

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2011	
NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES				STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN47362			
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F0000	<p>This visit was for the Investigation of Complaint IN00094307.</p> <p>Complaint IN00094307 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-309 and F-385.</p> <p>Survey dates: August 18, &amp; 19, 2011</p> <p>Facility number: 000080 Provider number: 155160 AIM number: 100289330</p> <p>Survey team: Angel Tomlinson RN TC Cheryl Fielden RN</p> <p>Census bed type: SNF/NF: 67 SNF: 3 Total: 70</p> <p>Census payor type: Medicare: 10 Medicaid: 50 Other: 10 Total: 70</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>			F0000			

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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F0309 SS=G	<p>16.2.</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to thoroughly assess a resident's pain, failed to consistently attempt to obtain a hip x-ray for a resident experiencing pain and failed to have a physician evaluate a resident's pain, resulting in the resident experiencing unrelieved pain, for 1 of 3 residents sampled for fractures in a total sample of 4 (Resident #A).</p> <p>Finding include:</p> <p>The record of Resident #A reviewed on 8-18-11 at 11:00 a.m., indicated the resident's diagnoses included, but were not limited to, osteoporosis, Parkinson disease, osteoarthritis, history of right hip fracture, anxiety, depression and left hip fracture.</p> <p>The Minimum Data Set (MDS) assessment for Resident #A dated 5-9-11, indicated the following: functional limitation of range of motion- no impairment.</p>	F0309	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. Please accept this Plan of Correction as our credible allegation of compliance as of September 18, 2011. F309 QUALITY OF CARE - The facility's practice is to provide care/services for the highest well being. 1) Resident A has been evaluated by Physician , pain medication appropriate, pain assessment and care plan reviewed. Resident A will have pain evaluated thru weekly nursing summaries and updated pain assessment when applicable. 2) Residents who reside in the facility have the potential to be affected by the alleged deficient practice. Residents pain assessments have been reviewed for completion and assessments updated if indicated. Nursing</p>	09/18/2011	

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	<p>The MDS assessment for Resident #A dated 8-3-11, indicated the following: making self understood- usually understood, ability to understand others- usually understands others, cognitive skills for daily living- severely impaired, bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- did not occur, toilet use- total dependence of two people, functional limitation in range of motion- impairment on one side of the lower extremity.</p> <p>The physician recapitulation for Resident #A dated July 2011, indicated the resident had a routine pain medication ordered of Vicodin 5-500 milligrams at 8 a.m. and 6 p.m. The original date the pain medication was ordered was March 2011.</p> <p>The medication administration record for Resident #A dated July 2011, indicated the resident had a Tylenol 325 milligram, two tablets every 4 hours as needed for pain ordered. The Tylenol was not signed as given to the resident in the month of July 2011.</p> <p>The resident progress note for Resident #A dated 6-18-11 at 1:50 p.m., indicated the resident was calling out for help. When asked what was wrong the resident</p>		<p>education on pain management, pain assessment, documentation guidelines , and change in condition with physician notification by SDC/DNS 9/18/11. Post test completed. Residents pain assessments reviewed no less than quarterly by IDT. 3) The facility policy for pain management was reviewed. Situation Background Assessments Recommendations (SBAR) assessment and notification form will be utilized to identify new or worsening conditions has been implemented. Daily monitoring of 24 hour condition reports will be conducted by Nursing management. Nurses have been educated on the above policy and SBAR form by SDC/DNS 9/18/11. Nursing management will review the 24 hour condition report daily on scheduled work days (5times weekly) on an ongoing basis to ensure appropriate follow up on any new or worsening pain, pain assessment updates, and physician notification. DNS/ Designee will monitor for compliance. 4) Results of SBAR and 24 hour condition report will be discussed during facility's monthly CQI meeting for a minimum of 6 months and will develop an action plan if threshold is not achieved. DNS/ Designee will monitor weekly times 4 weeks, monthly times 2 months, and quarterly thereafter. 5) The corrective actions will be</p>		

