

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/07/2013	
NAME OF PROVIDER OR SUPPLIER HEARTH AT PRESTWICK				STREET ADDRESS, CITY, STATE, ZIP CODE 182 S CR 550 E AVON, IN 46123			
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R000000	<p>This visit was for State Residential Licensure survey.</p> <p>Survey dates: October 4 and 7, 2013</p> <p>Facility number: 003902 Provider number: 003902 AIM number: N/A</p> <p>Survey team: Lora Brettnacher, RN- TC Jeanna King, RN</p> <p>Census bed type: Residential: 125 Total: 125</p> <p>Census payor type: Other: 125 Total: 125</p> <p>Residential sample: 8</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 10/10/2013 by Brenda Marshall Nunan, RN.</p>	R000000					

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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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to monitor oxygen saturation when needed as ordered by the resident's physician for 1 of 6 residents reviewed for provision of nursing care as ordered by a physician (Resident #5). Findings include: Resident #5's record was reviewed on 10/7/2013 at 11:00 A.M., Resident #5 had diagnoses which included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease [COPD] with a history of respiratory failure, insulin dependant diabetes, and atrial fibrillation. Resident #5's September 2013, physician's recapitulation orders, indicated Resident #5 had a current order originally dated 1/7/13, for continuous administration of 2 L [liters] of oxygen via nasal cannula (2L/nc) and a current order originally dated 2/21/2013, which indicated nursing was to monitor Resident #5's pulse oximeter(O2 sats) as needed to keep her oxygen saturation above</p>	R000241	The corrective action to be accomplished is to ensure Resident #5's oxygen saturation is monitored when needed per physician orders and documented in the resident's record. To determine whether other residents may be affected, the DON and/or designee will do a review of all residents' records that have oxygen ordered by their physician to ensure that oxygen saturation is being monitored correctly per their physician's orders and documented in the resident's record. The Resident Services Coordinator completes all rewrites monthly and will ensure that all oxygen saturation monitoring orders are located on the monthly rewrite and the MAR. This will ensure that nursing staff is aware of the oxygen saturation monitoring orders. Regarding monitoring, the DON and/or designee will do monthly audits on the residents' records that have oxygen ordered by their physician to ensure that oxygen saturation is being monitored corrcctly per physican orders and documented in the	11/20/2013			

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	<p>90%.</p> <p>A nurse's note dated 9/5/2013-9:10 A.M., indicated, "Fax sent to (physician named) per resident's request for current weakness et [and] cold s/s [signs and symptoms]. Will await return fax. The record lacked documentation nursing staff assessed Resident #5's respiratory status and/or oxygen saturation.</p> <p>A nurse's note dated 9/6/2013-1:00 P.M., indicated nursing assessed Resident 5's blood pressure and faxed the doctor regarding a drop in her blood pressure. The record lacked documentation nursing assessed Resident #5's oxygen saturation.</p> <p>A nurse's note dated 9/6/2013-1:30 P.M., indicated, "Call placed to [physician named] office regarding resident's weakness, cold s/s, et temp (temperature) 102." This note indicated the physician ordered antibiotics for Resident #5. The record lacked documentation nursing assessed Resident #5's respiratory status and/or oxygen saturation.</p> <p>A nurse's note dated 9/6/2013-5:00 P.M., indicated, "Upon walking into resident's room, observed resident was having white foam coming out of the right side of her mouth. Took blood sugar, it was 147, BP [blood pressure] 120/60, R[respirations] 18,</p>		<p>residents' records. Regarding education/training: an inservice was provided to all nursing staff on the topic of Oxygen Therapy on October 24, 2013. The inservice included the monitoring of oxygen saturation and respiratory status when appropriate.</p>				

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	<p>P [pulse] 112, T [Temperature] 101.5. Resident was very confused and unable to sit up or answer questions. After calling 911, another nurse assisted this writer to sit resident up enough for resident to take ATB [antibiotic] and drink some water. Resident unable to remain sitting and remained lying in bed until ambulance arrived." The record lacked documentation nursing assessed Resident #5's respiratory status and/or oxygen saturation. An emergency department physician's progress note dated 9/6/2013-6:00 P.M., indicated, "...patient presents with altered mental status, confusion... with a history of ...COPD, hypertension... CHF [congestive heart failure]... on chronic oxygen at 2 L, presenting to the ER [emergency room] for evaluation of decreased energy, confusion, "cold symptoms", and fever. [Facility nurse named] at the nursing home reports that patient having generalized weakness and "no energy" for about one week.... Nursing home reports the patient is typically very active and needs minimal assistance and is essentially independent.... They report that she's been having "cold symptoms" which apparently was some slight cough and congestion and reports of</p>						

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	<p>shortness of breath. The patient reports she's had these "cold symptoms" since yesterday and just generally feeling very weak.... She only complains of some congestion and slight shortness of breath.... Respiratory: ...diminished bilateral breath sounds, scant upper field wheezes..." This note indicated stat [immediate] respiratory treatments were administered, labs including arterial blood Gas [ABG] were obtained, and a stat chest X-ray was ordered.</p> <p>Lab results dated 9/6/2013-7:11 P.M., indicated blood gas results were, "... PO2 [arterial blood oxygen level] 64 mmHG [millimeters of mercury] "LOW...." This note indicated, "...physician's impression and plan diagnoses: Confusion... Altered mental status. Healthcare associated pneumonia versus COPD exacerbated. Possible early sepsis.... transfer to [hospital named] for further evaluation and treatment." A radiology note dated 9/6/2013-7:22 P.M., indicated, "Impression: mild... lung opacities are noted. These appear slightly increased on the left compared to previous study. These likely represent atelectasis [partially or completely collapsed lung]. Infection is not excluded."</p> <p>During an interview on 10/7/2013 at</p>						

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	2:00 P.M., the DON [Director of Nursing] indicated Resident #5 had a PRN [as needed] order to monitor her O2 levels. The DON indicated the facility did not have a policy but she would have expected the nursing staff to assess Resident #5's respiratory status including her oxygen saturation as ordered when she experienced the change in respiratory status leading up to her hospitalization. The DON indicated the record lacked documentation Resident #5 had been assessed for oxygen saturation levels. The DON indicated the O2 saturation assessment should have been documented in the MAR [Medication Administration Record]. Resident #5's September 2013, MAR lacked documentation which indicated her O2 saturation had been assessed as ordered by the physician.				