

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2012
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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
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F0000	<p>This visit was for Investigation of Complaint IN00101711.</p> <p>Complaint IN00101711 Substantiated. Federal/State deficiencies related to the allegations are cited at F224, F226, F282, F314, F328.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: January 6, 9 & 10, 2012</p> <p>Facility number: 000103 Provider number: 155196 AIM number: 100290000</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF: 0 SNF/NF: 71 Residential: 54 Total: 125</p> <p>Census payor type: Medicare: 18 Medicaid: 33 Other: 74 Total: 125</p> <p>Sample: 5</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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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/13/12 Cathy Emswiller RN</p>			

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F0167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents, family members or visitors had the opportunity to examine the survey results, in that when a family member expressed a desire to review the facility survey results, the facility failed to include the most recent complaint investigation surveys in the facility binder. This deficient practice had the potential to affect 125 of 125 residents and their visitors/family members who wished to review the facility survey results.</p> <p>Findings include:</p> <p>During an interview on 01-09-11 at 3:30 p.m. the Administrator indicated the facility had 3 complaint survey investigations during the 2011 calendar year.</p>	F0167	<p>This plan of correction is to serve as Altenheim Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report are 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. F-167 1.) The survey binder was immediately updated with all current survey results, to include the 2011 complaint investigation surveys. 2.) All residents, families and visitors will have access to the survey binder. The survey binder has been and will be updated with all survey documents to include annual and complaint investigations and placed in a public/common area for examination. 3.) The systemic</p>	02/09/2012			

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	<p>Interview on 01-10-12 at 1:20 p.m., an interested family member questioned where the Indiana State Department of Health surveys were located.</p> <p>During this interview, the family member was informed the most recent results were located on a table adjacent to the front entrance of the facility in a white binder.</p> <p>During observation on 01-10-12 at 1:30 p.m. the white binder was reviewed with the family member in attendance. The binder lacked the most recent surveys.</p> <p>Interview on 01-10-12 at 2:45 p.m., with facility Administrative staff member #23 verified the complaint surveys on 01-13-11, 07-21-11 and 09-29-11 had not been placed in the binder for resident's, family members and visitors to review.</p> <p>3.1-3(b)(1)</p>		<p>change is that after each survey (annual or complaint), and receipt of the results has been received, the survey binder will be updated with the required reports/documents. The systemic change is that the Administrator will immediately; upon receipt, place copies into the binder. Education has been provided to the Administrator on requirements of the survey binder and when to place survey documents into the binder. 4.) The Administrator or Designee will complete an observation audit of the survey binder utilizing a QA&A audit tool 3 times per week for 12 weeks to determine appropriate documents remain in the survey binder. This audit will then continue monthly for 9 months to total 12 months. Results of these audits will be forwarded to the QA&A Committee for review and further recommendation. 5.) DOC = 02/09/2012</p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow a resident's plan of care and physician orders, in that when a resident had an existing pressure ulcer, the nursing staff failed to ensure the appropriate anti pressure device utilized and repositioning needs were met which resulted in extensive pressure on a resident's coccyx area. In addition when a resident had physician orders for the administration of pain medication, the nursing staff failed to follow the physician orders to alleviate the resident's pain. This deficient practice affected 1 of 4 residents reviewed for pressure ulcers and 1 of 3 resident's reviewed for pain/comfort in a sample of 5. [Resident "B" and "D"]</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 01-06-12 at 11:30 a.m. Diagnoses included but were not limited to history of pressure ulcers, incontinence of bowel and bladder, dementia and failure to thrive. These diagnoses remained current at the time of the record</p>	F0282	<p>F-282 1.) Resident B no longer resides at the facility. Resident D was immediately assessed for his current pain status. Routine and PRN pain medication/s will be administered as requested by Resident D and as ordered by the Physician. 2.) All residents with current pressure ulcers have been identified and have had their care plans and physician orders reviewed for anti-pressure devices and repositioning needs. Each of these have been audited to determine that ordered and care planned interventions are in place. Any identified areas noted were corrected and /or put in place. All residents with pain medication administered within the past 30 days have been identified. These residents have been interviewed or assessed to determine that they are comfortable and current pain plan is followed and meeting their needs. Any identified areas noted were addressed with the physician. 3.) The systemic change is that all newly identified pressure ulcers or newly admitted residents with pressure ulcers will be reported immediately to the DON/Designee. The DON/Designee will review to determine</p>	02/09/2012	