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	<p>indicated her "bottom hurts." The nurse attempted to place resident in a proper placement in the wheelchair to help alleviate the pain. The nurse requested occupational therapy to provide a new pad for the chair to help the resident.</p> <p>The resident progress note for Resident #A dated 6-18-11 at 9:21 p.m., indicated the resident was leaning forward and tipping the wheelchair and trying to get out.</p> <p>The resident progress note for Resident #A dated 6-19-11 at 3:10 p.m., indicated the resident continues to complain of her bottom being sore. There were no open areas noted, but the buttocks was reddened.</p> <p>The resident progress note for Resident #A dated 6-29-11 at 2:27 p.m., indicated the resident complained of her bottom hurting. The area was inspected and an small open area found. The physician was notified and a treatment ordered.</p> <p>The resident progress note for Resident #A dated 7-3-11 at 9:09 p.m. indicated the resident was leaning forward in the wheelchair and putting her legs under the wheelchair.</p> <p>The resident progress note for Resident</p>		completed on or before September 18, 2011.				

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	<p>#A dated 7-5-11 at 10:53 a.m., indicated the open area to coccyx was almost closed. The area was red and blanchable, and the resident complained at times that it hurts.</p> <p>The resident progress note for Resident #A dated 7-6-11 at 2:52 p.m., indicated the resident had been very restless while in the wheelchair. The resident was leaning forward to take the pressure off of the coccyx.</p> <p>The resident progress note for Resident #A dated 7-6-11 at 12:24 p.m., indicated the resident continues to complain of pain in the area of the coccyx while sitting in the wheelchair. The resident was squirming, trying to stand and leaning forward and over the arm rest to get relief from pain. Therapy was called to have resident reviewed for a new chair or pad to allow comfortable sitting.</p> <p>The resident progress note for Resident #A dated 7-7-11 at 10:44 a.m., indicated the resident was complaining of pain in the area of the wound, but it did not appear to be related to the wound. The physician was notified of complaints of pain and waiting for a response.</p> <p>The resident progress note for Resident #A dated 7-7-11 at 1:37 p.m., indicated</p>				

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	<p>the resident was occasionally complaining of discomfort in the buttock area. The physician was faxed again about the pain and a request for an x-ray was requested. No return fax at that time.</p> <p>The resident progress note for Resident #A dated 7-7-11 at 7:20 p.m., indicated the physician on call was called to obtain an order for an x-ray due to the resident was having discomfort when up in the wheelchair. The physician on call indicated it was not an emergency and was something that could be faxed or called to get an order. Will continue to monitor for increase signs and symptoms of pain.</p> <p>The resident progress note for Resident #A dated 7-8-11 at 10:12 a.m., indicated the staff talked with the Nurse Practitioner (NP) and informed her that the resident was having discomfort while sitting and the pain appeared to be in the buttocks area. The NP gave an order for an x-ray of sacrum and coccyx. The local radiology facility was notified.</p> <p>The resident progress note for Resident #A dated 7-8-11 at 10:30 a.m., indicated the NP called back the facility and discontinued the order for the x-ray of the sacrum and coccyx. The NP ordered lab work and for the resident to be off the</p>				

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	<p>buttocks as much as possible.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 1:45 a.m., indicated the resident was in wheelchair awake until 12:00 a.m., due to restlessness. The resident was leaning forward until chair alarm sounded.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 9:28 a.m., indicated the resident continued to complain of sacral area hurting when up in wheelchair.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 5:15 p.m., indicated the resident was getting upset and squirming in the chair.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 10:15 p.m., indicated the resident was sitting in the wheelchair yelling out "help me, I can't walk" repetitively. The resident was also squirming in the wheelchair.</p> <p>The resident progress note for Resident #A dated 7-11-11 at 8:54 p.m., indicated the resident was trying to stand up out of wheelchair.</p> <p>The resident progress note for Resident #A dated 7-12-11 at 7:00 p.m., the resident took off a piece of her wheelchair</p>				

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	<p>and began hitting nursing staff. The resident was trying to tip her wheelchair back and rocking back and forth. The resident was attempting to pull the printer on the nurses desk. The on call physician was called and an order received to send the resident for a psychiatric evaluation.</p> <p>The resident progress note for Resident #A dated 7-13-11 at 12:44 p.m., indicated the resident's family wished to increase the resident's antianxiety medication before sending the resident to a psychiatric unit.</p> <p>The resident progress note for Resident #A dated 7-15-11 at 11:57 p.m., indicated the resident was standing up in the chair.</p> <p>The resident progress note for Resident #A dated 7-16-11 at 10:04 p.m., indicated the resident was sitting in the wheelchair at the nursing station. The resident continues to rock back and forth.</p> <p>The resident progress note for Resident #A dated 7-17-11 at 5:59 a.m., indicated the resident had been rocking back and forth and pushing herself into other residents.</p> <p>The resident progress note for Resident #A dated 7-17-11 at 9:25 a.m., indicated the resident had attempted to climb out of</p>			

