indicated an order for a CBC (complete blood count) and BMP to be drawn on 12/29/14.</p> <p>The results for the BMP ordered on 12/29/14 were received by the facility on 12/30/14 at 4:43 p.m., which indicated, sodium 149 (high), potassium 3.8, BUN</p>			

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	<p>36 (high), and Creatinine 1.1.</p> <p>A Physician's Order, dated 12/29/14 at 6 p.m., indicated to administer one liter of 0.9% of normal saline over four hours and follow with 0.45% of normal saline at 150 ml (milliliter) an hour for two liters, per IV (intravenous) due to dehydration and to obtain a CBC and BMP when fluids were completed.</p> <p>A Physician's Progress Note, dated 12/30/14, indicated the resident had been having increasing issues with taking food and liquids and overall had decreased intakes and last week the resident was well hydrated and now the labs currently showed dehydration and the resident was started on IV fluids. The note indicated the resident was still struggling with oral intake and the plan was to IV hydrate for now and to discuss future plans with feeding and hospice related to advanced dementia and dysphagia.</p> <p>There were no further Nurses' Notes from 12/28/14 at 6 p.m. until 12/30/14, no date documented, indicated an assessment of the resident's hydration status had not been completed and extra oral fluids had not been offered to the resident.</p> <p>The BMP results for 12/31/14 (after the first three liters of fluid were infused),</p>			

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	<p>were received by the facility on 12/31/14 at 12:13 p.m. The resident's sodium was 150 (high), potassium 4.1, Chloride 115 (normal 99-109), BUN 27 (high), and Creatinine 0.8.</p> <p>A Physician's Order, dated 12/31/14, indicated an order to administer 0.45% of normal saline at 150 ml per hours for four liters by IV due to abnormal laboratory (lab) results and to obtain a BMP after the fluids have been administered.</p> <p>The Nurses' Note, dated 12/31/14, no time documented, indicated the resident complained of nausea and was medicated and resident was offered 120 ml (milliliters) of cranberry juice was consumed. The note indicated an assessment of the resident's hydration status had not been completed.</p> <p>Further in the Nurses' Notes, dated 12/31/14 at 11:30 a.m. and 12/31/14 at 6:45 p.m., 11:35 p.m., and 11:45 p.m. there was no assessment of the resident's hydration status and no documentation extra oral fluids were offered.</p> <p>The BMP, dated 01/02/15, indicated the resident's sodium was 142, potassium 4.2, chloride 107, BUN 19, and Creatinine 0.9 (all within normal range).</p>			

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	<p>There were no further Nurses' Notes until 01/04/15 at 12:30 p.m., which there was still no documentation of the resident's hydration status.</p> <p>There was no dehydration assessments located on the Change in Condition Form, dated 12/31/14 at 11:30 a.m. through 01/03/15, 7 a.m. to 3 p.m. shift.</p> <p>During an interview on 02/24/15 at 8:30 a.m. with the Executive Director and the Director of Healthcare Services (DHS), the DHS indicated there were no assessments for the resident's hydration status. She indicated lab tests were done. She indicated intakes could be on the care tracker and she would print them.</p> <p>As of exit from the facility on 02/24/15 at 1 p.m., the DHS had not provided the care tracker information to provide fluid intake records for the resident.</p> <p>2. Resident #C's record was reviewed on 02/24/15 at 10:35 a.m. The resident's diagnoses included, but were not limited to, hypertension and chronic kidney disease.</p> <p>A BMP results, dated 01/26/15 at 5:07 p.m., indicated the resident's sodium was 143 (normal 135-147), potassium 4.3 (normal 3.5-5.0), chloride 110 (normal</p>			

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F 328 SS=D	<p>99-109), BUN 41(normal 7-22), and Creatinine 3.0(normal 0.4-1.5). The Physician documented on the results , "Please encourage oral hydration".</p> <p>The Nurses' Notes, dated 1/22/15 at 11:05 a.m., 01/31/15 at 8:30 a.m., and the last note in the record, dated 01/31/15 8:50 a.m., indicated an assessment of the resident's hydration status had not been completed and extra oral fluids had not been offered to the resident.</p> <p>During an interview on 02/24/15 at 11:30 a.m. with the ED and DHS, the DHS indicated there were no hydration assessments completed.</p> <p>This Federal Tag relates to complaint IN00166926.</p> <p>3.1-46(b)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p>			