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	<p>review.</p> <p>During the initial tour of the facility on 01-06-12 at 10:30 a.m. the Assistant Director of Nurses indicated the resident was cognitively impaired, had nutrition concerns, and had an acquired pressure ulcer on the coccyx, which had been treated for approximately 6 months. The Director of Nurses indicated the resident had previously been seen at a local Wound Care Clinic for treatment, but was not currently going to the clinic due to decline.</p> <p>The resident's record contained a progress note dated 12-22-11 at 5:44 a.m., which indicated "Area found by CNA [certified nurses aide] 3rd shift Thursday morning. It is a stage 2 pressure sore 2 cm [centimeters] by 2 cm lower down from original one on the left buttocks."</p> <p>Review of the resident's current plan of care, dated 07-05-11 indicated "Resident is at risk for skin breakdown r/t [related to] immobility, episodes of bowel/bladder incontinence and history of pressure ulcer." An intervention/approach to this "problem" included, "turn and reposition frequently" and "use pressure relieving cushion for pressure reduction when resident is in chair."</p>		<p>that the care plan is initiated for each wound to include anti-pressure devices and repositioning needs based on the patient's risk. Education provided to nursing staff regarding utilizing anti-pressure devices, following pressure ulcer care plans, and prevention of skin breakdown. The systemic change is that all residents with stable medical condition and orders for pain medication will receive medication when requested and per physician's order unless the unit manager or administrative nurse is contacted for consult. In addition, this systemic change includes that a nurse manager will be contacted immediately with any nurses concern/question related to a patient's request for additional pain medicine, or if a patient expresses concern for not receiving pain medication as requested. Education will be provided to nurses and Q.M.A.'s regarding pain management/assessment, pain medications, and documentation of same. In addition, this education will include following physician orders and the system change above mentioned.4.) The DON/Designee will audit care plans regarding anti-pressure devices and repositioning needs utilizing a QA&A audit tool 5 times per week for 12 weeks then monthly for 9 months to total 12 months. The DON/Designee will audit wheelchairs and reclining</p>				

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	<p>During an observation on 01-10-12 at 9:00 a.m., the resident was observed seated in a recliner in room with legs elevated. A subsequent observation on 01-10-12 at 11:50 a.m., a request was made to observe the resident for incontinence and the area of the pressure ulcer.</p> <p>Employees, CNA #18 and RNA [restorative nurse aide] #25, applied the gait belt to the resident's waist and assisted the resident to a standing position. The resident's slacks were lowered as well as the resident's incontinence brief. A dressing was observed covering the pressure ulcer. However the resident's lower back, sacral/coccyx area, as well as bilateral buttocks were bright tomato red in color. The anti pressure device had not been utilized while the resident was in the recliner, but was observed in the resident's wheelchair.</p> <p>During interview on 01-10-12 at 3:45 p.m., the Director of Nurses verified the lack of positioning for the resident and the condition of the resident's skin in consideration of the acquired existent pressure ulcer.</p> <p>2. The record for Resident "D" was reviewed on 01-10-12 at 2:25 p.m.</p>		<p>chairs for anti-pressure devices utilizing a QA&A audit tool 5 times per week for 12 weeks then monthly for 9 months to total 12 months. The DON or Designee will interview residents which receive and/or request pain medications; to include Resident D, utilizing a QA&A audit tool to determine staff compliance with patient requests/needs and with administration of pain medications timely. This audit will also be completed 3 times per week for 12 weeks, then monthly for 9 months to total 12 months. The results of these audits will then be forwarded to the QA&A Committee for review and further recommendation. 5.) DOC = 02/09/2012 <u>Plan of Correction Addendum</u> F-282/F-314 = Question = How is the facility ensuring residents at risk for developing pressure ulcers are also being identified for the potential need for pressure devices? Answer = All residents at risk for pressure ulcer development have been identified through a Skin at Risk Assessment. These residents identified as at risk have been audited and pressure devices have been implemented. Skin at Risk assessments will be completed on admission, with significant change, and quarterly on all residents. Interventions will be implemented at that time.</p>				