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	<p>bed several times.</p> <p>The resident progress note for Resident #A dated 7-20-11 at 7:12 a.m., indicated the resident had been up all night. The resident was standing up in her chair and leaning over in the chair, touching the floor almost tipping the chair over. The resident was placed in bed, but kept getting out of bed. The resident sat up in wheelchair all night in front of the nursing station. The resident had to be redirected multiple times to sit up in the chair.</p> <p>The resident progress note for Resident #A dated 7-21-11 at 7:01 a.m., indicated the resident kept getting out of bed during the night. The resident was up in the wheelchair and kept leaning forward.</p> <p>The resident progress note for Resident #A dated 7-21-11 at 1:10 p.m., indicated the resident continues to be restless in the wheelchair and attempts to stand up occasionally.</p> <p>The resident progress note for Resident #A dated 7-22-11 at 2:21 a.m., indicated the resident was restless in the wheelchair. The resident repeatedly took off her gown. The resident was leaning forward in the wheelchair attempting to reach her feet.</p> <p>The resident progress note for Resident</p>						

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	<p>#A dated 7-22-11 at 9:36 p.m., indicated the resident was standing in the wheelchair all shift.</p> <p>The resident progress note for Resident #A dated 7-23-11 at 11:03 p.m., indicated the resident was standing up in wheelchair and leaning forward in the chair, touching the floor.</p> <p>The resident progress note for Resident #A dated 7-24-11 at 12:05 a.m., indicated the resident was out of the bed four times. The resident was sitting at the nursing station in her wheelchair and kept leaning over, almost tipping the chair over.</p> <p>The resident progress note for Resident #A dated 7-24-11 at 12:25 a.m., indicated the resident was unable to sit in the wheelchair. The resident was standing up and leaning over in the wheelchair. The nurse was holding the resident up in the chair. The resident states "can't sit up". The physician on call was notified and an order was received to send the resident to the emergency room.</p> <p>The resident progress note for Resident #A dated 7-24-11 at 4:30 a.m., indicated the resident returned from the emergency room with a new order for Haldol (antipsychotic medication) 1-2 milligrams for agitation.</p>						

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	<p>The resident progress note for Resident #A dated 7-25-11 at 12:19 a.m., indicated the resident was at the nursing station in the wheelchair rocking back and forth. The resident was attempting to stand. The resident was asking for someone to take her home and yelling for help.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 3:00 a.m., indicated the resident was standing up in her wheelchair. The resident also was leaning over in the chair and holding the bottom of the wheelchair.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 5:50 a.m., indicated the resident had been up all night sitting in wheelchair in front of the nursing station. The resident had been rocking back and forth and attempting to stand up.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 9:35 a.m., indicated the physician was in to see the resident and ordered an x-ray of the coccyx.</p> <p>The physician progress note for Resident #A dated 7-25-11, indicated the resident had behavior issues. The resident had been up and down, throwing things, wont stay in bed. Sundown's about 1:00 p.m. everyday. The resident does hit. This had</p>						

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	<p>been going on for one month, but was worse for the past two weeks. The resident was sent to the emergency room and was given Haldol. The resident complained of tail bone pain. "Coccyx films".</p> <p>The resident progress note for Resident #A dated 7-25-11 at 3:43 p.m., indicated the resident had been tearful and crying off and on. The resident had been moving all day. The resident was trying to stand up and rocking back and forth.</p> <p>The resident progress note for Resident #A dated 7-26-11 at 1:15 a.m., indicated the x-ray results showed a displaced intertrochanteric fracture of the left hip with superior displaced of the femur. An order was received to send the resident to the emergency room.</p> <p>The local emergency room record for Resident #A dated 7-26-11, indicated the had left hip pain for one month. The pain was worse when the resident was up and with movement. The diagnosis was left hip fracture.</p> <p>The radiology report for Resident #A dated 7-26-11, indicated the indication was in pain for one month; fall. The discussion was displaced transverse left femoral neck fracture (left hip fracture).</p>						

