

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
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NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN47501
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F0000	<p>This visit was for the Investigation of Complaint IN00097832.</p> <p>Complaint IN00097832- Substantiated. Federal/State deficiencies related to the allegations are cited at F-157 and F-329.</p> <p>Survey date: 10/12/11</p> <p>Facility number: 000301 Provider number: 155341 AIM number: 100289090</p> <p>Survey team: Sharon Whiteman, RN</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 07 Medicaid: 51 Other: 11 Total: 69</p> <p>Sample: 03</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</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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F0157 SS=D	<p>Quality review completed on October 14, 2011 by Bev Faulkner, RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to notify the resident's physician of a significant change in condition when the resident first became lethargic and was unable to follow</p>	F0157	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider</i>	10/25/2011

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	<p>instructions. This affected 1 of 3 sampled residents. (Resident A)</p> <p>Findings Include:</p> <p>Review of the closed clinical record of Resident A on 10/12/11 at 10:10 a.m. indicated:</p> <p>Resident A had diagnoses which included, but were not limited to: chronic back pain, sleep apnea, chronic obstructive pulmonary disease, obesity, and recent hemilaminectomy surgery (surgery to remove a layer of membrane from the spine).</p> <p>A physician's telephone order, dated 08/16/11, (date of Resident A's admission to facility) indicated Resident A was to have her oxygen concentration checked every shift and was also to have oxygen at 2 liters per nasal cannula to keep her oxygen saturation over 88%.</p> <p>An admission physician's order sheet, dated 08/16/11 through 08/31/11, listed medications which included, but were not limited to, Fentanyl pain patch 75 mcg [micrograms]/hour - change every 72 hours and Dilaudid (pain medication) 4 mg [milligrams], 1 or 2 every 4 hours as needed.</p>		<p><i>of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><i>Eastgate Manor Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective October 25, 2011.</i></p> <p><i>F 157</i></p> <p><i>It is the policy of Eastgate Manor to inform the resident's physician when there is a significant change in condition.</i></p> <p><i>Resident A is not currently in the facility.</i></p> <p><i>A 100% medical review of current in house residents charts for the last 30 days was completed by Nursing Administration to identify any change in condition</i></p>		

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	<p>Review of a 2010 Nursing Spectrum Drug Handbook indicated Dilaudid had side effects which included, but were not limited to, sedation, low blood pressure and slow heart rate. The drug handbook indicated Fentanyl had side effects which included, but were not limited to, sedation, lethargy, low blood pressure, slow heart rate, cardiac arrest, slow and shallow respirations.</p> <p>A Physician Notification sheet, dated 08/18/11, indicated, "...(Resident A) getting dilaudid (sic) 4 mg ii [2] q [every] 4 [hour sign symbol] for pain - Tyl [Tylenol] 325 (mg) 2 between - she states this isn't effective for her pain - any suggestions!"</p> <p>A physician's order sheet, dated 08/19/11, indicated, Resident A's Fentanyl patch was increased to 100 micrograms/hour every 72 hours, the order for Dilaudid 4 milligrams every 4 hours was discontinued, and a new order given for Dilaudid 8 milligrams every 4 hours as needed.</p> <p>The August MAR indicated Resident A's oxygen saturation had been checked every shift since the resident's admission and ranged from 90% - 96%. On 08/20/11 (date Resident A was sent out to the ER) the MAR indicated the resident's oxygen</p>		<p><i>requiring physician notification. The review included, but was not limited to, nurses notes and 24 hour report sheets. None were identified.</i></p> <p><i>Re-education related to physician notification was initiated on October 12, 2011. No licensed nursing staff member will be permitted to work until re-education by the Education/Training Director/designee is complete.</i></p> <p><i>This information will also be included in new hire orientation of all newly hired licensed nurses.</i></p> <p><i>The Licensed Nurses are required to document on the 24 hour shift report any change in condition. The Director of Nursing/designee will review the 24 hour shift report daily for 14 days then five times weekly to identify any resident change in condition requiring physician notification.</i></p>		