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	<p>Diagnoses included but were not limited to Menuier's disease, congestive heart failure, history of prostate cancer, renal failure and chronic pain. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 07-04-11 for Hydroco/apap tab. [tablet][a pain medication] 7.5-325, take 1 tablet by mouth three times a day and 2 tablets at 6:00 p.m. In addition the physician order included Hydrodo/Apap 7.5-325 1 tablet every four hours as needed.</p> <p>Interview on 01-10-12 at 12:45 p.m., the resident indicated a need for pain medication from QMA [Qualified Medication Aide] employee #19. The resident indicated on one occurrence the staff member refused to administer pain medication. "One time I had to wait 4 hours to get a pain pill. I told her it's ordered PRN [as needed], and the staff member said 'well I'm not giving it to you.' I had to explain to her what PRN meant and that I've been around this business for 42 years."</p> <p>This Federal Tag relates to IN00101711.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary care and services to a resident with a diagnosis of chronic pain which the nursing staff refused to administer the physician ordered pain medication for 1 of 5 resident's reviewed for emergency and medication nursing intervention. [Resident "D"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 01-06-12 at 11:40 a.m. Diagnoses included but were not limited to Glioblastoma, epilepsy, muscle weakness, history of falls, dysphasia and cerebral vascular accident. These diagnoses remained current at the time of the record review.</p> <p>A review of the clinical record progress notes, dated 11-22-11 [no time designated] indicated "resident was in bed during bed check. Resident was found shaking and hard to get to respond. vital</p>	F0309	F-309 This citation is being disputed using the IDR process To clarify: The physician was called immediately related to the seizure, did respond timely and orders were received and followed. 1.) Resident A was assessed immediately when seizure was noted and physician was called. Orders were received, but then changed to send the patient to the emergency room per family request. Ambulance was called at that time, and resident A was treated in the emergency room. After return, resident A received an order and has a medication readily available to treat any future seizure. Resident D was immediately assessed for his current pain status. Resident D will receive Routine and PRN pain medications requested by Resident D and as ordered by the Physician. 2.) All residents with a diagnosis of seizure activity or a history of have been identified and will receive an audit of their current medications to determine appropriate medications are ordered and available.	02/09/2012			

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	<p>signs 168/104 [blood pressure], 144 [heart rate, 98.4 [temperature], and [oxygen saturation level] 93 % on RA [room air]. Resident's POA [power of attorney] notified, [name of physician] notified. Family decided at 4:45 a.m. to send resident out to [name of local area hospital]. Resident was non responsive to verbal ques. Resident could not voice weather <sic> in pain or not."</p> <p>Review of the local are hospital record, dated 11-22-11 indicated "[resident] with recent hx. [history] of GBM [Glioblastoma] s/p [status post] resection, chemo. [chemotherapy] and XRT [radiation therapy]. Had a seizure this morning that lasted 2 hours, finally broken in ED [emergency department]. Currently awake, denies problems but family notes that pt. [patient] cannot move left arm or leg and this is new. Speech chronically slurred but [family member] notes it is worse this AM."</p> <p>During an interview on 01-10-12 at 9:15 a.m., licensed nurse employee #16 indicated he worked the night shift that the resident was observed with seizure activity. The licensed nurse indicated the resident's family did not want to send the resident to the local area hospital, but wanted the physician to be called for intervention.</p>		<p>Medications will be ordered and available as indicated. All residents with pain medication administered within the past 30 days have been identified. These residents will receive pain medications as ordered and/or as requested based on assessment and Physician order. 3.) The systemic change is that residents with diagnoses of seizure activity or history of will have current PRN physician orders for medication/s assigned to the patient to be given in the event of a seizure. Education provided to nurses on immediate response/interventions to treat a patient during seizure activity and the systemic change above that a PRN medication is likely to be ordered and available if there is a history. The systemic change is that a nurse manager will be contacted immediately with any nurses concern/question related to a patients request for additional pain medicine, if concerned in regards to amount for guidance. Education provided to nurses and Q.M.A.'s regarding pain management/assessment, pain medications, and documentation of the same and following resident request and physician's order. In addition, this education will include the system change above. 4.)The DON/Designee will audit the M.A.R.'s of patients with diagnoses of seizure activity or history of activity for appropriate medication orders and/or usage</p>				