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	<p>Osteopenia or osteoporosis is suggested.</p> <p>The orthopedic staff initial consult for Resident #A dated 7-26-11, indicated the resident was seen for an orthopedic assessment concerning a fractured left hip. There was some shortening of the left lower limb on comparison to the right. There was mild external rotation. Review of the x-ray showed subacute to chronic fracture of the left hip. "It is obviously old." The recommendation was that management be focused on pain management.</p> <p>During observation on 8-18-11 at 10:35 a.m., CNA #1 and CNA #2 transferred Resident #A with a hooyer lift from and geri chair to the bed. Interview with CNA #1 at this time indicated the resident was transferred with two people and a gait belt before she fractured her hip. CNA #1 indicated Resident #A could stand good before the hip fracture. CNA #1 indicated Resident #A's family came in all the time every day to see the resident.</p> <p>Interview with Resident #A's family on 8-18-11 at 12:05 p.m., indicated she was told the facility did not know how Resident #A's left hip fracture happened. The family member indicated the orthopedic doctor told the family the fracture was at least 6 weeks old. The</p>						

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	<p>family member indicated the resident had been complaining of pain and the nurse tried to order an x-ray, but the physician did not feel it was necessary to get an x-ray. The family member indicated the resident had been crying with pain for weeks, approximately 1 month. The family member indicated when the resident's doctor came to see the resident, a family member asked the doctor to get an x-ray and then the facility did.</p> <p>Interview with LPN #3 on 8-18-11 at 12:35 p.m., indicated she was the nurse who called the on call physician on 7-7-11 to obtain an x-ray order for Resident #A. LPN #3 indicated the resident had been having pain. LPN #3 indicated the facility had attempted to call and fax the doctor and did not get any response. LPN #3 indicated she told the on call physician that the resident was in pain and the resident needed an x-ray. LPN #3 indicated the physician on call would not give her an order to do the x-ray. LPN #3 indicated the resident was up in a wheelchair and leaning over. LPN #3 indicated the resident seemed in pain and was leaning over like her back or tail bone hurt. LPN #3 indicated the resident was fidgety. LPN #3 indicated the resident was acting different from her normal. LPN #3 indicated the facility had not told her what to do in this type of situation, LPN #3</p>						

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	<p>indicated she didn't know if she could call someone else or not.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 8-18-11 at 1:00 p.m., indicated the Nurse Practitioner called her on 7-8-11 in the morning and wanted to know what happened the night before and why was the nurse calling the physician on call. The ADON indicated initially the Nurse Practitioner gave her an order for an x-ray and then called back and said the physician on call said no to the x-ray and to get blood work. The ADON indicated Resident #A's physician was the Medical Director of the facility and she was out of town. The ADON indicated the facility did not have a Director of Nursing (DON) at the time either. The ADON indicated there was a RN acting as DON at the time, but she was working her regular shift as normal.</p> <p>Interview with LPN #4 on 8-18-11 at 1:40 p.m., indicated she was the nurse on 7-7-11 during the day. LPN #4 indicated Resident #A was complaining her bottom hurt and doing a lot of fidgeting. LPN #4 indicated the resident was lifting herself up off the wheelchair a lot trying to relieve pressure. LPN #4 indicated Resident #A had been exhibiting signs of pain for a few days. LPN #4 indicated she had called and faxed the physician and did</p>						

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	<p>not get any response. LPN #4 indicated she told the nurse on the next shift.</p> <p>Interview with the DON on 8-19-11 at 9:40 a.m., indicated the hospital told the facility, Resident #A's left hip fracture was at least 6 weeks old. The DON indicated she did not think the physician on call had assessed Resident #A. The DON indicated the first physician progress note that Resident #A was assessed by a physician was 7-25-11.</p> <p>Interview with the physician on call on 8-19-11 at 11:20 a.m., indicated the facility called him on 7-7-11 at 8:30 p.m. The physician on call indicated the nurse told him Resident #A had been having pain for 3 days. The physician on call indicated he felt like it was something that could have been dealt with in the morning. The physician on call indicated he called the facility the next morning and asked how Resident #A was doing. The physician on call indicated he was told that the resident was not having any problems. The physician on call indicated he could not remember who he talked with. The physician on call indicated he did not want to ignore other problems the resident may have been having such as anemia.</p> <p>The "Pain Management" policy provided</p>						