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	<p>saturation was 90 percent on the day shift and evening shift, and was 94% on the night shift.</p> <p>A 5-day MDS [Minimum Data Set] assessment, dated 08/20/11, indicated Resident A had no cognitive impairment, understood what others said to her, was understood by others, and was on a scheduled pain regime. The MDS indicated Resident A was continent of bowel and bladder.</p> <p>A "Progress Note," dated 08/20/11 at 6:00 a.m. indicated, "(Up) to BR [bathroom] last noc [night] c [with] ii [2] assist. Dilaudid given x [times] 2 this shift et has had muscle relaxer. Res [Resident A] states relief. Resting quietly at present time. Pillow between legs et in back of incision....0 [No] c/o [complaints of] voiced. 0 distress noted."</p> <p>A "Progress Note," dated 08/20/11 at 11:00 a.m., indicated Resident A's vital signs were - blood pressure 112/48, heart rate 42, respiratory rate 16. The progress note indicated the resident's oxygen saturation was 88%. The progress note indicated, " (Resident A) awakens easily, but drowsy - unable to follow simple instructions - unable to sit (up) chair (sic) for brkfast (sic). No intake - new patch applied per N.O. [new order.]</p>		<p><i>Nurses notes of identified residents will be reviewed to insure notification.</i></p> <p><i>Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary action per facility policy.</i></p> <p><i>Findings will be forwarded to the monthly Quality Assurance Committee for review and recommendations.</i></p>		

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	<p>The clinical record lacked documentation indicating the physician was called to notify him of the resident's change in condition. Interview of staff indicated the physician was not called at this time to inform him of the resident's change of condition.</p> <p>An entry documented on the progress note just underneath the above note indicated, "13:30 [1:30 p.m.] Incont [Incontinent] of urine (clinical record indicated the resident was normally continent)- pupils pin pt [point] - slurred mumbling speech - Holding 1400 [2:00 p.m.] meds [medication] too sedative (sic) @ this X [time].....unable to follow any type instructions."</p> <p>The clinical record lacked documentation indicating the physician was called to notify him of the resident's continued change in condition. Interview of staff indicated the physician was not called at this time to inform him of the resident's change of condition.</p> <p>A "Progress Note," dated 08/20/11 at 4:47 p.m., indicated, "Received new order to hold Dilaudid and to see if Fentanyl patch will be enough to cover her pain."</p> <p>A facility "Resident Transfer Form,"</p>				

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	<p>dated 08/20/11, indicated, "Reason for Transfer...Pt unresponsive fentanyl (sic) patch dose (change) MD [Medical Doctor] advised to remove patch @ this time. EMT's aware et removed patch. Pt will not open eyes or respond (sic) some drooping of mouth noted." The only time on this form was the time vital signs were taken. The time documented for vital signs taken was 4:30 p.m. The form indicated the resident's vital signs at 4:30 p.m. were - blood pressure - 124/60, heart rate - 89, respirations - 20, and temperature 98.4. The form indicated the resident's oxygen saturation at that time was 90% on room air.</p> <p>Interview of the DON [Director of Nursing] on 10/12/11 at 10:00 a.m., indicated Resident A had been having increased pain so the doctor had increased her pain medication. The DON indicated she thought it was on a Saturday when the resident hadn't eaten much and the "PM" nurse came in and noticed the resident was a little lethargic. The DON indicated the PM nurse called the doctor and he told her to hold Resident A's Dilaudid. The DON indicated the family came in and were upset due to not being notified of the resident's lethargy. The DON indicated the doctor said the only thing they should have done differently was to remove the resident's Fentanyl patch. The DON</p>						

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	<p>indicated she was not aware of whether or not oxygen was started on the resident.</p> <p>A copy of a written report regarding incident with Resident A was provided by the DON on 10/12/11 at 2:20 p.m. This report was written by the ADON. The report indicated, "1531 [3:31 p.m.] [PT #2's name] called me [ADON] at home to notify me of a change in condition on (Resident A)...She reported resident appears sedated which is a change from previous condition. Approx [Approximately] 1540 [3:40 p.m] I [ADON] called facility & spoke with (RN #5) the nurse who had started at 1500 [3:00 p.m.]. I informed her to do an assessment and call [doctor's name] with resident condition and request any new orders. The report indicated the ADON received a call from the facility on 08/20/11 at approximately 5:00 p.m., to report that Resident A's family was at the facility and were very upset that they had not been notified of (Resident A's) change in condition. I called and spoke with the resident's (family) who said she wanted (Resident A) transported to ER [Emergency Room]....RN #5 informed me that ambulance (sic) was already in route...."</p> <p>Review of a local hospital emergency room report on 10/12/11 at 12:10 p.m.,</p>				

