

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2015
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00187464.</p> <p>This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint IN00187464- Substantiated. Federal/State deficiencies related to the allegations are cited at F 225, F272, F279, and F309.</p> <p>Survey dates: November 25, 30 and December 1, 2015</p> <p>Partially extended survey dates: December 2, 3 and 4, 2015.</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Census bed type: SNF: 46 SNF/NF: 10 Total: 56</p> <p>Census payor type: Medicare: 32 Medicaid: 8 Other: 16</p>	F 0000		

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 0225 SS=D Bldg. 00	<p>Total: 56</p> <p>Sample: 4</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on December 9, 2015.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law</p>			

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	<p>through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an incident in which a resident required emergency medical services and subsequently expired due to blood loss was immediately reported to the State Agency. One of three resident of three reviewed for incident reporting in a population of four. (Resident #B)</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 11/25/15 at 10:30 A.M., and indicated Resident #B was admitted most recently on 11/05/15. Diagnoses, obtained from the current electronic medical records diagnosis list, included, but were not limited to, end stage renal disease, chronic congestive heart failure, coronary</p>	F 0225	<p>F 225 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B expired Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The facility has determined that all residents have the potential to be affected Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Administrator was educated by the Assistant Divisional Vice President to follow the Indiana State Department of Health Incident Reporting Policy regarding Reporting Unusual Occurrences and that occurrences should be reported</p>	12/15/2015

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	<p>artery disease, hypertension, and occlusion and stenosis of carotid artery.</p> <p>On 11/19/15 at 2:03 P.M., the facility reported through the Indiana State Department of Health Survey Reporting System an initial report regarding an incident involving Resident #B. The report indicated that on 10/19/15 at 4:50 A.M., Resident #B was "...found by Aide in supine position on floor next to bed at (room number for Resident #B). Nurse notified. CPR started immediately. Emergency services (911) called immediately...EMT's arrived on scene 0459 (4:59 A.M.)..."</p> <p>A follow up to the above report filed with the State Agency on 11/24/15 at 9:28 A.M., added "At the time of the incident, the CNA (CRCA #1; Certified Resident Care Assistant) was walking down the hallway and looked in the resident's (Resident B) room as she was passing by. Noted resident to be laying on the floor. Called for nurse. Resident was laying on her left side. Approximately a 2 inch laceration to left eyebrow noted and bleeding. Left arm shunt (fistula) area for dialysis also noted to be bleeding. No respirations or pulse noted. Code status checked and resident was a Full Code. CPR initiated 911 was called and Paramedics arrived and at this time they</p>		<p>immediately. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be completed 2 times per week for 8 weeks, then monthly for 4 months to ensure: 1) a thorough investigation of injury of unknown origin is completed, and 2) Immediate notification to the State Agency of injury of unknown origin occurred. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>took over performing CPR. Unable to resuscitate resident. Per the nurse assessment and paramedics report, the blood appeared to be from the renal shunt in her left arm, that had been 'displaced'. Per interview with the Medical Director and Dialysis MD, both stated that if the resident manipulate the renal shunt and removed the 'scab' portion over the opening, there would be significant bleeding."</p> <p>A timeline provided by the Executive Director (E.D.) on 11/25/15 at 1:30 P.M., and indicated to be an accurate account of events related to Resident #B's events on the evening of 11/18/15 and the morning of 11/19/15 indicated:</p> <p>Note by CRCA #1: 11/19/15 4:50 A.M., "Observed resident (Resident #B) on the floor and called out to the nurse."</p> <p>Notes by L.P.N. #3: 11/19/15 4:50 A.M., "Nurse responded to CRCA call to the resident's room. Resident on the floor with blood and emesis on the floor and on the sheets.</p> <p>11/19/15 4:55 A.M., "Code status confirmed."</p> <p>11/19/15 4:59 A.M., "Medics Arrived...Medics took over CPR."</p>			