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	<p>by the DON on 8-18-11 at 2:40 p.m., indicated it was the facility's policy to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, including pain management. It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keeping the resident as comfortable and pain free as possible. The residents are assessed for pain upon admission, quarterly, and with significant change in the resident's condition and/or new onset of pain. The non-interviewable resident pain management program will be determined based upon staff observation of non-verbal signs of pain as follows: non- verbal sounds (crying, whining, gasping, moaning, or groaning), vocal complaints of pain (that hurts, ouch, stop), facial expressions (grimacing, wincing, wrinkled forehead, furrowed brow, clenched teeth) and protective body movements or postures (bracing, guarding, rubbing or massaging a body part, clutching or holing a body part during movement).</p> <p>This federal tag relates to Complaint IN00094307.</p> <p>3.1-37(a)</p>						

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F0385 SS=D	<p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on interview and record review the facility failed to ensure a resident's medical care was supervised by a physician for one resident experiencing pain. the facility faxed the physician two times and called the physician for medical treatment and no medical treatment or evaluation was done. The resident was not evaluated or treated by a physician for the pain for 18 days after the initial request for treatment and evaluation of the pain, for 1 of 3 residents sampled for fracture in a total sample of 4 (Resident#A).</p> <p>Findings include:</p> <p>The record of Resident #A reviewed on 8-18-11 at 11:00 a.m., indicated the resident's diagnoses included, but were not limited to, osteoporosis, Parkinson disease, osteoarthritis, history of right hip fracture, anxiety, depression and left hip fracture.</p> <p>The Minimum Data Set (MDS)</p>	F0385	<p>F 385 PHYSICIAN SUPERVISION - The facility's practice is to provide care supervised by a physician and another physician supervises the medical care when their attending physician is unavailable. 1) Resident A has been evaluated by primary care physician. Medications have been reviewed and pain management has been addressed. Care plans and assessments are up to date. 2) Residents who reside in the facility have the potential to be affected by the alleged deficient practice. Residents are reviewed daily thru 24 hour condition report to identify any need for physician notification of any new or significant changes and orders obtained if indicated. Nursing education of change in condition and physician notification by SDC/DNS 9/18/11. Post test completed. 3) The facility's policy for change in condition and physician notification were reviewed. Situation Background Assessment Recommendation (SBAR) assessment and notification form has been</p>	09/18/2011	

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	<p>assessment for Resident #A dated 5-9-11, indicated the following: functional limitation of range of motion- no impairment.</p> <p>The MDS assessment for Resident #A dated 8-3-11, indicated the following: making self understood- usually understood, ability to understand others- usually understands others, cognitive skills for daily living- severely impaired, bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- did not occur, toilet use- total dependence of two people, functional limitation in range of motion- impairment on one side of the lower extremity.</p> <p>The resident progress note for Resident #A dated 6-18-11 at 1:50 p.m., indicated the resident was calling out for help. When asked what was wrong the resident indicated her "bottom hurts." The nurse attempted to place resident in a proper placement in the wheelchair to help alleviate the pain. The nurse requested occupational therapy to provide a new pad for the chair to help the resident.</p> <p>The resident progress note for Resident #A dated 6-18-11 at 9:21 p.m., indicated the resident was leaning forward and tipping the wheelchair and trying to get</p>		<p>implemented. Daily monitoring of 24 hour condition report will be conducted by nursing management. Any resident with a change in condition or orders obtained from the call physician, the primary care physician will be notified on the next business day and updated on resident condition. Nurses have been educated on SBAR form and physician notification by SDC/DNS 9/18/11. Nursing management will review the 24 hour condition report and SBAR form daily on scheduled work days (5times weekly) on an ongoing basis to ensure appropriate follow up on physician notification of any resident change in condition and primary care physician notification. Discussion with Medical Director to review Medical Director responsibilities by DNS 9/18/11. 4) Results of SBAR and 24 hour condition report will be discussed during facility's monthly CQI meeting for a minimum of 6 months and an action plan will be developed if threshold is not achieved. Medical Director attends CQI meeting quarterly. 5) The corrective actions will be completed on or before September 18, 2011.</p>		