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	<p>indicated Resident A was on her way to the emergency room from the facility on 08/20/11. The report indicated Resident A arrived at the emergency room [ER] on 08/20/11 at 6:35 p.m. The report indicated, "... (Resident A) has had increase in Dilaudid and Fentanyl patch & today has been unresponsive since 11:00. The report indicated Resident A's physician "called & spoke with this RN & states contact EMS [Emergency Medical Service] to remove patch [Fentanyl patch] & have Narcan (medication frequently used to treat known or suspected opioid-induced respiratory depression). EMS contacted & patch removed. U/A [Upon arrival] pt unresponsive -eyes closed - not speaking. Pt will respond to painful stimuli... - Applies monitor, O2 [oxygen], IV.... "</p> <p>This Federal/State deficiency relates to Complaint IN00097832.</p> <p>3.1-5(a)(2)</p>				

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F0329 SS=G	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor for side effects and potential cumulative effects related to administration of pain medications and a muscle relaxer for 1 of 3 sampled residents reviewed for pain medication which led to the resident becoming non-responsive and being sent out to the Emergency Room by ambulance. (Resident A)</p> <p>Findings Include:</p> <p>Review of the closed clinical record of Resident A on 10/12/11 at 10:10 a.m., indicated:</p>	F0329	<p><i>F 329</i></p> <p><i>It is the policy of Eastgate Manor to ensure that each resident's drug regime is free from unnecessary drugs.</i></p> <p><i>Resident A is not currently in the facility.</i></p> <p><i>100% of current residents in the facility were assessed by Nursing Administration for any side effects or cumulative effects of pain</i></p>	10/25/2011			

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	<p>Resident A had diagnoses which included, but were not limited to: chronic back pain, sleep apnea, chronic obstructive pulmonary disease, obesity, and recent hemilaminectomy surgery (surgery to remove a layer of membrane from the spine).</p> <p>A physician's telephone order, dated 08/16/11, (date of Resident A's admission to facility) indicated Resident A was to have her oxygen concentration checked every shift and was also to have oxygen at 2 liters per nasal cannula to keep her oxygen saturation over 88%.</p> <p>An admission physician's order sheet, dated 08/16/11 through 08/31/11, listed medications which included, but were not limited to, Fentanyl pain patch 75 mcg [micrograms]/hour - change every 72 hours and Dilaudid (pain medication) 4 mg [milligrams], 1 or 2 every 4 hours as needed.</p> <p>Review of a 2010 Nursing Spectrum Drug Handbook indicate Dilaudid had side effects which included, but were not limited to, sedation, low blood pressure and slow heart rate. The drug handbook indicated Fentanyl had side effects which included, but were not limited to, sedation, lethargy, low blood pressure,</p>		<p><i>medications or muscle relaxers.</i></p> <p><i>A record review of all resident charts for the last 30 days was completed by Nursing Administration for any side effects or cumulative effects of pain medications and muscle relaxers.</i></p> <p><i>The review consisted of but was not limited to nurses notes, physician orders, and 24 hour reports. No additional residents were identified.</i></p> <p><i>Nursing staff were re-educated regarding monitoring for side effects or cumulative effects when pain medications or muscle relaxers are administered. No licensed staff member will be permitted to work until re-education is complete.</i></p> <p><i>The Director of Nursing/designee will review 24 hour report for those residents receiving pain medications or muscle</i></p>		

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	<p>slow heart rate, cardiac arrest, slow and shallow respirations.</p> <p>A Physician Notification sheet, dated 08/18/11, indicated, "... (Resident A) getting dilaudid (sic) 4 mg ii [2] q [every] 4 [hour sign symbol] for pain - Tyl [Tylenol] 325 (mg) 2 between - she states this isn't effective for her pain - any suggestions!"</p> <p>A physician's order sheet, dated 08/19/11, indicated, Resident A's Fentanyl patch was increased to 100 micrograms/hour every 72 hours, the order for Dilaudid 4 milligrams every 4 hours was discontinued, and a new order given for Dilaudid 8 milligrams every 4 hours as needed. The physician's order sheet also included a new order for Baclofen (a muscle relaxer) 10 mg by mouth three times daily.</p> <p>Review of a 2010 Nursing Spectrum Drug Handbook indicated side effects of Baclofen included, but were not limited to, fatigue, confusion, difficulty speaking, low blood pressure and palpitations. The drug handbook indicated when taking Baclofen nursing should "Observe closely for signs and symptoms of overdose (drowsiness, light-headedness, dizziness, respiratory depression, especially during initial screening.... Advise patient to take</p>		<p><i>relaxers daily for 14 days and then 5 times weekly. Any new orders for pain medications or muscle relaxers will be reviewed by the interdisciplinary team 5 times weekly.</i></p> <p><i>Identified non-compliance will result in 1:1 re-education with repeat non compliance resulting in progressive disciplinary action per facility policy.</i></p> <p><i>Findings will be submitted to the Quality Assurance Committee for review and recommendations.</i></p>				

