STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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F000000	This visit was for the Investigation of Complaint IN00155919. Complaint IN00155919 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, F406 and F505. Survey dates: September 10, 11 & 12, 2014 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 Survey Team: Mary Jane G. Fischer RN-TC Census Bed Type: SNF: 24 SNF/NF: 117 Total: 141 Census Payor Type: Medicare: 25 Medicaid: 101 Other: 15 Total: 141 Sample: 5 These deficiencies reflect state findings	F000000	This plan of correction is to serve as Carmel Health and Living's Credible Allegation of Compliance. The facility respectfully requests a desk review of this survey. Submission of this plan of correction does not constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by Tammy Alley RN on September 17, 2014.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal			

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	representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview the facility failed to ensure the facility physician, concerned family members and transplant coordinator were aware of the resident's condition, in that when a resident had specific orders related to elimination and ammonia levels, the nursing staff failed to notify those individuals who had the potential to order interventions for expressed concerns for the resident's status for 1 of 4 residents reviewed for notification in a sample of 5. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 09-10-14 at 10:45 a.m. Diagnoses included, but were not limited to, Puerpal sepsis, constipation, acute kidney failure, cirrhosis, and open wounds. These diagnoses remained current at the time of the record review. At the time the resident was admitted to	F000157	**F157 483.10(b)(11) NOTIFY OF CHANGES(INJURY/DECLINE/ROOM,ETC) I. Resident A no longer resides in the facility. II. All residents awaiting an organ transplant or have orders for Physical Therapy (PT) to treat for compression therapy have the potential to be affected. An audit was conducted to ensure all ordered labs for residents on the transplant list were communicated to the appropriate transplant coordinator. An audit of all residents on the transplant list that have orders for Lactulose or MiraLax have been audited to determine the recommended number of bowel movements are occurring. An audit of all residents for PT to treat for compression therapy have been audited to determine the ordered treatment is being completed. Any discrepancies have been communicated to the MD. III. The systemic change includes that education**	10/03/2014

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	the facility, orders and instructions included the following: a. "Comprehensive Metabolic Panel - every Monday, Complete Blood Count with Differential and platelets - every Monday, PT/INR [Protime/International Normalized Ratio] every Monday, Ammonia level - every Monday. Contact liver transplant coordinator about any additional orders that may be needed while resident is currently at facility while awaiting liver transplant." The orders instructed the nursing staff to send the laboratory results to the Transplant Coordinator. During an interview on 09-11-14 at 1:30 p.m., the Transplant Coordinator at the local area hospital indicated she did not receive the laboratory results of the ammonia level, but received the other laboratory results. "A [name of family member] called me and told me [resident] was re-admitted to the hospital, and also indicated [resident's] ammonia level was high. When I called the nurse at Carmel [Health and Living Community] on 08-27-14 is when I found out that the ammonia level drawn on Monday [08-25-14] was '72' [with a reference range of less than 45]. I would have notified our Doctor."		**was provided to licensed nurses that all ordered labs for residents on the transplant list are to be communicated to the Transplant Coordinator. Education was provided to licensed nurses regarding notification of the physician if a resident on the transplant list does not have the recommended amount of bowel movements. Education was provided to the licensed nurses and PT department on obtaining alternative treatments on 9-30-14. IV. DON/Designee will audit all residents on the transplant list through review of lab orders and MARs (Medication Administration Records) to determine appropriate notification has occurred. The DON/Designee will also audit all residents with PT ordered compression therapy to determine if orders are being followed. This review will be done for 100% of transplant residents 7 times a week for 8 weeks. Following this initial 8 weeks, random review of 3 residents will occur on each of the 6 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits. Any identified concerns from audits will be addressed immediately. The**	