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	<p>"I went over to help the nurse who was involved. She tried for two hours to get the doctor to call her back. Finally the family got so upset with the waiting, they decided to send [resident] to the hospital." When further questioned, the licensed nurse indicated the family member wanted the resident to get Valium for the seizure activity. We didn't have an order, and the doctor didn't call us back. We wouldn't have been able to get into the emergency controlled drug kit anyway because no one working that shift was an 'authorized agent' to get into the narcotics. It's pretty frustrating for the nursing staff."</p> <p>During an interview on 01-10-12 at 9:30 a.m., an interested family member indicated, "They called us to let us know [resident] was having a seizure. We told them not to send [resident] to the hospital but to call the doctor. Once we got there [to the facility], we kept checking with the nurse to see if the doctor had called back and he hadn't. If they could get an order for Valium that would have brought [resident] out of it. Our doctor is [name] and when we talked to him about this issue he said he never received a call. I knew that if the EMT's [Emergency Medical Technicians] were called they could give [resident] something."</p>		<p>of medications. The DON/Designee will also complete an audit after any seizure activity utilizing a QA&A audit tool to determine staffs response and interventions to include meeting patients needs. The DON or Designee will interview residents which receive and/or request pain medications; to include Resident D, utilizing a QA&A audit tool to determine staff compliance with patient requests/needs and with administration of pain medications timely. This audit will also be completed 3 times per week for 12 weeks, then monthly for 9 months to total 12 months. The DON or Designee will audit patients M.A.R. pain ratings for compliance 5 times per week for 12 weeks, then monthly thereafter to total 12 months. The results of these audits will then be forwarded to the QA&A Committee for review and further recommendation.5.) DOC = 02/09/2012</p>	

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	<p>Interview on 01-10-12 at 10:05 a.m., the Director of Nurses verified there were only certain nurses who the Medical Director allowed to be "authorized agents" due to the possibility of drug diversion. "The Medical Director makes that decision. They never called me to let me know they weren't able to get ahold of the physician. They should have called the Medical Director when they couldn't get [name of physician] to call them back."</p> <p>The nursing staff failed to involve the Medical Director for intervention and the facility failed to ensure the availability of an "authorized agent" on night shift to gain access to the emergency narcotic drug kit, in the event of an emergency.</p> <p>2. The record for Resident "D" was reviewed on 01-10-12 at 2:25 p.m. Diagnoses included but were not limited to Menuier's disease, congestive heart failure, history of prostate cancer, renal failure and chronic pain. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 07-04-11 for Hydroco/apap tab. [tablet][a pain medication] 7.5-325, take 1 tablet by mouth three times a day and 2 tablets at 6:00 p.m. In addition the physician order</p>			

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	<p>included Hydrodo/Apap 7.5-325 1 tablet every four hours as needed.</p> <p>Interview on 01-10-12 at 12:45 p.m., the resident indicated a need for pain medication from QMA [Qualified Medication Aide] employee #19. The resident indicated on one occurrence the staff member refused to administer pain medication. "One time I had to wait 4 hours to get a pain pill. I told her it's ordered PRN [as needed], and the staff member said 'well I'm not giving it to you.' I had to explain to her what PRN meant and that I've been around this business for 42 years."</p> <p>3.1-37(a)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to provide devices to prevent additional decline or a resident with a pressure ulcer, in that when a resident had an existing pressure ulcer, the nursing staff failed to ensure the appropriate anti pressure device was utilized which resulted in extensive pressure on a resident's coccyx area for 1 of 4 residents reviewed for pressure ulcers in a sample of 5. [Resident "B"]</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 01-06-12 at 11:30 a.m. Diagnoses included but were not limited to history of pressure ulcers, incontinence of bowel and bladder, dementia and failure to thrive. These diagnoses remained current at the time of the record review.</p>	F0314	F-314 1.) Resident B no longer resides at the facility. 2.) All residents with current pressure ulcers have been identified and have had their care plans and physician orders reviewed for anti-pressure devices and repositioning needs. Physical rounds were provided to determine that these interventions were in place. No issues were identified. 3.) The systemic change is that all newly identified or newly admitted residents with pressure ulcers will be reported immediately to the DON/Designee. The DON/ Designee will ensure the care plan is initiated for each wound to include anti-pressure devices and repositioning needs based on the patient's risk. In addition, the systemic change will include that an administrative nurse will determine that the care plan interventions are included on aide assignments and staff nurses review assignments that interventions are followed during	02/09/2012	