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	<p>oral dose with food or milk."</p> <p>A PRN [as needed] analgesic record/pain flow sheet indicated Resident A received 8 milligrams of Dilaudid on the following dates and times: 08/16/11 at 4:45 a.m. 08/17/11 at 12:30 a.m., 08/17/11 at 5:00 a.m., 08/17/11 at 9:00 a.m., 08/17/11 at 1:15 p.m., 08/17/11 at 5:15 p.m., 08/17/11 at 9:15 (does not indicate a.m. nor p.m.), 08/18/11 at 1:30 a.m., 08/18/11 at 6:30 a.m., 08/18/11 at 10:30 (does not indicate whether a.m. or p.m.), 08/18/11 at 2:30 p.m., 08/18/11 at 6:30 p.m. 08/19/11 at 2:50 a.m., 08/19/11 at 7:00 a.m. 08/20/11 at 12:15 a.m., 08/20/11 at 5:35 a.m., 08/20/11 at 10:30 a.m.</p> <p>The PRN analgesic record indicated Resident A received 4 milligrams of Dilaudid on 08/18/11 at 10:50 p.m.</p> <p>A Medication Administration Record (MAR) indicated a Fentanyl patch 75 mcg was signed out as being applied to Resident A on 08/18/11 at 9:00 a.m.</p> <p>A MAR indicated a Fentanyl patch 100 mcg was signed out as being applied to Resident A on 08/20/11 at 9:00 a.m.</p>				

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NAME OF PROVIDER OR SUPPLIER EASTGATE MANOR NURSING & RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2119 E NATIONAL HWY WASHINGTON, IN47501
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	<p>A MAR indicated the first dose of Baclofen was given to the resident on 08/20/11 at 6:00 a.m. The MAR indicated the 2:00 p.m. dose for that day was not given to the resident.</p> <p>A MAR indicated Resident A's oxygen saturation had been checked every shift since the resident's admission and ranged from 90% - 96%. On 08/20/11 (date Resident A was sent out to the ER), the MAR indicated the resident's oxygen saturation was 90 percent on the day shift and evening shift, and was 94% on the night shift.</p> <p>A 5-day MDS [Minimum Data Set] assessment, dated 08/20/11, indicated Resident A had no cognitive impairment, understood what others said to her, was understood by others, and was on a scheduled pain regime. The MDS indicated Resident A was continent of bowel and bladder.</p> <p>A "Progress Note," dated 08/20/11 at 6:00 a.m., indicated, "(Up) to BR [bathroom] last noc [night] c [with] ii [2] assist. Dilaudid given x [times] 2 this shift et has had muscle relaxer. Res [Resident A] states relief. Resting quietly at present time. Pillow between legs et in back of incision....0 [No] c/o [complaints of] voiced. 0 distress noted."</p>			

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	<p>A "Progress Note," dated 08/20/11 at 11:00 a.m., indicated Resident A's vital signs were - blood pressure 112/48, heart rate 42, respiratory rate 16. The progress note indicated the resident's oxygen saturation was 88%. The progress note indicated, " (Resident A) awakens easily, but drowsy - unable to follow simple instructions - unable to sit (up) chair (sic) for brkfast (sic). No intake - new patch applied per N.O. [new order.]...13:30 [1:30 p.m.] Incont [Incontinent] of urine - pupils pin pt [point] - slurred mumbling speech - Holding 1400 [2:00 p.m.] meds [medication] too sedative (sic) @ this X [time]....unable to follow any type instructions."</p> <p>A facility "Resident Transfer Form," dated 08/20/11, indicated, "Reason for Transfer...Pt unresponsive fentanyl (sic) patch dose (change) MD [Medical Doctor] advised to remove patch @ this time. EMT ' s aware et removed patch. Pt will not open eyes or respond (sic) some drooping of mouth noted." The only time on this form was the time vital signs were taken. The time documented for vital signs taken was 4:30 p.m. The form indicated the resident ' s vital signs at 4:30 p.m. were - blood pressure - 124/60, heart rate - 89, respirations - 20, and temperature 98.4. The form indicated</p>			