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	<p>11/19/15 5:05 A.M., "NP (Nurse Practitioner) notified of event."</p> <p>11/19/15 5:08 A.M., "DHS (Director of Health Services) notified of event."</p> <p>11/19/15 5:20 A.M., "ED (Executive Director) notified of event."</p> <p>11/19/15 5:37 A.M., "Medics ceased cardiac code following a 30 min (minute) attempt to revive resident."</p> <p>11/19/15 8:07 A.M., "Police and medics have finished immediate investigation and advised facility may obtain orders for release of remains."</p> <p>The above timeline indicates the E.D. was initially notified of the incident involving Resident #B on 11/19/15 at 5:20 A.M. The initial report of the incident notes a time of submission of 11/19/15 at 2:03 P.M., indicated 8 hours and 43 minutes elapsed from the time the E.D. was advised of the incident until it was reported to the State Agency.</p> <p>This Federal tag relates to Complaint IN00187464.</p> <p>3.1-28(c)</p>			

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F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure a resident (Resident #B) who was admitted with diagnoses including, but not limited to, end stage renal disease, chronic</p>	F 0272	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: On 11/25/15 the MDS Coordinator completed a	12/17/2015

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	<p>congestive heart failure, coronary artery disease, hypertension, and occlusion and stenosis of carotid artery, was on hemodialysis, and had a venous access fistula (an implanted device to allow access for dialysis) had a completed Minimum Data Set (M.D.S.) assessment within 14 days of admission as required by regulation and facility policy. One resident of four reviewed for M.D.S. assessments.</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 11/25/15 at 10:30 A.M., and indicated Resident #B was admitted most recently on 11/05/15. Diagnoses, obtained from the current electronic medical records diagnosis list, included, but were not limited to, end stage renal disease, chronic congestive heart failure, coronary artery disease, hypertension, and occlusion and stenosis of carotid artery.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 11/12/15 indicated Resident #B was cognitively impaired, with a Basic Interview for Mental Status score of 7 of a possible 15. The remainder of the M.D.S. was incomplete.</p> <p>The staff member responsible for</p>		<p>Comprehensive Assessment for Resident #B Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>All residents of this facility have the potential to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>The MDS Coordinator attended an in-service presented by the MDS Nurse Consultant on 12/1/15 related to timely completion of MDS. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Health Services will audit the assessment schedule weekly to ensure timely completion. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>completing Resident #B's M.D.S. was interviewed on 11/25/15 at 12:05 P.M., with the Executive Director (E.D.) and Director of Health Services (D.H.S.) present. She indicated she was aware Resident #B's M.D.S. was incomplete, and past due. She indicated the M.D.S. should have been completed by 14 days after admission, which would correspond to 11/19/15. She stated the reason it was not done was "I'm behind."</p> <p>The admission M.D.S. was completed on the afternoon of 11/25/15. It indicated Resident #B had mood concerns of feeling down or depressed, sleep troubles, and little energy; had no behavior issues; required staff assistance of 1 person for bed mobility and transfers; was able to walk in her room with the assist of 1 person; and required staff assistance for toileting and personal hygiene. She was continent of bowel and bladder.</p> <p>On 11/30/15 at 9:10 A.M., the D.H.S. provided a copy of CMS's RAI Version 3.0 Manual Chapter 5: Submission and Correction of the MDS Assessment, dated October 2015. She indicated this represented the facility's policy on MDS completion and submission. The document indicated:</p>			

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F 0279 SS=D Bldg. 00	<p>"5.1 Transmitting MDS Data: All Medicare and/or Medicaid-certified nursing homes...must transmit required MDS data to CMS Quality Improvement and Evaluation System...</p> <p>5.2 Timeliness Criteria:...long term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:...For the Admission assessment, the MDS completion date...must be no later than 13 days after the Entry Date..."</p> <p>This Federal tag relates to complaint IN00187464.</p> <p>3.1-31(a) 3.1-31(b)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>			