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	<p>out.</p> <p>The resident progress note for Resident #A dated 6-19-11 at 3:10 p.m., indicated the resident continues to complain of her bottom being sore. There were no open areas noted, but the buttocks was reddened.</p> <p>The resident progress note for Resident #A dated 6-29-11 at 2:27 p.m., indicated the resident complained of her bottom hurting. The area was inspected and an small open area found. The physician was notified and a treatment ordered.</p> <p>The resident progress note for Resident #A dated 7-3-11 at 9:09 p.m. indicated the resident was leaning forward in the wheelchair and putting her legs under the wheelchair.</p> <p>The resident progress note for Resident #A dated 7-6-11 at 2:52 p.m., indicated the resident had been very restless while in the wheelchair. The resident was leaning forward to take the pressure off of coccyx.</p> <p>The resident progress note for Resident #A dated 7-6-11 at 12:24 p.m., indicated the resident continues to complain of pain in the area of the coccyx while sitting in the wheelchair. The resident was</p>				

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	<p>squirming, trying to stand and leaning forward and over the arm rest to get relief from pain. Therapy was called to have resident reviewed for a new chair or pad to allow comfortable sitting.</p> <p>The resident progress note for Resident #A dated 7-7-11 at 10:44 a.m., indicated the resident was complaining of pain in the area of the wound, but it does not appear to be related to the wound. The physician was notified of complaints of pain and waiting for a response.</p> <p>The resident progress note for Resident #A dated 7-7-11 at 1:37 p.m., indicated the resident was occasionally complaining of discomfort in the buttock area. The physician was faxed again about the pain and a request for an x-ray was requested. No return fax at that time.</p> <p>The resident progress note for Resident #A dated 7-7-11 at 7:20 p.m., indicated the physician on call was called to obtain an order for an x-ray due to the resident was having discomfort when up in the wheelchair. The physician on call indicated it was not an emergency and was something that could be faxed or called to get an order. Will continue to monitor for increase signs and symptoms of pain.</p>						

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	<p>The resident progress note for Resident #A dated 7-8-11 at 10:12 a.m., indicated the staff talked with the Nurse Practitioner (NP) and informed her that the resident was having discomfort while sitting and the pain appeared to be in the buttocks area. The NP gave an order for an x-ray of sacrum and coccyx. The local radiology facility was notified.</p> <p>The resident progress note for Resident #A dated 7-8-11 at 10:30 a.m., indicated the NP called back the facility and discontinued the order for the x-ray of the sacrum and coccyx. The NP ordered lab work and for the resident to be off the buttocks as much as possible.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 1:45 a.m., indicated the resident was in wheelchair awake until 12:00 a.m., due to restlessness. The resident was leaning forward until chair alarm sounded.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 9:28 a.m., indicated the resident continued to complain of sacral area hurting when up in wheelchair.</p> <p>The resident progress note for Resident #A dated 7-9-11 at 5:15 p.m., indicated the resident was getting upset and squirming in the chair.</p>				

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	<p>The resident progress note for Resident #A dated 7-9-11 at 10:15 p.m., indicated the resident was sitting in the wheelchair yelling out "help me, I can't walk" repetitively. The resident was also squirming in the wheelchair.</p> <p>The resident progress note for Resident #A dated 7-11-11 at 8:54 p.m., indicated the resident was trying to stand up out of wheelchair.</p> <p>The resident progress note for Resident #A dated 7-12-11 at 7:00 p.m., the resident took off a piece of her wheelchair and began hitting nursing staff. The resident was trying to tip her wheelchair back and rocking back and forth. The resident was attempting to pull the printer on the nurses desk. The on call physician was called and an order received to send the resident for a psychiatric evaluation.</p> <p>The resident progress note for Resident #A dated 7-13-11 at 12:44 p.m., indicated the resident's family wished to increase the resident's antianxiety medication before sending the resident to a psychiatric unit.</p> <p>The resident progress note for Resident #A dated 7-15-11 at 11:57 p.m., indicated the resident was standing up in the chair.</p>				