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	<p>the resident's oxygen saturation at that time was 90% on room air.</p> <p>Interview of the DON [Director of Nursing] on 10/12/11 at 10:00 a.m., indicated Resident A had been having increased pain so the doctor had increased her pain medication. The DON indicated she thought it was on a Saturday when the resident hadn't eaten much and the "PM" nurse came in and noticed the resident was a little lethargic. The DON indicated the PM nurse called the doctor and he told her to hold Resident A's Dilaudid. The DON indicated the family came in and were upset due to not being notified of the resident's lethargy. The DON indicated the doctor said the only thing they should have done differently was to remove the resident's Fentanyl patch. The DON indicated she was not aware of whether or not oxygen was started on the resident.</p> <p>A copy of a written report regarding incident with Resident A was provided by the DON on 10/12/11 at 2:20 p.m. This report was written by the ADON. The report indicated, "1531 [3:31 p.m.] [PT #2's name] called me [ADON] at home to notify me of a change in condition on (Resident A)....She reported resident appears sedated which is a change from previous condition. Approx [Approximately] 1540 [3:40 p.m] I</p>			

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	<p>[ADON] called facility & spoke with (RN #5) the nurse who had started at 1500 [3:00 p.m.]. I informed her to do an assessment and call [doctor's name] with resident condition and request any new orders. The report indicated the ADON received a call from the facility on 08/20/11 at approximately 5:00 p.m., to report that Resident A's family was at the facility and were very upset that they had not been notified of (Resident A's) change in condition. I called and spoke with the resident's (family) who said she wanted (Resident A) transported to ER [Emergency Room].....RN #5 informed me that ambulance (sic) was already in route...."</p> <p>A copy of an OT documentation form was provided by the DON on 08/20/11 at 2:20 p.m. The OT documentation form was signed by OT #3. The form indicated, "On Sat [Saturday] 8/20/2011 [Physical Therapy Assistant's name] PTA #4 and [Occupational Therapist name] OT #3....arrived at pts [Resident A's] room [symbol for around] 2:45 p.m. CNA x [times] 2 were performing a bed bath. Pt demo [demonstrated] significant change from previous day. Previous day pt was answering questions and making needs known, on this day pt was unable to answer simple yes/no questions, only moan & groan. Then left pt's room and</p>				

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	<p>called Physical Therapy Department Director's name], collaborated briefly with [RN on duty's name] RN #1, and wrote on 24 hour report.</p> <p>Review of a local hospital emergency room report on 10/12/11 at 12:10 p.m., indicated Resident A was on her way to the emergency room from the facility on 08/20/11. The report indicated Resident A arrived at the emergency room [ER] on 08/20/11 at 6:35 p.m. The report indicated, "... (Resident A) has had increase in Dilaudid and Fentanyl patch & today has been unresponsive since 11:00. The report indicated Resident A's physician "called & spoke with this RN & states contact EMS [Emergency Medical Service] to remove patch [Fentanyl patch] & have Narcan (medication frequently used to treat known or suspected opioid-induced respiratory depression). EMS contacted & patch removed. U/A [Upon arrival] pt unresponsive -eyes closed - not speaking. Pt will respond to painful stimuli... - Applied monitor, O2 [oxygen], IV.... "</p> <p>An "Emergency Department Nursing Progress Note," dated 08/20/11 at 6:45 p.m., indicated, "Narcan given - Pt started jerking & twitching entire body - moaning."</p>				

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	<p>An "Emergency Department Nursing Progress Note," dated 08/20/11 at 7:45 p.m., indicated, "Pt cont [continues] to flail & jerk - central line placed.... "</p> <p>An "Emergency Department Triage Report," dated 08/20/11 at 6:44 p.m., indicated, "Patient Narrative: Staff at (facility) states (Resident A) had a lumbar dissection 1 wk [week] ago and had pain meds increased yesterday. (Resident A) found unresponsive by staff and shallow resp [respirations] with left side facial drooping."</p> <p>A local hospital physician summary, dated 08/20/11, indicated, "....Patient clinically has improved....I am thinking that patient is alert and awake and denies any complaints....I think we can send her to (Rehabilitation Hospital) for further management.... "</p> <p>A local hospital "History and Physical Examination" report, dated 08/21/11, indicated, "female with fever, confusion, and a little low pressure and tachycardia (rapid heart rate) and now with elevated cardiac enzymes and possible cerebrovascular accident....I also think we should keep her in the Intensive Care Unit and refer her to (Rehabilitation Center) some time and go from there.... "</p>			

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	This Federal/State deficiency relates to Complaint IN00097832. 3.1-48(a)(3)				