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Bldg. 00	<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 record review and interview, the facility failed to ensure residents receiving oxygen and intravenous (IV) therapy received the proper care and treatment, related to insertion, maintenance, assessments, and medication administration for residents with IV's and mid-lines (peripheral IV guided into a vein below the armpit) and reason for oxygen usage, for 2 of 5 residents reviewed for quality of care, in a total sample of 5. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 02/23/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, advanced dementia, dysphagia, and acute kidney injury. The resident was 90 years old.</p> <p>A) A Physician's Order, dated 12/29/14 at 6 p.m., indicated to administer one liter</p>	F 328	<p>1. Resident B is no longer in the facility. -Resident C is no longer receiving IV fluids. 2. No other residents are currently receiving IV fluids. -Other residents receiving oxygen were reviewed to ensure appropriate diagnosis for usage. These residents have appropriate diagnosis for usage at this time. -DHS/Designee will inservice Licensed Nurses on insertion, maintenance, assessments, and medication administration for residents with IV's and mid-lines; and for the indication for oxygen usage. 3. DHS/Designee to audit residents with IV orders for appropriate documentation of insertion, maintenance, assessment of site, and medication administration 3 times weekly for 6 months or until QAA states otherwise. -DHS/Designee to audit residents with new orders for oxygen for indication for usage, physicians order, and assessment of respiratory status 3 times weekly for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA</p>	03/26/2015

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	<p>of 0.9% of normal saline over four hours and follow with 0.45% of normal saline at 150 ml (milliliter) an hour for two liters, per IV (intravenous).</p> <p>There was no Nurses' Note in the record dated for 12/29/14 to indicate the resident's IV had been initiated, where the IV was placed, and what Nurse had initiated the IV.</p> <p>The Medication Administration Record (MAR), dated 12/14, indicated, 0.9 % normal saline, one liter over four hours, and was signed out with a zero on 12/30/14. The MAR indicated 0.45% of normal saline, two liters to run at 150 ml and hour to start when the 0.9% normal saline was complete. There were initials on 12/20/14. No time was documented and the MAR lacked documentation when the last bag of fluid was administered.</p> <p>The MAR, dated 12/14, lacked documentation to indicate where the IV had been inserted at, what time the IV was inserted, who inserted the IV and lacked documentation of an assessment of the IV site.</p> <p>The Nurses' Note, dated 12/31/14, no time documented (first note in the record since 12/28/14 at 6 p.m.) indicated the</p>		<p>monthly for 6 months and then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of compliance: March 26, 2015.</p>	

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	<p>resident was sitting in a wheelchair and complained of nausea, was given medication for the nausea, and the resident's daughter was with the resident and noted white patchy areas to the tongue and the Physician was faxed. There was no documentation of the IV being present.</p> <p>A Nurses' Note, dated 12/31/14 at 11:30 a.m., indicated the Physician had notified the facility and gave the facility new orders and the resident's wife and daughter were in the facility and were notified of the orders. There was no documentation of the IV being present.</p> <p>The Director of Health Services provided a faxed communication form, dated 12/30/14 at 3 p.m. to 11 p.m., on 02/24/15 at 8:30 a.m., which indicated, "upon completion of residents IV, it was noticed there was no clamp on tubing to stop blood flow or clamp the line. There fore IV was removed..."</p> <p>A Physician's Order, dated 12/31/14 at 1:30 p.m. indicated an order for 0.45% normal saline IV to run at 150 ml per hour for four liters. "Insert midline was written in on the copy of the Physician's Order.</p> <p>A Physician's Order, dated 01/05/14 (five</p>			

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	<p>days later), indicated, "Clarification: insert midline for IV fluids..."</p> <p>A Nurses' Note, dated 12/31/14 at 6:45 p.m., indicated the Vascular Access Insertion Nurse had notified the facility and indicated she would be at the facility later in evening or in the morning to start the midline IV.</p> <p>A documentation form from the Ascular Access Insertion Nurse, dated 12/31/14 at 9:30 p.m., indicated a midline IV was inserted into the left arm with a 4 french cath (catheter), 1 lumen, cath and internal length at 20 cm (centimeters) with no external length. The IV was flushed easily with 30 ml of saline and a tegaderm (clear) dressing was applied.</p> <p>The MAR, dated 12/14, lacked documentation the 0.45 % normal saline IV for the additional four liters had been initiated on 12/31/14 after the midline had been placed.</p> <p>The MAR, dated 1/15, indicated three liters of 0.45% normal saline had been administered, there was a lack of documentation when each liter had began.</p> <p>There was no documentation about the midline in the Nurses' Notes dated</p>			