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	<p>mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a resident (Resident #B) who was admitted with a diagnosis of end stage renal disease, was on hemodialysis, and had a venous access fistula (an implanted device to allow access for dialysis) had care plans to address care needs appropriate to a hemodialysis patient, care, assessment, and management of the fistula, or address the specific needs of other diagnoses, including but not limited to, chronic congestive heart failure, coronary artery disease, hypertension, and occlusion and stenosis of carotid artery. One resident of four reviewed for care plans.</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 11/25/15 at 10:30 A.M., and indicated Resident #B was admitted most recently on 11/05/15. Diagnoses, obtained from the current electronic medical records diagnosis list, included, but were not limited to, end stage renal disease, chronic congestive heart failure, coronary artery disease, hypertension, and</p>	F 0279	<p>F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B expired. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Director of Health Services (DHS) or designee reviewed all residents receiving dialysis services to ensure they have a care plan in place. DHS will review all resident care plans to determine identified risks are care planned. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Director of Health Services or designee will re-educate the Interdisciplinary Team on the following campus guidelines: 1) Care Plans, and 2) Dialysis services. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee 2 times per week for 8 weeks, then monthly for 4 months to ensure</p>	12/05/2015

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	<p>occlusion and stenosis of carotid artery.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 11/12/15 indicated Resident #B was cognitively impaired, with a Basic Interview for Mental Status score of 7 of a possible 15. The remainder of the M.D.S. was incomplete.</p> <p>Care plans documented for Resident #B were limited to one for code status initiated 11/06/15 which indicated Resident #B was a "Full Code" status, and one initiated 11/12/15 indicating a potential for weight fluctuation and alterations in labs due to receiving dialysis treatments. There were no care plans related to identified diagnoses, treatments, assistance with activities of daily living, appropriate care and assessment of the resident's dialysis fistula, communication with the dialysis center, or any other issues.</p> <p>An undated facility document titled "Guidelines for Dialysis Provider Communication" received from the Campus Clinical Support person on 12/04/15 indicated:</p> <p>"Purpose: To provide guidelines for communication and partnership of Dialysis Providers and the campus.</p>		<p>compliance: Review of all residents receiving dialysis services and any residents with identified risks to ensure a comprehensive plan of care has been developed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>Procedure:..6. A care plan shall be developed containing the necessary information for ongoing care interventions and approaches regarding Dialysis services."</p> <p>A facility document titled "Interdisciplinary Team Care Plan Guideline" dated 6/15 received from the Director of Health Services (D.H.S.) on 11/25/15 at 3:00 P.M., indicated: "Purpose: To ensure the appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines.</p> <p>Procedure: a. The initial plan of care included in the Nursing Assessment will be initiated within 24 hours and completed within 72 hours of admission to address pertinent areas of care, treatment and risk...</p> <p>c. A comprehensive care plan will be developed within 7 days of the completion of the admission comprehensive assessment...</p> <p>d. Care plans to address acute problems are to be written on the appropriate</p>			

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F 0309 SS=J Bldg. 00	<p>Circumstance form. Problems that become on-going or chronic, will then be addressed in the comprehensive care plan...</p> <p>g. Nurse managers shall communicate pertinent care plan approaches to the nursing staff via the Resident Profile, or in the clinical software.</p> <p>During an interview with the D.H.S. on 11/25/15 at 3:00 P.M., she indicated there were no other care plans for Resident #B.</p> <p>This Federal tag relates to complaint IN 00187464.</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure necessary services, including assessments, observations, and safety interventions,</p>	F 0309	F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B expired.	12/05/2015

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	<p>were implemented for a resident (Resident #B) with a venous access fistula (an implanted device to allow access for dialysis) who was identified as at risk for bleeding from the fistula and who suffered a fatal loss of blood from the fistula site. One of two residents reviewed for venous access fistula care and one of four residents reviewed for assessment of risk.</p> <p>The Immediate Jeopardy began on 11/18/15 at 9:30 P.M., when Resident #B returned from dialysis, and L.P.N. #1 identified bleeding from the resident's dialysis venous access fistula in her left arm, cleaned the area, and applied a reinforcement to the dressing. The Executive Director, Director of Health Care Services, and Assistant Director of Health Care Services were notified of the Immediate Jeopardy at 4:30 P.M., on 11/30/15.</p> <p>Findings include:</p> <p>On 11/19/15 at 2:03 P.M., the facility reported through the Indiana State Department of Health Survey Reporting System an initial report regarding an incident involving Resident #B. The report indicated that on 10/19/15 at 4:50 A.M., Resident #B was "...found by Aide in supine position on floor next to bed at</p>		<p>On 11/20/15, campus identified another dialysis resident potentially affected by the alleged deficient practice who had since been discharged home effective 12/1/15 without complications.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Current residents will be assessed to identify risks related to diagnoses and to ensure the plan of care has been updated to reflect the risks. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Director of Health Services (DHS) or Assistant DHS will educate the Nursing Team on the following campus guidelines:</p> <p>1. Educate licensed nurses on dialysis provider communication and guidelines for monitoring dialysis shunt.</p> <p>1. Educate licensed nurses on 24 hour report guidelines to include reviewing the Facility Activity Report during shift change. This includes communicating any change in resident status during shift to shift report.</p>	