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	<p>During the initial tour of the facility on 01-06-12 at 10:30 a.m. the Assistant Director of Nurses indicated the resident was cognitively impaired, had nutrition concerns, and had an acquired pressure ulcer on the coccyx, which had been treated for approximately 6 months. The Director of Nurses indicated the resident had previously been seen at a local Wound Care Clinic for treatment, but was not currently going to the clinic due to decline.</p> <p>The resident's record contained a progress note dated 12-22-11 at 5:44 a.m., which indicated "Area found by CNA [certified nurses aide] 3rd shift Thursday morning. It is a stage 2 pressure sore 2 cm [centimeters] by 2 cm lower down from original one on the left buttocks."</p> <p>Review of the resident's current plan of care, dated 07-05-11 indicated "Resident is at risk for skin breakdown r/t [related to] immobility, episodes of bowel/bladder incontinence and history of pressure ulcer." An intervention/approach to this "problem" included, "turn and reposition frequently" and "use pressure relieving cushion for pressure reduction when resident is in chair."</p> <p>During an observation on 01-10-12 at 9:00 a.m., the resident was observed</p>		<p>their shift. Education will be provided to nursing staff regarding utilizing anti-pressure devices, following pressure ulcer care plans, and prevention of skin breakdown. This education will include the responsibility of staff to follow care plans for interventions and the systemic change mentioned above. 4.) The DON/Designee will audit care plans regarding anti-pressure devices and repositioning needs utilizing a QA&A audit tool 5 times per week for 12 weeks then monthly for 9 months to total 12 months. The DON/Designee will audit wheelchairs and reclining chairs for anti-pressure devices utilizing a QA&A audit tool 5 times per week for 12 weeks then monthly for 9 months to total 12 months. The results of these audits will then be forwarded to the QA&A Committee for review and further recommendation. 5.) DOC = 02/09/2012 <u>Plan of Correction Addendum</u> F-282/F-314 = Question = How is the facility ensuring residents at risk for developing pressure ulcers are also being identified for the potential need for pressure devices? Answer = All residents at risk for pressure ulcer development have been identified through a Skin at Risk Assessment. These residents identified as at risk have been audited and pressure devices have been implemented. Skin at Risk</p>	

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	<p>seated in a recliner in room with legs elevated. A subsequent observation on 01-10-12 at 11:50 a.m., a request was made to observe the resident for incontinence and the area of the pressure ulcer.</p> <p>Employees, CNA #18 and RNA [restorative nurse aide] #25, applied the gait belt to the resident's waist and assisted the resident to a standing position. The resident's slacks were lowered as well as the resident's incontinence brief. A dressing was observed covering the pressure ulcer. However the resident's lower back, sacral/coccyx area, as well as bilateral buttocks were bright tomato red in color.</p> <p>During interview on 01-10-12 at 3:45 p.m., the Director of Nurses verified the lack of positioning for the resident and the condition of the resident's skin in consideration of the acquired existent pressure ulcer.</p> <p>This Federal Tag relates to IN00101711.</p> <p>3.1-40(a)(2)</p>		<p>assessments will be completed on admission, with significant change, and quarterly on all residents. Interventions will be implemented at that time.</p>		

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure the suctioning of a resident in that when a resident had physician orders to be suctioned as needed, which resulted in mental and physical anquish for a resident who stated "I couldn't breath, it was a difficult night for me, I thought I was dying," for 1 of 1 residents reviewed for suctioning in a sample of 5. [Resident "D"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 01-06-12 at 11:40 a.m. Diagnoses included but were not limited to Glioblastoma, epilepsy, muscle weakness, history of falls, dysphasia and cerebral vascular accident. These diagnoses remained current at the time of the record review.</p>	F0328	<p>F-328 This citation is being disputed using the IDR process 1.) Resident A was assessed for secretions and suctioned as needed and/or as requested.2.) All residents that require suctioning have been identified. Suctioning will be provided to the patient per the patient's request and/or the nurse's assessment of the patient's need for suctioning. Currently Resident A only requires suctioning. 3.) The systemic change is that all nurses will provide return demonstration/competency validations on suctioning of patients annually and upon hire. Education will be provided to nurses on suctioning techniques and assessment of patients requiring suctioning. This education will also include accommodating patient's request for suctioning and understanding the anxiety of a patient that feels they need suctioning to clear their airway. 4.) The DON or Designee will complete suctioning</p>	02/09/2012			