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	The nursing staff failed to alert the Transplant Coordinator of the high ammonia level. b. "Lactulose [a laxative] 20 GR. [Grams] by mouth every six hours - Patient should take enough Lactulose to have 3 - 5 bowel movements every day. Dose should be adjusted to make this happen but [resident] must take at least one dose every day. This will prevent the buildup of ammonia which causes confusion." "MiraLax [a laxative] 17 GR. by mouth once a day for sluggish bowels." A subsequent physician order, dated 08-23-14, instructed the nursing staff to administer "MiraLax 17 GR. PRN (as needed)." During an interview on 09-12-14 at 10:00 a.m., the LPN #10 indicated, "When the nurse transcribed this order, she discontinued the original daily Miralax order." During an interview on 09-11-14 at 9:00 a.m., Resident "B" indicated, "[Resident A] couldn't have a bowel movement, and nothing seemed to be done by the nurses. Me and [name of Resident "E"] gave her some laxatives on Monday [08-25-14]. I gave her 4 pills of an over the counter		**results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 10/3/2014**	

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	medication that I had. [Name of Resident "E"] gave her pills at the same time." During an interview on 09-12-14 at 9:00 a.m., Resident "E" indicated, "[Resident A] could hardly sit upright, she leaned backwards and she told us she needed to go to the bathroom but couldn't. I had some laxatives of my own and I gave her 4 tablets when [name of Resident "B"] gave her her's. [Resident A] had a bowel movement later that day and said she felt better." A review of the "Vitals Report - bowel movements," on 09-10-14 at 2:00 p.m., indicated the resident did not have a bowel movement on 08-22-14, 08-23-14, and 08-24-14. On 08-25-14 the resident was noted with a "large" bowel movement. During an interview on 09-11-14 at 11:45 a.m., the Assistant Director of Nurses indicated he attended a "Meet and Greet" meeting on Wednesday (08-27-14). "I came in to the meeting a little late and when I got in there they [the resident, family members, two friends, representatives from Activities, Social Services and Admissions] were already talking about being concerned about bowel movements. The [name of family member] was leading that part of the			

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	conversation and wanted to know how many bowel movements [resident] had. [Name of Social Service Director] went to get the chart and I had my laptop so I could review the orders." A review of the electronic medication administration record indicated the resident received the daily MiraLax order on 08-23-14, and did not receive any additional laxative medications including the "as needed" MiraLax, through 08-26-14. A review of the clinical record lacked documentation the physician had been notified that the resident had not had a bowel movement from the time of admission until 08-25-14 at 4:47 p.m. c. "PTWT [physical therapy/wound therapy] to eval. [evaluate] and treat for compression therapy." A review of the "Physical Therapy Plan of Care," dated 08-25-14 indicated the resident had "B [bilateral] LE [lower extremity] edema with seeping, waiting for Liver Transplant." During an interview on 09-10-14 at 3:45 p.m., a concerned family member indicated she was concerned about the "weeping wounds on [resident's] legs.			

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	"When I asked the LPN's about the need to at least change the dressings she said 'Oh yeah - we'll change it after lunch." During an interview on 09-12-14 at 12:00 p.m., the Physical Therapist indicated, "The order I got was for PT [Physical Therapy] to evaluate and treat. I didn't know anything about the doctor's order for compression therapy. We don't even do that here - no lymphodema therapy and no wrapping. I saw that [resident] had lower extremity edema, it's in my notes, but all we do is positioning and elevation, that sort of thing." A review of the nurses notes documented assessment of the resident's wounds as follows: "08-23-14 at 3:45 p.m., Writer re-wrapped res. [resident] leg after shower per request due to weeping." "08-24-14 at 9:01 a.m., Res. states lower extremities weeping and are wrapped no noted drainage." "08-25-14 at 8:15 a.m., Skin warm to touch weeping noted to lower extremities wrap in place." The physical therapist failed to notify the physician they were unable to provide the ordered treatment for compression.			

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	d. A review of the facility policy on 09-11-14 at 8:20 a.m., titled "Change in a Resident's Condition or Status," dated as revised October 2010, indicated the following: "Policy Statement - Our facility shall promptly notify the resident, his or her Attending Physician, and representative (Sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights etc.)." "Policy Interpretation and Implementation - 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:... d. A significant change in the resident's physical/emotional/mental condition, e. A need to alter the resident's medical treatment significantly,...h. Instructions to notify the physician of changes in the resident's condition. 2. A "significant change" of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self limiting"). b. Impact more than one area of the resident's health status: and c.			