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	<p>(room number for Resident B). Nurse notified. CPR started immediately. Emergency services (911) called immediately...EMT's arrived on scene 0459 (4:59 A.M.)..."</p> <p>A follow up to the above report filed with the State Agency on 11/24/15 at 9:28 A.M., added "At the time of the incident, the CNA (CRCA #1; Certified Resident Care Assistant) was walking down the hallway and looked in the resident's (Resident B) room as she was passing by. Noted resident to be laying on the floor. Called for nurse. Resident was laying on her left side. Approximately a 2 inch laceration to left eyebrow noted and bleeding. Left arm shunt (fistula) area for dialysis also noted to be bleeding. No respirations or pulse noted. Code status checked and resident was a Full Code. CPR initiated 911 was called and Paramedics arrived and at this time they took over performing CPR. Unable to resuscitate resident. Per the nurse assessment and paramedics report, the blood appeared to be from the renal shunt in her left arm, that had been 'displaced'. Per interview with the Medical Director and Dialysis MD, both stated that if the resident manipulate the renal shunt and removed the 'scab' portion over the opening, there would be significant bleeding."</p>		<p>1. Educate licensed nurses on Guidelines for Admission Assessment to identify potential risks (may include but not limited to- fall risk, elopement potential, skin breakdown, dialysis)</p> <p>1. Educate licensed nurses on Assessment and Documentation of Change of Condition related to identified risks</p> <p>1. Educate nursing leadership team on Assessment Review and Consideration which assists in identifying risk factors upon admission and/or change of condition.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Director of Health Services or Assistant Director of Health Services 7 times per week until 95% compliance is reached for 30 days, then 3 times a week until 95% compliance is reached for 30 days, then weekly until 95% compliance is reached for 30 days, then monthly until 95% compliance is reached for 3 months. - The percentage of</p>	

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	<p>The record of Resident #B was reviewed on 11/25/15 at 10:30 A.M., and indicated Resident #B was admitted most recently on 11/05/15. Diagnoses, obtained from the current electronic medical records diagnosis list, included, but were not limited to, end stage renal disease, chronic congestive heart failure, coronary artery disease, hypertension, and occlusion and stenosis of carotid artery.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 11/12/15 indicated Resident #B was cognitively impaired, with a Basic Interview for Mental Status score of 7 of a possible 15. The remainder of the M.D.S. was incomplete.</p> <p>The staff member responsible for completing Resident #B's M.D.S. was interviewed on 11/25/15 at 12:05 P.M., with the Executive Director (E.D.) and Director of Health Services (D.H.S.) present. She indicated she was aware Resident #B's M.D.S. was incomplete, and past due. She indicated the M.D.S should have been completed by 14 days after admission, which would correspond to 11/19/15. She stated the reason it was not done was "I'm behind."</p> <p>The admission M.D.S. was completed on</p>		<p>compliance is determined by adding the total number of "Y" answers in the boxes divided by the total number of boxes answered. - Abnormal Audit results found on weekends will be reported to the Director of Health Services immediately. If the Director of Health Services is the weekend auditor, he/she will report abnormal audits to Campus Clinical Support. Twice weekly the Campus Clinical Support, Area Vice President of Clinical Support, or Divisional Vice President will review audits to ensure compliance.</p> <p>1. Review all new admissions to ensure their record accurately reflect resident's identified risk and plan of care</p> <p>2. Review residents with change in condition (change in resident status; i.e. altered mental status, increased agitation, fever, fall, etc.) to ensure change was identified, documented, and that physician and responsible party were notified</p> <p>3. Review of 24 hour report to ensure licensed nurses are documenting any abnormal findings and communicating to the on-coming shift</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then quarterly or more often if compliance not achieved. - QA</p>	

