

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155804	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2015
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NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00183034.</p> <p>Complaint IN00183304 - Substantiated. Federal/State deficiencies related to the allegations are cited at F333.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: October 1, 2 and 5, 2015.</p> <p>Facility number: 013017 Provider number: 155804 AIM number: 201237680</p> <p>Census bed type: SNF: 28 SNF/NF: 23 Total: 51</p> <p>Census payor type: Medicare: 28 Medicaid: 23 Total: 51</p> <p>Sample:7</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>QR completed by 14454 on October 14, 2015.</p> <p>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).</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</p>			

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	<p>the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was timely notified of a resident's condition related to swallowing difficulties and refusing recommended interventions and of a significant change in a resident's condition for 1 of 3 residents reviewed. (Resident B)</p> <p>Finding includes:</p> <p>The clinical record for Resident B was reviewed on 10/1/15 at 9:00 A.M. The clinical record indicated Resident B was admitted to the facility on 9/9/15. The diagnoses included, but were not limited to, unspecified generalized pain, unspecified debility, other pulmonary insufficiency nec (not elsewhere classified) and congestive heart failure.</p> <p>A 5 day Minimum Data Set (MDS) assessment, reference date of 9/16/15, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating she was cognitively intact. The assessment indicated she required supervision of one with eating.</p> <p>A Speech Therapy Evaluation & Plan of Treatment Initial Assessment/Current</p>	F 0157	<p>1. Resident B was not identified in a sample, however the facility was fully aware of who the residents identified were. Resident B's Primary Care Physician was notified of the change of condition.</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> · Residents who have experienced a change of condition, have had their Primary Care Physician Notified as well as the responsible party and/or the resident themselves if no responsible party exists. · 3. The nursing department will be re educated on the Notification requirement by 10/30/15, including timeliness of MD notification · The Speech Therapist has been educated on their role at it relates to non compliance of recommendations provided to residents and/or their family members, including providing more detailed communication to the physician. · The Director of Nursing will run Order summary reports daily to ensure the notification to the physician has occurred. <p>4. The Director of Nursing will conduct monthly audits, that includes physician notification, these will be forwarded to the QA&A committee for</p>	11/02/2015

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	<p>Level of Function & Underlying Impairments, dated 9/11/15, indicated, "...Current Referral: Reason for Referral: Patient referred to ST [Speech Therapy] by DON [Director of Nursing] after patient had a witnessed coughing episode with breakfast with wheezing and wet vocal quality following. Patient has a chest xray today that showed 'superimposed patchy right perihilar infiltrates.'...Prior Level(s): PLOF [prior level of function]: Intake/Diet Level:= Regular textures, thin liquids, successive swallows..(Patient's daughter reported decreased or absent epiglottic inversion and stated "she has always had to be careful when eating"); PTA [prior to admission] patient was on a regular diet with thin liquids but has a hx [history of dysphagia]. Assessment Summary: Clinical Impressions:...Patient demonstrated s/s [signs and symptoms] of aspiration with thin liquids 50% of the time. Patient tolerated 80% of nectar thickened liquid trials without overt s/s aspiration. Cough/wet vocal quality observed towards end of meal. Recommended regular diet with nectar thick liquids. Also recommended MBS [Modified Barium Swallow Study] d/t inconsistency of s/s of aspiration and results of chest xray. Recommend patient eat in the dining room where supervision is available...."</p>		<p>review, These audits will be reported monthly for a period of 6-months until compliance is achieved</p>	

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	<p>A Physicians order, dated 9/11/15, indicated, "... ST [Speech Therapy] Clarification: ST to eval [evaluate]& treat 5x [times] week for 4 weeks for dysphagia. Change to nectar thick liquids. Recommend supervision with meal. Small bites/sips. Alternate bites/sips. Up in chair for meal...."</p> <p>A Speech Therapy Discharge Summary, dates of service 9/11/15 through 9/17/15, indicated, " Pt. and Caregiver Training: Patient and patient's daughter educated on swallow strategies and risks of aspiration. Education also provided on patient being up in chair or wheel chair for meals and eating in the dining room r/t supervision...Patient Response: Patient did not meet goals. Patient and patients family reports that her dysphagia is premorbid and do not want repeat MBS or thickened liquids...."</p> <p>A Nursing Progress Note, dated 9/12/15 at 12:58 P.M., indicated "... Res. [resident] continues to request water thin liquids despite recommendations for other wise. Res. states that she will not drink the thickened liquids that she "hates them." Res. advised of possible illness, and even death should she aspirate the fluids. Res. states " I understand" daughter present and is also requesting</p>			