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	Required interdisciplinary review and/or revision to the care plan. 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's responsible party or family when: ...b. There is a significant change in the resident's physical, mental, or psychosocial status.... 6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information related to changes in the resident's medical/mental condition or status." This Federal tag relates to Complaint IN00155919. 3.1-5(a)			
F000309 SS=D	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. Based on record review and interview the facility failed to ensure the resident's elimination needs were met, in that when a resident with a diagnosis of liver failure was admitted to the facility with specific orders for medications to aid in elimination, the nursing staff incorrectly discontinued the resident's physician	F000309	**F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING I. Resident A no longer resides in the facility. II. All residents awaiting an organ transplant or have orders for Physical Therapy (PT) to treat for compression therapy have the potential to be affected. An**	10/03/2014

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	ordered daily laxative which resulted in the resident becoming constipated and thus being unable to have the minimum required 3- 5 bowel movements daily as noted in the discharge instructions. In addition the facility failed to ensure the resident received specific therapy interventions, in that when a resident had open and weeping wounds to the bilateral lower extremities the facility failed to provided the physician ordered treatment. This deficient practice affected 1 of 3 residents reviewed for care and services in a sample of 5. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 09-10-14 at 10:45 a.m. Diagnoses included, but were not limited to, Puerpal sepsis, constipation, acute kidney failure, cirrhosis, and open wounds. These diagnoses remained current at the time of the record review. a. At the time the resident was admitted to the facility, orders and instructions included the following: "MiraLax [a laxative] 17 GR. by mouth once a day for sluggish bowels."		**audit of all residents on the transplant list that have orders for Lactulose or MiraLax have been audited to determine the recommended number of bowel movements are occurring. An audit of all residents for PT to treat for compression therapy have been audited to determine the ordered treatment is being completed. Any discrepancies have been communicated to the MD. III. The systemic change includes that education was provided to licensed nurses regarding notification of the physician if a resident on the transplant list does not have the recommended amount of bowel movements. Education was provided to the licensed nurses and PT department on obtaining alternative treatments 9-30-14. IV. DON/Designee will audit all residents on the transplant list through review of lab orders and MARs (Medication Administration Records) to determine appropriate notification has occurred. The DON/Designee will also audit all residents with PT ordered compression therapy to determine if orders are being followed. This review will be done for 100% of transplant residents 7 times a week for 8**	

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	A review of the Admission Nursing Assessment, dated 08-22-14 at 10:13 p.m., indicated the resident's abdomen was "firm and distended." An additional physician order, dated 08-23-14, instructed the nursing staff to provide "MiraLax 17 GR. PRN (as needed)." A review of the "Prescription Order" documentation, dated 08-23-14, indicated Licensed Nurse #9, discontinued the original hospital physician discharge order for the daily MiraLax when she transcribed the PRN MiraLax order. During an interview on 09-12-14 at 10:00 a.m., LPN #10 verified and indicated, "When the nurse transcribed the PRN order, she discontinued the daily Miralax order." The physician History and Physical, dated 08-24-14, indicated the resident had confusion, weakness, poor oral intake and constipation, with lower abdominal fullness without fluid wave." During an interview on 09-11-14 at 9:00 a.m., Resident "B" indicated, "[Resident A] couldn't have a bowel movement, and nothing seemed to be done by the nurses. Me and [name of Resident "E"] gave her		**weeks. Following this initial 8 weeks, random review of 3 residents will occur on each of the 6 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits. Any identified concerns from audits will be addressed immediately. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 10/3/2014**	

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	some laxatives on Monday [08-25-14]. I gave her 4 pills of an over the counter medication that I had. [Name of Resident "E"] gave her pills at the same time." During an interview on 09-12-14 at 9:00 a.m., Resident "E" indicated, "[Resident A] could hardly sit upright, she leaned backwards and she told us she needed to go to the bathroom but couldn't. I had some laxatives of my own and I gave her 4 tablets when [name of Resident "B"] gave her her's. [Resident A] had a bowel movement later that day and said she felt better." A review of the "Vitals Report - bowel movements," on 09-10-14 at 2:00 p.m., indicated the resident did not have a bowel movement on 08-22-14, 08-23-14, and 08-24-14. On 08-25-14 the resident was noted with a "large" bowel movement. A review of the electronic medication administration record indicated the resident received the daily MiraLax order on 08-23-14, and did not receive any additional laxative medication from 08-23-14 thru 08-25-14, when two alert and oriented residents (Resident's "B" and "E") provided Resident "A" with 8 laxative tablets to aid in the resident's elimination needs.			