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	<p>the afternoon of 11/25/15. It indicated Resident #B had mood concerns of feeling down or depressed, sleep troubles, and little energy; had no behavior issues; required staff assistance of 1 person for bed mobility and transfers; was able to walk in her room with the assist of 1 person; and required staff assistance for toileting and personal hygiene. She was continent of bowel and bladder.</p> <p>Care plans for documented for Resident #B were limited to one for code status initiated 11/06/15 indicated Resident #B was a "Full Code" status, and one initiated 11/12/15 indicating a potential for weight fluctuation and alterations in labs due to receiving dialysis treatments. There were no care plans related to diagnoses, treatments, assistance with activities of daily living, appropriate care and assessment of the resident's dialysis fistula, communication with the dialysis center, or any other issues.</p> <p>The resident's family member and Power of Attorney was interviewed by phone on 12/02/15 at 11:00 A.M. She indicated that on the evening of 11/18/15 she brought the resident back to the facility from dialysis, and brought dinner as was her custom. She noted seeing a "small amount" of blood on the resident's</p>		<p>meets monthly with the following in attendance: Executive Director, Director of Health Services, Medical Director or designee and at least three other members of the Interdisciplinary Team. o Other recommended committee members may include but not limited to: Director of Food Services, Consultant Pharmacist, Social Services Director, Activity Director, Environmental Services Director, Medical Records, MDS Nurse, Staff Development Employee Assistance Program (EAP) - the employees at Clearvista Lake that were affected by the resident identified event have been offered counseling services via EAP (see Attachment G). The Vice President of Communications will provide a customer service recovery response letter to campus families in the event of inquiries are noted. Once all appropriate staff members have been educated, compliance of policy is expected. Lack of policy compliance will result in disciplinary action up to and including termination if needed.</p>	

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	<p>sweater, and observing while the nurse cleaned and reinforced the dressing. She did not note any problems after the dressing was reinforced. She indicated she had been called to the facility on the early morning of 11/19/15. When she arrived at the facility at 6:15 A.M., she indicated she was told the resident had "bled to death" in her room and that due to the amount of blood in the room the police advised her that it would not be good for her to see it. She indicated she was not allowed to see the resident until after the room and the resident's body had been cleaned. She indicated she had regularly transported the resident to dialysis, and the facility had never sent any paperwork with her to give to the dialysis center. She also indicated the facility had never asked for any report of the resident's status or condition at dialysis, and the dialysis facility had never provided any documentation for her to present to the facility.</p> <p>An "Investigation Interviews" form completed by the Assistant Director of Health Services (A.D.H.S.) indicated:</p> <p>"Resident Name: (Resident B) Date of Occurrence: 11/19/15 Description of Occurrence: Resident found unresponsive on floor. 'This writer notified at 0522 (5:22</p>			

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	<p>A.M.)...that resident was found on the floor...This writer was notified that police were notified by EMS (Emergency Medical Services) because of the amount of blood in resident's room...This writer entered room...Resident was lying on her back covered by a blanket. Blood stretched from head of resident's bed to the opposite wall...this writer walked to (symbol for "left") side of bed and found kerlix dressing covered in blood...Large pile of vomit noted in pile of blood next to wall along (symbol for "right") side of bed. Multiple pools of blood noted on bed and sheets...large cut noted above resident's (symbol for "left") eyebrow. Also noted was a bloody hand print on wall...""</p> <p>A written statement by the Director of Health Services (D.H.S.) dated 12/02/15 indicated: "I cleaned up/post mortem care given to resident, a large amount of blood was noted all around the resident, while cleaning her up there were numerous blood clots from the shoulder to the wrist were noted...she had a cut on her left eyebrow, approximately 1 inch...(we) transferred to the bed, we washed her hair, a moderate amount of bright red blood was noted on the bottom sheet under her head. I steri stripped (a bandage dressing) her left eye and it stopped bleeding. The family then viewed her."</p>			