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	<p>The resident progress note for Resident #A dated 7-16-11 at 10:04 p.m., indicated the resident was sitting in the wheelchair at the nursing station. The resident continues to rock back and forth.</p> <p>The resident progress note for Resident #A dated 7-17-11 at 5:59 a.m., indicated the resident had been rocking back and forth and pushing herself into other residents.</p> <p>The resident progress note for Resident #A dated 7-17-11 at 9:25 a.m., indicated the resident had attempted to climb out of bed several times.</p> <p>The resident progress note for Resident #A dated 7-20-11 at 7:12 a.m., indicated the resident had been up all night. The resident was standing up in her chair and leaning over in the chair, touching the floor almost tipping the chair over. The resident was placed in bed, but kept getting out of bed. The resident sat up in wheelchair all night in front of the nursing station. The resident had to be redirected multiple times to sit up in the chair.</p> <p>The resident progress note for Resident #A dated 7-21-11 at 7:01 a.m., indicated the resident kept getting out of bed during the night. The resident was up in the</p>				

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	<p>wheelchair and kept leaning forward.</p> <p>The resident progress note for Resident #A dated 7-21-11 at 1:10 p.m., indicated the resident continues to be restless in the wheelchair and attempts to stand up occasionally.</p> <p>The resident progress note for Resident #A dated 7-22-11 at 2:21 a.m., indicated the resident was restless in the wheelchair. The resident repeatedly took off her gown. The resident was leaning forward in the wheelchair attempting to reach her feet.</p> <p>The resident progress note for Resident #A dated 7-22-11 at 9:36 p.m., indicated the resident was standing in the wheelchair all shift.</p> <p>The resident progress note for Resident #A dated 7-23-11 at 11:03 p.m., indicated the resident was standing up in wheelchair and leaning forward in the chair, touching the floor.</p> <p>The resident progress note for Resident #A dated 7-24-11 at 12:05 a.m., indicated the resident was out of the bed four times. The resident was sitting at the nursing station in her wheelchair and kept leaning over, almost tipping the chair over.</p> <p>The resident progress note for Resident</p>				

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	<p>#A dated 7-24-11 at 12:25 a.m., indicated the resident was unable to sit in the wheelchair. The resident was standing up and leaning over in the wheelchair. The nurse was holding the resident up in the chair. The resident states "can't sit up". The physician on call was notified and an order was received to send the resident to the emergency room.</p> <p>The resident progress note for Resident #A dated 7-24-11 at 4:30 a.m., indicated the resident returned from the emergency room with a new order for Haldol (antipsychotic medication) 1-2 milligrams for agitation.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 12:19 a.m., indicated the resident was at the nursing station in the wheelchair rocking back and forth. The resident was attempting to stand. The resident was asking for someone to take her home and yelling for help.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 3:00 a.m., indicated the resident was standing up in her wheelchair. The resident also was leaning over in the chair and holding the bottom of the wheelchair.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 5:50 a.m., indicated</p>						

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	<p>the resident had been up all night sitting in wheelchair in front of the nursing station. The resident had been rocking back and forth and attempting to stand up.</p> <p>The resident progress note for Resident #A dated 7-25-11 at 9:35 a.m., indicated the physician was in to see the resident and ordered an x-ray of the coccyx.</p> <p>The physician progress note for Resident #A dated 7-25-11, indicated the resident had behavior issues. The resident had been up and down, throwing things, wont stay in bed. Sundown's about 1:00 p.m. everyday. The resident does hit. This had been going on for one month, but was worse for the past two weeks. The resident was sent to the emergency room and was given Haldol. The resident complained of tail bone pain. "Coccyx films".</p> <p>The resident progress note for Resident #A dated 7-25-11 at 3:43 p.m., indicated the resident had been tearful and crying off and on. The resident had been moving all day. The resident was trying to stand up and rocking back and forth.</p> <p>The resident progress note for Resident #A dated 7-26-11 at 1:15 a.m., indicated the x-ray results showed a displaced intertrochanteric fracture of the left hip</p>						