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	<p>thin liquids "whatever mom wants." Daughter aware and acknowledges risk. Daughter does not want to sign waiver at this time. States that she doesn't want her mother refused thin liquids but wants to wait until Monday until speech therapist is in. Res. observed swallowing, no cough noted, however approx. [approximately] 15 - 20 seconds after drinking thin water res. vomited clear fluid up small amount. Res. states that was "the pills," however there was [sic] no pills, applesauce noted in emesis. Res. continued to be encouraged to use thickened liquids but is refusing at this time...."</p> <p>A Late Entry Therapy Department Note, dated 9/14/15 at 11:33 A.M., indicated "... Order written this date for mechanical soft diet with thin liquids d/t patient's daughter request and patient refusal of nectar thickened liquids. Patient and Patient's daughter were both educated on aspiration and patient being at risk for aspiration...."</p> <p>A Speech Therapy Daily Note, dated 9/16/15 at 11:16 A.M., indicated "... Patient seen during breakfast...Patient required mod [moderate] verbal cues [reminders] to utilize chin tuck with liquids...Patient reported that yesterday she coughed after she took a water and</p>			

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	<p>then vomited...Educated patient on the risks of aspiration and patient stated "I can swallow just fine. I don't need that thick stuff..."</p> <p>A Nurses Note, dated 9/17/15 at 7:11 P.M., indicated, "Patient Temp [Temperature] at 4:30 P.M., 102.0, P [pulse] 95, R [respirations] 20, BP [blood pressure] 132/71, Biox [a measure of the oxygen level in the blood] 91% on 2L [liter of oxygen] per nasal cannula, Patient alert, drowsy, stated that she felt ill, moist cough, productive of yellow sputum, L/S [lung sounds] diminished, tremors to bilat [bilateral] arms, patient unable to hold cup to take drink of water. Remains on ABT [antibiotic] for UTI [Urinary Tract Infection] ...daughter requested that Xanax [an antianxiety medication] be administered as ordered, Tylenol [a medication used for pain and increased temperature] also administered, this nurse offered to send patient to ER [Emergency Room] daughter appeared hesitant, did not want to drag patient out if it was "nothing"...Daughter thought Xanax would help with tremors, daughter requested that patient let rest [sic] and that she would return after she went home to change clothes, at 5:30 P.M., patient noted sitting up in bed, alert with eyes open, temp down 101.5, Biox remained 91-92 % at 2 L, Patient feeding</p>			

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	<p>self applesauce, assistance provided for patient to take drink of water, patient refused this nurses offer to feed her, patient to be monitored...."</p> <p>A Nursing Progress note, dated late entry 9/17/15 at 08:27 P.M., indicated, Resident B was unresponsive and sent to the hospital on 9/17/2015 at 8:27 P.M.</p> <p>A Nurses Note, dated 9/18/15 at 06:02 A.M., titled Health Status Late Entry indicated, "... Called to resident's room noticed resident unresponsive, b/p [blood pressure]114/57, p [pulse] 78, r [respiration] 20, t [temperature] 100.6 biox 94%, daughter here 911 notified, don aware, and md [medical doctor] aware...."</p> <p>The hospital History and Physical Exam, dated 9/19/15, indicated "...For the past five days, the patient has been regurgitating and aspirating at the nursing home, had a fever of 100.5, shaking chills, tremor, became unresponsive. 911 was called at the nursing home."</p> <p>On 10/1/15 at 3:33 P.M., a Incident Report, provided by the Executive Director and dated 9/18/15 at 4:45 P.M., was reviewed. The Incident Report indicated, "...Brief Description of Incident: 9/18/15 Residents' daughter</p>			

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	<p>reports the facility neglected her mother by not providing her with a puree diet...Immediate action taken: 9/18/15...1. Resident sent to the hospital at the request of the family...Follow Up: Preventative Measures Includes: Upon review and investigation of the clinical record, hospital records and investigation completion, it was determined that the allegation of failing to provide puree foods was deemed unsubstantiated, Resident was on speech therapy, was trialed [sic] w [with] /a puree diet, had an active order for mechanical soft w/nectar thick liquids, there is multiple notations of resident and resident's daughter refusing the thickened liquids as recommended by the speech therapist...Speech therapist discontinued skilled services d [due] / t [to] resident and resident's daughter refusing recommendations....In servicing for licensed therapist regarding residents who are non-compliant w[with]/recommendations, education on reporting change of conditions to the Director of Nursing for follow up...."</p> <p>On 10/1/15 at 4:40 P.M., an interview was conducted with LPN # 8. LPN #8 indicated she took over care for Resident B around 3 P.M. on 9/17/15. At 4:00 P.M., she indicated she noted Resident B was tremoring in her hands and Resident</p>			

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	<p>B told her she felt ill. LPN #8 indicated vitals were assessed and the resident's vitals were found to be over 102.0 F [Fahrenheit] LPN #8 indicated she mentioned to Resident B's daughter that she could be septic but LPN #8 felt the daughter was more concerned with her tremors, LPN #8 indicated, "... I explained we should send to ER they would get faster results than having blood work drawn here. The daughter wanted me to give her anxiety medication and the daughter did not want her sent out at that time she was going to go home and change her clothes. I checked her at 6:00 P.M. r/t she had a tray on her table. No one was with her when she was eating. She was eating yogurt or applesauce or something like that. Her temp. [temperature] was around 101 then I was giving report at 6:30 P.M. when her other daughter reported she needed help in the hallway she (Resident B) was not responding... I did not notify the doctor prior to her unresponsive episode I was waiting for the daughter who was changing her clothes to get back. I was not aware she was an aspiration risk..."</p> <p>On 10/2/15, between 12:30 P.M. and 1:30 P.M., an interview was conducted with the facility Medical Director. The Medical Director indicated had not been fully informed of the residents condition</p>			