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	The nurses notes, dated 08-25-14 at 11:18 p.m., indicated "Resident stated she had a large BM [bowel movement] at 6:00 p.m., but requested Miralax. [Family member] was concerned that [resident] was not on Miralax. MD [Medical Doctor] notified and ordered PRN 1 times a day." During an interview on 09-11-14 at 11:45 a.m., the Assistant Director of Nurses indicated he attended a "Meet and Greet" meeting on Wednesday (08-27-14). "I came in to the meeting a little late and when I got in there they [the resident, family members, two friends, representatives from Activities, Social Services and Admissions] were already talking about being concerned about bowel movements. The [name of family member] was leading that part of the conversation and wanted to know how many bowel movements [resident] had. [Name of Social Service Director] went to get the chart and I had my laptop so I could review the orders." During further interview the Assistant Director of Nurses indicated the nursing staff did not notify the physician when a resident did not have a bowel movement for three days, even though this resident had physician orders/instructions for the			

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	resident to have 3 - 5 bowel movements daily. The clinical record lacked documentation the physician had been notified that the resident had not had a bowel movement from the time of admission on 08-22-14 until 08-25-14 at 4:47 p.m. b. The Hospital "Final Report," dated 08-22-14, indicated the resident "now with +3 BLE [bilateral lower extremity] pitting edema. Location - LLE [left lower extremity]. RLE [right lower extremity] oozing copious amounts of serosang. [serosanguineous] fluid from various open areas. Moliform placed around draining area and secured with surginet. Recommend PTWT to eval and treat for compression therapy." At the time the resident was admitted to the facility, orders and instructions included the following: "PTWT [physical therapy/wound therapy] to eval. [evaluate] and treat for compression therapy." The Admission Nursing Assessment, dated 08-22-14 at 10:13 p.m., indicated the resident had "ble (bilateral lower extremity) and pitting edema."			

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	A review of the physician admission History and Physical, dated 08-24-14 indicated the resident had LE (lower extremity edema) and weeping. A review of the "Clinical Documentation - 72 hour Post Admission Assessments indicated the following in regard to the resident's bilateral lower extremity edema: "08-23-14 at 4:45 a.m., BLE 2+ pitting edema." "08-23-14 at 1:52 p.m., BLE 2+ and 3+ pitting edema." "08-23-14 at 11:12 p.m., non-pitting edema." "08-24-14 at 9:13 a.m., BLE 1+ pitting edema." "08-24-14 at 2:54 p.m., BLE 4+ pitting edema." "08-24-14 at 12:06 a.m., BLE no edema." "08-25-14 at 1:24 p.m., BLE 2+ pitting edema." "08-26-14 at 6:57 a.m., BLE 4+ pitting edema." During an interview on 09-12-14 at 10:00 a.m., Licensed Nurse #8 indicated when she worked night shift it was difficult to perform the assessment as the resident			

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	was always wrapped up in blankets due to being so cold. The resident was not evaluated or seen by a therapist until 08-25-14. A review of the "Physical Therapy Plan of Care," dated 08-25-14 indicated the resident had "B [bilateral] LE [lower extremity] edema with seeping, waiting for Liver Transplant." During an interview on 09-10-14 at 3:45 p.m., a concerned family member indicated she was concerned about the "weeping wounds on [resident's] legs. When I asked the LPN's [Licensed Practical Nurse] about the need to at least change the dressings she said 'Oh yeah - we'll change it after lunch.'" During an interview on 09-12-14 at 12:00 p.m., the Physical Therapist indicated, "The order I got was for PT [Physical Therapy] to eval. [evaluate] and treat. I didn't know anything about the doctor's order for compression therapy. We don't even do that here - no lymphodema therapy and no wrapping. I saw that [resident] had lower extremity edema but all we do is positioning and elevation, that sort of thing." c. During an interview on 09-10-14 at 3:45 p.m., a concerned family member			