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NAME OF PROVIDER OR SUPPLIER  STONEBROOKE REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN47362		
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	<p>with superior displaced of the femur. An order was received to send the resident to the emergency room.</p> <p>The local emergency room record for Resident #A dated 7-26-11, indicated the had left hip pain for one month. The pain was worse when the resident was up and with movement. The diagnosis was left hip fracture.</p> <p>The radiology report for Resident #A dated 7-26-11, indicated the indication was in pain for one month; fall. The discussion was displaced transverse left femoral neck fracture (left hip fracture). Osteopenia or osteoporosis is suggested.</p> <p>The orthopedic staff initial consult for Resident #A dated 7-26-11, indicated the resident was seen for an orthopedic assessment concerning a fractured left hip. There was some shortening of the left lower limb on comparison to the right. There was mild external rotation. Review of the x-ray shows subacute to chronic fracture of the left hip. "It is obviously old." The recommendation was that management be focused on pain management.</p> <p>Interview with Resident #A's family on 8-18-11 at 12:05 p.m., indicated she was told the facility did not know how</p>				

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	<p>Resident #A's left hip fracture happened. The family member indicated the orthopedic doctor told the family the fracture was at least 6 weeks old. The family member indicated the resident had been complaining of pain and the nurse tried to order an x-ray, but the physician did not feel it was necessary to get an x-ray. The family member indicated the resident had been crying with pain for weeks, approximately 1 month. The family member indicated when the resident's doctor came to see the resident, a family member asked the doctor to get an x-ray and then the facility did.</p> <p>Interview with LPN #3 on 8-18-11 at 12:35 p.m., indicated she was the nurse who called the on call physician on 7-7-11 to obtain an x-ray order for Resident #A. LPN #3 indicated the resident had been having pain. LPN #3 indicated the facility had attempted to call and fax the doctor and did not get any response. LPN #3 indicated she told the on call physician that the resident was in pain and the resident needed an x-ray. LPN #3 indicated the physician on call would not give her an order to do the x-ray. LPN #3 indicated the resident was up in a wheelchair and leaning over. LPN #3 indicated the resident seemed in pain and was leaning over like her back or tail bone hurt. LPN #3 indicated the resident was</p>						

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	<p>fidgety. LPN #3 indicated the resident was acting different from her normal. LPN #3 indicated the facility had not told her what to do in this type of situation, LPN #3 indicated she didn't know if she could call someone else or not.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 8-18-11 at 1:00 p.m., indicated the Nurse Practitioner called her on 7-8-11 in the morning and wanted to know what happened the night before and why was the nurse calling the physician on call. The ADON indicated initially the Nurse Practitioner gave her an order for an x-ray and then called back and said the physician on call said no to the x-ray and to get blood work. The ADON indicated Resident #A's physician was the Medical Director of the facility and she was out of town. The ADON indicated the facility did not have a Director of Nursing (DON) at the time either. The ADON indicated there was a RN acting as DON at the time, but she was working her regular shift as normal.</p> <p>Interview with LPN #4 on 8-18-11 at 1:40 p.m., indicated she was the nurse on 7-7-11 during the day. LPN #4 indicated Resident #A was complaining her bottom hurt and doing a lot of fidgeting. LPN #4 indicated the resident was lifting herself up off the wheelchair a lot trying to</p>				

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	<p>relieve pressure. LPN #4 indicated Resident #A had been exhibiting signs of pain for a few days. LPN #4 indicated she had called and faxed the physician and did not get any response. LPN #4 indicated she told the nurse on the next shift.</p> <p>Interview with the DON on 8-19-11 at 9:40 a.m., indicated the hospital told the facility, Resident #A's left hip fracture was at least 6 weeks old. The DON indicated she did not think the physician on call had assessed Resident #A. The DON indicated the first physician progress note that Resident #A was assessed by a physician was 7-25-11.</p> <p>Interview with the physician on call on 8-19-11 at 11:20 a.m., indicated the facility called him on 7-7-11 at 8:30 p.m. The physician on call indicated the nurse told him Resident #A had been having pain for 3 days. The physician on call indicated he felt like it was something that could have been dealt with in the morning. The physician on call indicated he called the facility the next morning and asked how Resident #A was doing. The physician on call indicated he was told that the resident was not having any problems. The physician on call indicated he could not remember who he talked with. The physician on call indicated he did not want to ignore other problems the</p>						

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	<p>resident may have been having such as anemia.</p> <p>This federal tag relates to Complaint IN00094307.</p> <p>3.1-22(b)(1) 3.1-22(b)(2)</p>				