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	<p>A progress note recorded by L.P.N. #2 with a date and time of 11/18/15 at 9:40 P.M., entered as a Late Entry on 11/20/15 at 4:51 P.M., indicated " Resident (Resident# B) arrived back to facility in w/c (wheelchair) with (family member) at this time. Resident has no c/o fatigue. When (family member) took residents jacket off blood was noted to left sweater sleeve. Sweater removed and drsg (dressing) to fistula site was bloody. Area cleansed and wrapped with kerlix and secured with tape. Resident had no further bleeding noted at this time. (Family member) stated that resident was anxious to leave dialysis this evening. No paperwork from dialysis returned. (Family member) brought resident dinner to facility. Aided resident into bed. No c/o (complaint of) pain or discomfort. Skin is warm, dry, and pink. No SOB (shortness of breath) noted. Resident's (family member) left the facility aroun (sic) 10:15-20 (P.M.)"</p> <p>A written statement from L.P.N. #2 dated 11/20/15 included, but was not limited to, "... (symbol for "at") 11 P.M. report given to night shift nurse (nurse #3) the drsg applied to fistula site and no further bleeding had been noted (symbol for "after") drsg applied..."</p>			

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	<p>L.P.N. #2 was interviewed in person on 12/02/15 at 1:45 P.M. She indicated she provided care for Resident #B when she returned from dialysis on 11/18/15 at approximately 9:00 P.M. During care she noted blood on the resident's fistula dressing, which she noted as about the size of a fifty cent piece. She indicated she had taken care of dialysis patients before, and did not consider this to be an unusual occurrence. She indicated she cleaned the area and reinforced the dressing, and saw no more bleeding. She assisted the resident to prepare for and get into bed. She indicated the resident was pleasant and happy and gave her a hug before she left. She indicated she did tell the oncoming nurse about the bleeding and dressing reinforcement at shift change, but did not write it down anywhere.</p> <p>Progress notes entered by L.P.N. #3 included:</p> <p>11/19/15 4:40 A.M., "Nursing called to resident's room by CRCA. Resident found lying on right side and facing the doorway. Blood and emesis of partially digested food noted on floor to left of bed. Blood also noted on sheets."</p> <p>11/19/15 4:55 A.M., "Resident's code status confirmed as full code. NRSRG</p>			

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	<p>(nursing) directed CRCA to call 911 and additional CRCA to get crash cart and notify another nurse for assist. CPR initiated. Resident positioned on back and sternal rub given with no response. Chest compressions started. Additional nurse on scene and assisting. CRCA at building entrance to assist medics to resident room. AED (automatic electronic defibrillator) applied and it instructed to continue with chest compressions. Ambu bag (a hand held device used to provide ventilation for a person who is not breathing) utilized by assisting nurse."</p> <p>11/19/15 4:59 A.M., "Medics have arrived at facility and to resident's room. Chest compressions in progress. Medics taking over CPR at this time."</p> <p>11/19/15 5:37 A.M., "Medics have ceased cardiac code process at this time following a 30 minute attempt to revive resident."</p> <p>A written statement from L.P.N. #3 indicated to be for events of 11/19/15 included, but was not limited to, "On 11/18/15 I took report from (L.P.N. #2) evening shift nurse. This statement is concerning (Resident #B). I was told in report that (Resident #B) had come back from dialysis around 9 P.M. and to pass</p>			

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	<p>on that she wanted her legs shaved. That is the only information I received about this patient in report...(Resident #B's family member) returned my call at 5:25 A.M. I told her of the events taking place. (She) told me at that time that (Resident #B's) fistula was bleeding when she brought her back from dialysis. (She) stated that the evening shift nurse (L.P.N. #2) had put a dressing on the fistula site. I was not told any of this information in report..."</p> <p>L.P.N. #3 was interviewed in person on 12/02/15 at 11:30 A.M. She indicated that information noted above in her progress notes and her written statement were accurate. She indicated that when she was called into Resident #B's room, Resident #B's upper body was "completely covered in blood." She indicated that she saw no active bleeding. She also indicated she saw no significant bleeding from the cut over the resident's eyebrow. She reiterated that she had never been told of any bleeding or concerns about the dressing over the fistula. She provided a shift report sheet for 11/18/15, which she indicated she used to document information obtained in report at shift change. The box for Resident #B contained the notes "Dialysis" and "Wants legs shaved." There was nothing noted on the form</p>			