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	<p>The record indicated the resident had recently been diagnosed with pneumonia and the physician had prescribed Omnicef [an antibiotic] 300 mg two times a day for ten days on 11-29-11.</p> <p>Interview on 01-06-12 at 1:00 p.m. CNA employee #7 indicated [name of Resident "A"] needed to be suctioned and I heard [name of licensed nurse employee #26] say 'I don't have all night to stand in here and suction you, here's a kleenex, spit into it.'"</p> <p>Interview on 01-09-12 at 11:30 a.m., licensed nurse employee #26 indicated "yes I was working that night, [resident] had a lot of phlegm and I had to keep doing back to back suctioning. After awhile I did tell [resident] to just spit into a cup."</p> <p>Interview on 01-10-12 at 9:30 a.m., an interested family member for Resident "A" indicated, "[resident] has a cleft palate and has always had a lot of phlegm. Before [resident] was able to bring it up on [resident] own, but now [resident] has gotten too weak to do it and the nursing staff need to use the suction."</p> <p>Interview on 01-09-12 at 2:30 p.m., Resident "A" indicated "She [in reference to licensed nurse employee #26] told me</p>		<p>observations with competency validation to determine compliance with all nurses. The DON or Designee will continue to complete random audits, on all 3 shifts of suctioning observations by nurses 3 times per week for 12 weeks, then monthly for 9 months to total 12 months. The DON or Designee will also interview Resident A utilizing a QA&A audit tool to determine staff are compliant per resident's expectations, requests and needs. This audit will also be completed 3 times per week for 12 weeks, then monthly for 9 months to total 12 months. These audits will then be forwarded to the QA&A Committee for review and further recommendation. 5.) DOC = 02/09/2012</p>	

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	<p>she didn't have time for me because she had 19 other people to take care of - I guess I can understand that, but I couldn't breath, it was a hard night for me." During this interview, the resident indicated the need to be suctioned and the nurse was informed.</p> <p>A review of the clinical record Progress Notes, dated 12-14-11 at 4:44 a.m., indicated "I sat with resident and explained that I would suction [resident] at [resident] request. Res. [resident] with left sided hemiparesis and said 'I had a bad night last night [in reference to licensed nurse #26 refusal to suction] and thought I was dying."</p> <p>During observation on 01-09-12 at 2:40 p.m., licensed nurse employee #13 prepared to suction the resident. The unit manager employee #6 was in attendance. The licensed nurse donned gloves and explained to the resident she was going to start the suction. The licensed nurse picked up the yankauer and turned on the suction machine. The unit manager provided two plastic cups of water. The licensed nurse placed the end of the suction catheter into the water and then instructed the resident to open mouth for suctioning. The nurse took the yankauer and positioned it toward the back of the resident's oral cavity. This process was</p>			

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	<p>repeated three times. Upon completion the nurse again placed the yankauer into the cup of water to clean the yankauer, and then placed it into a paper covering. The nurse removed her gloves.</p> <p>Review of an Observation notation, provided by the Director of Nurses and dated 12-13-11, prepared by licensed nurse employee #26, indicated the following details related to the resident respiratory status for the night shift: "Pneumonia, no change in mental status, respirations were regular and unlabored, resident with crackles/rales, a productive cough, clear thick sputum, no signs of pain the last 5 days, has shortness of breath or trouble breathing when lying flat." The record lacked documentation of the number of times the licensed nurse had to perform suctioning for the resident, vital signs or lung sounds.</p> <p>Further review of the resident's clinical record indicated the following day, 12-14-11, the physician instructed the nursing staff to "Get chest x-ray today [indication edema, cough], start lasix 20 mg - one by mouth every day and provide a scopolamine 1.5 patch and change every three days for secretions."</p> <p>Review of the facility policy on 01-09-12 at 1:20 p.m., and titled "suctioning the</p>			