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	<p>12/31/14 at 11:35 p.m. and 11:45 p.m., which was the last Nurses' Notes in the record until 01/04/15.</p> <p>The Change in Condition Form, follow up notes, indicated there was no assessment of the midline site on 01/01/15 11 p.m. to 7 a.m. shift, 01/01/15 on the 7 a.m. to 3 p.m. shift, 01/01/15 on the 3 p.m. to 11 p.m. shift, and 01/02/15 on the 11 p.m. to 7 a.m. shift.</p> <p>A Physician's order, dated 01/02/15 at 5 p.m., indicated to administer 0.45% normal saline, three liters at 150 ml per hour per IV.</p> <p>There was a lack of documentation on the MAR, dated 01/15, to indicated what time the administration of each liter was started on 01/02/15 and 01/03/15.</p> <p>The MAR, dated 12/14 and 01/15 lacked documentation of an assessment of the midline IV site.</p> <p>A Change in Condition Form, dated 01/03/15 at 8:10 p.m., indicated to stop the IV and to give Lasix 20 mg (milligrams) (diuretic) now by IV push and again in six hours.</p> <p>The MAR, dated 01/15, indicated the Lasix 20 mg IV push was administered</p>			

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	<p>by LPN #1 on 01/02/15 at 8:10 p.m. There was no documentation to indicate LPN #1 flushed the midline after the medication was administered.</p> <p>A Physician's Order, dated 01/03/15 at 8:50 p.m., indicated to discontinue the second dose of Lasix 20 mg.</p> <p>The Nurses' Notes, dated 01/04/15 at 2:30 p.m. through 10:30 p.m., which was the first Nurses' Note since 12/31/14 at 11:45 p.m., lacked documentation of an assessment of the midline IV site.</p> <p>A Physician's Order, dated 01/06/15 at 5 p.m., indicated to discontinue the midline IV.</p> <p>The Nurses' Note, dated 01/06/15 at 7:30 p.m. (first note since 01/04/15 at 10:30 p.m.) indicated the midline IV was removed and the tip of the catheter was intact.</p> <p>There was no assessment of the midline IV site in the Nurses' Notes from insertion date of 12/31/14 at 9:30 p.m. through 01/06/15 at 7:30 p.m.</p> <p>There was no assessment of the midline IV site on the follow up notes on the Change in Condition Form, from 01/04/15 through 01/06/15 3 p.m. to 11</p>			

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	<p>p.m. shift.</p> <p>The Midline IV had not been flushed to keep the IV patent since the 0.45% normal saline had been discontinued on 01/03/15 at 8:10 p.m.</p> <p>During an interview on 02/23/15 at 3:10 p.m. with the Executive Director (ED) and the Director of Health Services (DHS), the DHS indicated she was still looking for the midline IV policy. She indicated there had been no documentation when the IV was first started and there had been no documentation of the time each liter had began to infuse.</p> <p>During an interview on 02/23/15 at 8:30 a.m. with the ED and the DHS, the DHS indicated there had not been an assessment completed on the IV nor the midline IV and there were no times and missing documentation when the liters of fluid were started. She indicated she had interviewed the Nurses' and they indicated they started the fluids as ordered by the Physician and she (DHS) could only go by what she was told by the Nurses. The DHS indicated the facility had no policies and procedures for IV's and midline IV's. She indicated if a Nurse had a question on what they were suppose to flush with or about the IV,</p>			

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	<p>they could call the Physician.</p> <p>During an interview on 02/24/15 at 9:15 a.m., the DHS indicated there was a form on the MAR for IV care, but it had not been initiated with the orders. She indicated the form states to assess the IV site every shift and this had not been completed.</p> <p>The Agency the facility used for midline insertion, provided their policy for midlines per fax on 02/24/15 at 11:08 a.m. The policy, titled, "Assessment", dated 08/10, indicated, "...2. Assessment of midline catheters is to be performed: at least once every 8 hours...before and after administration of intermittent intravenous infusions. 3. Assessment of midline catheter sites is to include observation, palpation, and patient reports for the absence or presence of: erythema, swelling, red streak, drainage, tenderness, discomfort...condition of dressing...4. Document in medical record..."</p> <p>The Agency policy, titled, "Flushing", dated 08/10, indicated, "2. A physician's order or facility policy is to state: frequency of flushing, volume of flush solution 3. Preservative-free 0.9% sodium chloride for injection is to be used for flushing a midline catheter...7. A midline catheter is to be flushed:...At</p>						