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	<p>about bleeding or concerns with the fistula dressing.</p> <p>"Employee Counseling Record" forms provided by the D.H.S. and dated 11/27/15 indicated both LPN #2 and LPN #3 had received written counseling, with a "Reason for Employee Counseling" noted as "Did not use 24 hour log to communicate bleeding to shunt site on 11/18/15."</p> <p>CRCA #1 was interviewed by phone on 12/02/15 at 4:30 P.M. She indicated that on 11/19/15 at 4:50 A.M. she passed Resident #B's room and observed her on the floor in "a huge pool of blood." She indicated she did not enter the room, but immediately called nursing who came to the room, and directed her to call 911, which she did. She indicated she did not participate in the code in any way other than directing E.M.S. to the room.</p> <p>A physician's order was obtained on 11/18/15 for Resident #B to assess the fistula site for bruit and thrill (used to assess the condition of a fistula or graft; "bruit" is a whooshing sound detected by listening with a stethoscope, and "thrill" is a vibration that is felt). The A.D.H.S. indicated this order was obtained following a chart review, and that this order should have been in place since</p>			

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	<p>admission. A Treatment Administration History document indicates these checks were performed on day, evening, and night night shifts on 11/18/15, all noted to have been done by L.P.N. #2. Resident #B's record, including progress notes and 24 hour reports, contain no other documentation of any assessment or observation of Resident #B, including the condition of her fistula site, other than as noted above, for the period following her return from dialysis on 11/18/15 until being found on the floor in her room at 4:50 A.M., on 11/19/15.</p> <p>During an interview on 11/30/15 at 11:30 A.M., the Director of Health Services indicated there was no additional documentation of observation or assessment of Resident #B other than as noted above.</p> <p>During the above interview, and confirmed by interview on 12/03/15 at 10:10 A.M., the D.H.S. indicated that Dialysis Communication Forms were sent with Resident #B to each dialysis appointment. The facility was responsible for completing the top section , "Communication From Campus to Dialysis Center", prior to sending the resident for treatment. The middle section, "Communication From Dialysis to Campus", was the responsibility of the</p>			

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	<p>dialysis center to complete before returning the resident to the facility. The bottom section, "Assessment Upon Return From Dialysis" was to be completed by the facility.</p> <p>Dialysis Communication Forms, as initiated by the facility, were received from the facility for the dates 11/06/15, 11/09/15, 11/11/15, 11/13/15, 11/16/15, and 11/18/15. Each had the top and bottom sections completed. None contained any documentation in the center section from the dialysis center. The D.H.S. indicated a facility nurse should have contacted the dialysis center to obtain the missing information, and did not.</p> <p>The dialysis center that treated Resident #B was visited on 12/01/15 and the dialysis clinic's treatment sheets for the dates 11/04/15 through 11/18/15 were reviewed. During the review, the dialysis clinic director indicated that all communication had been with the resident's family, and no information was communicated directly to the facility. The clinic director indicated a section on the clinic's reports called "notes" was used to document any unusual issues. None of the reports mentioned any issues with bleeding. Notes related to the resident's mood and behavior included:</p>			

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	<p>11/06/15 "pt (patient) unable to sit in chair, wanted to stand up...making it unsafe for the pt to continue tx...family called to make them aware..."</p> <p>11/11/15 "...needed continual verbal cueing to stay in chair...(family member)...made aware..."</p> <p>11/16/15 "...pt had to have a sitter at chairside to run tx (treatment)., continues to want to get out of chair and go home, needs continual cueing for safety..."</p> <p>11/18/15 "...needing verbal cueing to stay in chair...family made aware that pt may need a sitter with tx."</p> <p>During the phone interview with the resident's family member 12/02/15 at 11:00 A.M., she indicated the dialysis facility had discussed with the family about the possible future need for a sitter during treatment to ensure safety, but no decision had been made. She also indicated that the only time the resident was anxious or agitated was during the actual dialysis treatment, indicating "she has trouble sitting still that long."</p> <p>A written statement dated 12/01/15 and signed by the dialysis center manager indicated "To whom it may concern: To</p>			