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	<p>upper Airway (Oral Pharyngeal)," and dated as revised march 2004 indicated the following:</p> <p>"Purpose: the purpose of this procedure is to clear the upper airway of mucous secretions and prevent the development of respiratory distress."</p> <p>"General Guidelines - 6. Monitor the resident's vital signs during the procedure."</p> <p>"Steps in the Procedure - 5. Put on mask and protective eyewear as indicated,</p> <p>6. Assist the resident to semi-Fowler's position with head turned toward you,</p> <p>7. Place towel or Chux pad under the chin,</p> <p>8. Turn on suction unit and set to appropriate negative pressure,</p> <p>9. Fill cup or basin with approximately 100 cc of water,</p> <p>10. Verify that suction tubing is attached to wall or portable unit,</p> <p>11. Attach catheter to tubing,</p> <p>12. Suction a small mount <sic> of water</p>			

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	<p>from the basin,</p> <p>15 Advance the catheter into the mouth approximately 4 to 6 inches along the gum line,</p> <p>16. Staying along the gumline apply suction until secretions are cleared,</p> <p>19. Assess the respiratory status of the resident and effectiveness of procedure,</p> <p>20 Repeat procedure, if necessary,</p> <p>23. Remove towel or Chux pad and place in designated receptacle."</p> <p>The licensed nurse failed to perform the above appropriate steps while performing suctioning on this resident."</p> <p>This Federal deficiency relates to IN00101711.</p> <p>3.1-47(a)(6)</p>			

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F0493 SS=C	<p>483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN</p> <p>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>Based on observation and interview, the facility failed to ensure covered individuals were aware of their role and obligations in reporting reasonable suspicion of a crime, in that the facility Administrator failed to provide Inservice education and post signage related to the Elder Justice Act for 1 of 1 policy's reviewed. This deficient practice had the potential to affect 125 of 125 residents currently residing in the facility.</p> <p>Findings include:</p> <p>During interview on 01-06-12 at 10:00 a.m., the Administrator indicated the facility staff had received Inservice education related to Abuse. When further interviewed for a review of specific policy and procedures which included reporting reasonable suspicion of a crime against a resident, the Administrator indicated the facility had complied with the regulation.</p>	F0493	<p>F-493 1.) The Administrator immediately provided in-service education and posted signage related to the Elder Justice Act and included all covered individuals 2.) In-service education will continue to be provided for current staff and new staff regarding the Elder Justice Act. Signage will be maintained in place in 3 areas. 3.) The systemic change is that new hires and all covered individuals will be oriented to the Elder Justice Act during their orientation period, prior to beginning duties. Current staff education was provided, but will continue to be provided on a routine basis. Education includes their role and obligation in reporting suspicion of a crime and the Elder Justice Act. 4.) The Administrator has posted signage in 3 areas related to the Elder Justice Act and will audit placement of this signage 3 times per week for 12 weeks via a QA&A audit tool. This audit tool will then continue monthly for 9 months to total 12 months.</p>	02/09/2012

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	<p>During observation on 01-06-12 at 10:15 a.m., with the Administrator in attendance, signage or any type of posted notice in an area used by covered individuals which included the requirement to report, who is required to report, the time frame required to report and the employee's right to file a complaint against a facility that retaliates against the employee for filing a complaint or report under the Elder Justice Act, was not available by the facility.</p> <p>Interview on 01-06-12 at 1:00 p.m. CNA employee #7 indicated she had not received Inservice Education related to the Elder Justice Act, and then stated "what is that ?"</p> <p>Interview on 01-09-12 at 10:10 a.m. CNA employee #8 indicated she had not received any Inservice education or responsibilities related to the Elder Justice Act.</p> <p>Interview on 01-09-12 at 10:30 a.m. licensed nurse employee #9 indicated the Administrator came in on night shift, gave her a paper to read about the Elder Justice Act and then told her to sign the attendance sheet that she had received the education.</p>		Results of the audits will be forwarded to the QA&A Committee for review and further recommendations. 5.) DOC = 02/09/2012				

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	<p>Interview on 01-10-12 at 9:15 a.m., licensed nurse employee #16 indicated receipt of the information but had not had time to read it.</p> <p>3.1-13(t)(2)</p>			