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	<p>least daily for routine maintenance. Before and after intermittently administered medications. Following conversion of a continuous infusion to intermittent intravenous therapy..."</p> <p>An interview with LPN #1 on 02/24/15 at 10:15 a.m., indicated the Lasix was administered by IV push. LPN #1 indicated not sure of a specific policy for IV's and for giving IV pushes, but could ask. LPN #1 indicated he did not recall the chain of events he used to administer the IV push Lasix and explained he would administer the medication and monitor the resident.</p> <p>During an interview with the ED and DHS on 02/24/15 at 11:30 a.m., the DHS indicated the facility had not trained the Nurses' for starting IV's, care of IV's, and IV medications. She indicated the Nurses' had not had been monitored for IV competency.</p> <p>B) Resident # B's Physician's Recapitulation Orders, dated 01/15, indicated the resident did not have an order for oxygen administration.</p> <p>Resident #B's Physician Telephone Orders, dated 12/31/14 through 01/06/15 indicated the resident had no oxygen administration orders.</p>			

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	<p>A Change in Condition Form, dated 01/03/15 at 8:10 p.m., indicated the resident's oxygen saturation was 95-97% on oxygen at 2 liters per nasal cannula.</p> <p>The follow up notes on the back of the Change in Condition Form indicated: 01/03/15 at 7 a.m.-3 p.m.- no respiratory distress apparent at this time.</p> <p>01/03/15 at 3 p.m.-11 p. m.-Resting quietly in bed with oxygen at 2 liters per nasal cannula.</p> <p>There was a lack of documentation to indicate why the oxygen was being administered to the resident in the Nurses' Notes dated 12/22/14 at 8 p.m. through 01/04/15 at 2:30 p.m.</p> <p>A Physician's Order, dated 01/06/15 at 5 p.m., indicated to administer oxygen at 2 liters per minute continuous until 01/07/15, then wean off if oxygen saturations is above 93%. This is the first order for oxygen in the resident's record.</p> <p>During an interview on 02/24/15 at 9 a.m., LPN #1 indicated Resident #B already had the oxygen on when he was caring for the resident. LPN #1 indicated he did not recall when the oxygen had been started on the resident. LPN #1</p>			

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	<p>indicated the resident had not been in respiratory distress.</p> <p>During an interview with the ED and DHS on 02/24/15 at 11:30 a.m., the DHS indicated there had not been a Physician's Order for the oxygen and indicated an assessment had not been completed to indicate the reason the oxygen had been started.</p> <p>A facility policy, titled, "Guidelines for Administration of Oxygen", dated 04/14, and received from the ED as current, indicated, "...1. Verify physician's order for the procedure. 2. In cases of emergency oxygen may be administered as a nursing intervention until a physician order may be obtained...9. Before administering emergency oxygen or oxygen for the first time assess for the following: a. Signs or symptoms of cyanosis...b. Signs or symptoms of hypoxia...d. Vital signs e. Lung sounds..."</p> <p>A Nurses' Note, dated 01/04/15 at 2:30 p.m., indicated, "Received in w/c (wheelchair) nail bed (sic) pale SO 2 (oxygen saturation) 83% O2 (oxygen) hooked up to portable tank. Resident wants to go back to be hooked up to O2 concentrator temporarily 4 l (liters) O2 SO 2 up (arrow up) 99%. Transferred back to bed..."</p>						

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	<p>During an interview with RN #2, on 02/23/15 at 2:30 p.m., RN #2 indicated she could not remember if the portable oxygen tank had been turned on or was empty. She indicate she had not checked the portable oxygen tank and "if I was going to guess, the portable oxygen tank ran out of oxygen". RN #2 indicated some of the portable oxygen tanks do not hold the oxygen very well.</p> <p>2. Resident #C's record was reviewed on 02/24/15 at 10:35 a.m. The resident's diagnoses included, but were not limited to, hypertension and chronic kidney disease.</p> <p>A Physician's Order, dated 01/22/15 at 10:35 a.m., indicated to start IV access.</p> <p>A Physician's Order, dated 01/22/15 at 11:45 a.m., indicated to give calcium gluconate 2 GM (grams) IV over 60 minutes twice today only eight hours apart.</p> <p>A Physician's order, dated 01/23/15 at 9:45 a.m., indicated calcium gluconate 2 GM IV run over one hour twice today, eight hours apart and magnesium sulfate 2 GM IV run over four hours one dose only today.</p>			