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	indicated, "I believe [resident] was admitted to an area of the facility with no expertise. I don't think they knew how to take care of a person with liver failure and all that goes with it. They didn't do daily weights or measure her girth." During an interview on 09-11-14 at 10:45 a.m., the Director of Nurses and the Administrator indicated, "We don't approve of a resident to be admitted to the facility," and that the "clinical nurse Liaison will provide information and a clinical grid that tells if we can take care of the resident and based on that grid the nurse makes that determination. It goes to financial and if the call center say 'yes' and the grid is considered 'green', then we're to go ahead and admit. If they call back and the grid indicates 'yellow' then it would take longer and we would need to make more of a determination if we could meet their needs. If 'red" we wouldn't accept the resident. [Name of resident] was a 'yellow' because she was on a high cost medication and because she was a transplant candidate." Further interview the Director of Nurses indicated the facility did not have a specific policy on how to take care of a resident in liver failure. This Federal tag relates to Complaint IN00155919.			

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	3.1-31(a)			
F000406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on record review and interview the facility failed to ensure the resident received specific therapy interventions, in that when a resident had open and weeping wounds to the bilateral lower extremities the facility failed to provided the physician ordered treatment for 1 of 5 sampled residents. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 09-10-14 at 10:45 a.m. Diagnoses included, but were not limited to, Puerpal sepsis, constipation, acute kidney failure, cirrhosis, and open wounds. These diagnoses remained	F000406	**F406 483.45(a) PROVIDE OBTIAN SPECIALIZED REHAB SERVICES I. Resident A no longer resides in the facility. II. All residents awaiting an organ transplant or have orders for Physical Therapy (PT) to treat for compression therapy have the potential to be affected. An audit of all residents on the transplant list that have orders for Lactulose or MiraLax have been audited to determine the recommended number of bowel movements are occurring. An audit of all residents for PT to treat for compression therapy have been audited to determine the ordered treatment is being completed. Any discrepancies**	10/03/2014

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	current at the time of the record review. The Hospital "Final Report," dated 08-22-14 indicated the resident "now with +3 BLE [bilateral lower extremity] pitting edema. Location - LLE [left lower extremity]. RLE [right lower extremity] oozing copious amounts of serosang. [serosanguineous] fluid from various open areas. Moliform placed around draining area and secured with surginet. Recommend PTWT to eval and treat for compression therapy." At the time the resident was admitted to the facility, orders and instructions included the following: "PTWT [physical therapy/wound therapy] to eval. [evaluate] and treat for compression therapy." The Admission Nursing Assessment, dated 08-22-14 at 10:13 p.m. indicated the resident had "ble (bilateral lower extremity) and pitting edema." A review of the physician admission History and Physical, dated 08-24-14, indicated the resident had LE (lower extremity edema) and weeping. A review of the "Clinical Documentation - 72 hour Post Admission Assessments indicated the following in regard to the		**have been communicated to the MD. III. The systemic change includes that education was provided to licensed nurses regarding notification of the physician if a resident on the transplant list does not have the recommended amount of bowel movements. Education was provided to the licensed nurses and PT department on obtaining alternative treatments 9-30-14. IV. DON/Designee will audit all residents on the transplant list through review of lab orders and MARs (Medication Administration Records) to determine appropriate notification has occurred. The DON/Designee will also audit all residents with PT ordered compression therapy to determine if orders are being followed. This review will be done for 100% of transplant residents 7 times a week for 8 weeks. Following this initial 8 weeks, random review of 3 residents will occur on each of the 6 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits. Any identified concerns from audits will be addressed immediately. Any identified concerns from audits will be addressed**	