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	<p>the best knowledge of the staff employed at (name of dialysis center) no communication from Clearvista Lake nursing facility was presented with (name of Resident B) prior to treatments."</p> <p>A facility document received from the Executive Director on 11/20/15 at 9:10 A.M., titled "SNF Outpatient Dialysis Services Agreement" dated 8/13/14 and signed by representatives from the facility and the dialysis service provider indicated:</p> <p>"Transport and Referral of ESRD (end stage renal disease) Residents:...The facility shall be responsible for arranging for suitable and timely transportation...including...qualified personnel to accompany the ESRD Residents...</p> <p>Obligations of the ESRD Dialysis and/or Company...To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care...including, but not limited to, bleeding, infection, and care of dialysis access site."</p> <p>Mutual Obligations:</p> <p>Collaboration of Care: Both parties shall ensure that there is documented evidence</p>			

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	<p>of collaboration of care and communication...Documentation shall include, but not be limited to, participation in care conferences..."</p> <p>During an interview on 11/30/15 at 11:30 A.M., the Executive Director indicated he was uncertain of the definition of "qualified personnel" as required in the "Transport and Referral" section of the Dialysis Service Agreement above.</p> <p>A facility document titled "Guidelines for Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft, or Central Venous Catheter) dated 6/2015 received from the Campus Clinical Support person on 12/04/15 indicated:</p> <p>"Purpose: To effectively provide monitoring of vascular access utilized for hemodialysis.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Monitor AV shunt daily for: redness; swelling; signs and symptoms of infections... 2. Monitor the AV shunt daily for bruit and thrill... 3. Area of AV shunt dressing, is to be 			

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	<p>kept clean and dry. Dialysis will typically change the dressing...</p> <p>5. Notify attending physician, dialysis center and responsible party of adverse findings...</p> <p>6. Document assessment findings in medical record nursing notes and or in designated area on treatment record...</p> <p>7. If abnormal bleeding is noted apply pressure to area and call 911 for transfer to the hospital."</p> <p>An undated facility document titled "Guidelines for Dialysis Provider Communication" received from the Campus Clinical Support person on 12/04/15 indicated:</p> <p>"Purpose: To provide guidelines for communication and partnership of Dialysis Providers and the campus.</p> <p>Procedure:</p> <p>1. The campus shall have the information regarding the Dialysis Provider schedule and requirements such as but not limited to:..C. Required documentation from campus.</p> <p>2. The campus shall be responsible for</p>			

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	<p>arranging or providing transportation to and from the Dialysis Provider...</p> <p>4. A report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the the campus regarding:</p> <p>a. tolerance to procedure,</p> <p>b. vital signs,</p> <p>c. medications administered,</p> <p>d. other information deemed necessary for the ongoing provision of care.</p> <p>5. Upon return from the Dialysis Provider the campus shall:</p> <p>a. Provide ongoing monitoring of the shunt site for signs of complication.</p> <p>b. Review the Dialysis Provider paperwork for any necessary follow up requirements.</p> <p>6. A care plan shall be developed containing the necessary information for ongoing care interventions and approaches regarding Dialysis services."</p> <p>The Immediate Jeopardy that began on 11/18/15 was removed on 12/03/15 at</p>			

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	<p>3:30 P.M., when the facility provided documentation of re-education of staff members on dialysis fistula assessment and care, communication and documentation in report and on appropriate facility forms, and timeliness of resident observations. Staff were interviewed to ensure knowledge of assessment, observation, communication, and documentation; and a plan was initiated to ensure ongoing staff training and compliance with identified issues. Facility records were reviewed to ensure compliance with identified corrections. The noncompliance remained at the lower level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all employees had not been inserviced.</p> <p>This Federal tag relates to complaint IN 00187464.</p> <p>3.1-37(a)</p>			