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	<p>There was no documentation in the resident's Nurses' Notes to indicate the IV had been initiated and the location of the IV.</p> <p>There was no orders to flush the IV prior to or after the medication and what type of flush to use.</p> <p>There was no assessment of the IV site on the Change in Condition Form follow up notes on the 3 p.m. to 11 p.m. shift on 01/22/15 and the 11 p.m. to 7 a.m. shift on 01/23/15, 11 p.m. to 7 a.m. shift, 7 a.m. to 3 p.m. shift, and 3 p.m. to 11 p.m. shift on 01/24/15, and on all three shifts on 01/25/15.</p> <p>There was no order for the IV to be discontinued and documentation the IV had been discontinued. (the resident no longer had the IV)</p> <p>The MAR, dated 01/15, indicated the IV had not been assessed or flushed before or after the medications were administered.</p> <p>During an interview with the ED and DHS on 02/24/15 at 11:30 a.m., the DHS indicated the facility had not trained the Nurses' for starting IV's, care of IV's, and IV medications. She indicated the Nurses' had not had been monitored for</p>			
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F 431 SS=D Bldg. 00	<p>IV competency. She indicated there was no documentation of when the IV was started or discontinued.</p> <p>This Federal Tag relates to complaint IN00166926.</p> <p>3.1-47(a)(2) 3.1-47(a)(6)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and</p>			

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	<p>cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review and interview, the facility failed to ensure a controlled substance, morphine sulfate (narcotic pain medications), was reconciled to prevent missing dosages of the medication, for 1 resident reviewed for narcotic pain medication, in a total sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 02/23/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, advanced dementia, dysphagia, and acute kidney injury.</p> <p>A Physician's Order, dated 01/08/15 at 7</p>	F 431	<p>1. Resident B is no longer in the facility. 2. Other residents with orders for controlled medications were audited for appropriate count sheets and every shift reconciliation. No issues were found. -DHS/Designee will in-service Licensed nursing staff on receiving controlled medication, and completing and maintaining a count sheet to prevent missing dosages of the medication. 3. DHS/Designee will audit controlled medication count sheets for appropriate completion 3 times weekly for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months and then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and</p>	03/26/2015

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	<p>p.m., indicated morphine sulfate 5 mg (milligram) (0.25 ml) (milliliters) by mouth or sublingual (under tongue) for pain or shortness of breath every one hour.</p> <p>The as needed tracking record, indicated the resident received the morphine sulfate on the following dates and time: 01/09/15 at 12 a.m. 01/11/15 at 11:30 a.m. 01/11/15 at 8 p.m. 01/12/15 at 9:45 a.m.</p> <p>The MAR, dated 01/15, indicated the resident also received the medication on the following dates an time: 01/12/15 at 8 a.m. 01/13/15 at 4:50 p.m. 01/13/15 at 8 p.m. 01/14/15 at 10 a.m.</p> <p>During an interview on 02/23/15 at 3:10 p.m., the Director of Health Services indicated she was unsure how much morphine the pharmacy had sent and she was still looking for a controlled substance count sheet.</p> <p>During an interview on 02/24/15 at 8:30 a.m. with the Executive Director and the Director of Health Services (DHS), indicated the pharmacy had sent 10 individual vials of morphine 0.25 ml.</p>		changes as appropriate. 5. Date of compliance: March 26, 2015.	

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	<p>She indicated the facility could not locate a controlled substance count record and she was unsure where the other vials of morphine sulfate were. She indicated she had a call out to Hospice.</p> <p>During an interview on 02/24/15 at 11:30 a.m., the DHS indicated she was still waiting on Hospice to call back and indicated the facility was still unable to find a controlled substance count sheet.</p> <p>A facility policy, titled, "Ordering and Receiving controlled Medications", dated 09/13 and received from the Executive Director as current, indicated, "...An individual resident's controlled substance record is prepared by the pharmacy or the facility for each controlled substance medication prescribed for a resident...Controlled substance inventory sheets are placed with other count sheets to be included in shift to shift narcotic count."</p> <p>3.1-25(e)(2)</p>			