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	resident's bilateral lower extremity edema: "08-23-14 at 4:45 a.m., BLE 2+ pitting edema." "08-23-14 at 1:52 p.m., BLE 2+ and 3+ pitting edema." "08-23-14 at 11:12 p.m., non-pitting edema." "08-24-14 at 9:13 a.m., BLE 1+ pitting edema." "08-24-14 at 2:54 p.m., BLE 4+ pitting edema." "08-24-14 at 12:06 a.m., BLE no edema." "08-25-14 at 1:24 p.m., BLE 2+ pitting edema." "08-26-14 at 6:57 a.m., BLE 4+ pitting edema." During an interview on 09-12-14 at 10:00 a.m., Licensed Nurse #8 indicated when she worked night shift it was difficult to perform the assessment as the resident was always wrapped up in blankets due to being so cold. The resident was not evaluated or seen by a therapist until 08-25-14. A review of the "Physical Therapy Plan of Care," dated 08-25-14 indicated the resident had "B [bilateral] LE [lower extremity]		**immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 10/3/2014**	

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	edema with seeping, waiting for Liver Transplant." During an interview on 09-10-14 at 3:45 p.m., a concerned family member indicated she was concerned about the "weeping wounds on [resident's] legs. When I asked the LPN's [Licensed Practical Nurse] about the need to at least change the dressings she said 'Oh yeah - we'll change it after lunch." During an interview on 09-12-14 at 12:00 p.m., the Physical Therapist indicated, "The order I got was for PT [Physical Therapy] to eval. and treat. I didn't know anything about the doctor's order for compression therapy. We don't even do that here - no lymphodema therapy and no wrapping. I saw that [resident] had lower extremity edema but all we do is positioning and elevation, that sort of thing." This Federal tag relates to Complaint IN00155919. 3.1-23(a)(1) 3.1-23(a))2)			
F000505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the			

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	attending physician of the findings. Based on record review and interview the facility failed to ensure the resident's laboratory results were promptly reported to the local area hospital transplant coordinator, in that when a resident had orders related to laboratory results specifically ammonia levels, the nursing staff failed to promptly notify the transplant coordinator of the elevated results for 1 of 2 resident's reviewed for transplant parameters, liver failure and the need to monitor increased ammonia levels in a sample of 5. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 09-10-14 at 10:45 a.m. Diagnoses included, but were not limited to, Puerpal sepsis, constipation, acute kidney failure, cirrhosis, and open wounds. These diagnoses remained current at the time of the record review. At the time the resident was admitted to the facility, orders and instructions included the following: "Comprehensive Metabolic Panel - every Monday, Complete Blood Count with Differential and platelets - every Monday, PT/INR [Protime/International Normalized Ratio] every Monday,	F000505	**F505 483.75 (j)(2)(ii)** **PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS** **I. Resident A no longer resides in the facility. II. All residents awaiting an organ transplant have the potential to be affected. An audit was conducted to ensure all ordered labs for residents on the transplant list were communicated to the appropriate transplant coordinator. III. The systemic change includes that education was provided to licensed nurses that all ordered labs for residents on the transplant list are to be communicated to the Transplant Coordinator ON 9-30-14. IV. DON/Designee will audit all residents on the transplant list through review of lab orders to determine appropriate notification to the transplant coordinator has occurred. This review will be done for 100% of transplant residents 7 times a week for 8 weeks. Following this initial 8 weeks, random review of 3 residents will occur on each of the 6 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits. Any identified concerns from audits will be**	10/03/2014

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	Ammonia level - every Monday. Contact liver transplant coordinator about any additional orders that may be needed while resident is currently at facility while awaiting liver transplant." During an interview on 09-11-14 at 1:30 p.m., the Transplant Coordinator at the local area hospital indicated she did not receive the laboratory results of the ammonia level, but received the other laboratory results. "A [name of family member] called me and told me [resident] was re-admitted to the hospital, and also indicated [resident's] ammonia level was high. When I called the nurse at Carmel [Health and Living Community] on 08-27-14 is when I found out that the ammonia level drawn on Monday [08-25-14] was '72' [with a reference range of less than 45]. I would have notified our Doctor." Although the facility nurse notified the facility physician, the nursing staff failed to inform the transplant coordinator/team for additional instructions. This Federal tag relates to Complaint IN00155919. 3.1-49(f)(2)		**addressed immediately.** **The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 10/3/2014**	