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	<p>at the time the ST recommended a mechanical soft diet with thin liquids and further indicated had he known of the residents condition he would have met with the family and discussed options for care such as an educational meeting between himself and the Interdisciplinary team of the facility to properly educate of risks and consequences involved with non- compliance with ST recommendations. He further indicated that he would have discussed with the family alternative options such as Hospice care.</p> <p>On 10/5/15 at 3:30 P.M., a Notification of Change in Resident Condition policy, revised in July 2013, was provided by the Director of Nurses on 10/5/15. The policy indicated, "... Policy: It is the policy of Sprenger Retirement centers that the resident, physician, and , if known, the resident's legal party representative or interested family member (unless the resident does not want the family member informed) be informed when the following occur: significant change in the resident's physical, mental, or psychological status...."</p> <p>3.1-5(a)(2)</p>			

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F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident, established to be at risk for aspiration, was provided adequate supervision and monitoring with meals, which resulted in a hospital admission for Aspiration Pneumonia, for 1 of 3 residents reviewed. (Resident B)</p> <p>Finding includes:</p> <p>The clinical record for Resident B was reviewed on 10/1/15 at 9:00 A.M. The clinical record indicated Resident B was admitted to the facility on 9/9/15. The diagnoses included, but were not limited to, unspecified generalized pain, unspecified debility, other pulmonary</p>	F 0309	<p>1. Resident B was not identified in the survey sample, however the facility was fully aware of who the residents identified were. Resident B has been discharged from the facility.</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> · Residents assessed as having a potential for aspiration will be assessed by the Speech Therapist by 10/30/15 · Blue Wrist bands have been implemented for residents with swallowing precautions by 10/30/15 to assist staff in easily identifying them. <p>3 The nursing department has been educated on the Quality of Care requirement, which includes MD notification as it relates</p>	11/02/2015

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	<p>insufficiency nec (not elsewhere classified) and congestive heart failure.</p> <p>A 5 day Minimum Data Set (MDS) assessment, reference date of 9/16/15, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating she was cognitively intact. The assessment indicated she required supervision of one with eating.</p> <p>A Nutrition Assessment, dated 9/10/15 at 1:22 P.M., indicated, "...3. Dietary Consistency: Regular...Additional Dietary Restrictions: None noted. 7. Feeding Ability...1. Resident ability to feed self: Independent...2. Meal Location: Eats in dining room...Notes additional/Progress Notes: Diet is low sodium guidelines, regular texture-appropriate...."</p> <p>A Speech Therapy Evaluation & Plan of Treatment Initial Assessment/Current Level of Function & Underlying Impairments, dated 9/11/15, indicated, "...Current Referral: Reason for Referral: Patient referred to ST [Speech Therapy] by DON [Director of Nursing] after patient had a witnessed coughing episode with breakfast with wheezing and wet vocal quality following. Patient has a chest xray today that showed 'superimposed patchy right perihilar</p>		<p>tonon-compliance w/ diet orders by 10/26/15</p> <p>The Speech Therapist has been educated on theirrole as it relates to residents that are non compliant with dietrecommendations, this will include Physician Notification by 10/30/15.</p> <p>4. The Director of Nursing will perform monthlyaudits of residents with swallowing precautions, results of those audits willbe forwarded to QA&A for review. These audits will be reported monthly fora period of 6-months until compliance is achieved. IDR information included in the attachments provided</p>	

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	<p>infiltrates.'...Prior Level(s): PLOF [prior level of function]: Intake/Diet Level:= Regular textures, thin liquids, successive swallows..(Patient's daughter reported decreased or absent epiglottic inversion and stated "she has always had to be careful when eating"); PTA [prior to admission] patient was on a regular diet with thin liquids but has a hx [history of dysphagia]. Assessment Summary: Clinical Impressions:...Patient demonstrated s/s [signs and symptoms] of aspiration with thin liquids 50% of the time. Patient tolerated 80% of nectar thickened liquid trials without overt s/s aspiration. Cough/wet vocal quality observed towards end of meal. Recommended regular diet with nectar thick liquids. Also recommended MBS [Modified Barium Swallow Study] d/t inconsistency of s/s of aspiration and results of chest xray. Recommend patient eat in the dining room where supervision is available...."</p> <p>A Physicians order, dated 9/11/15, indicated, "... ST [Speech Therapy] Clarification: ST to eval [evaluate]& treat 5x [times] week for 4 weeks for dysphagia. Change to nectar thick liquids. Recommend supervision with meal. Small bites/sips. Alternate bites/sips. Up in chair for meal...."</p>			

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	<p>A Speech Therapy Discharge Summary, dates of service 9/11/15 through 9/17/15, indicated, " Pt. and Caregiver Training: Patient and patient's daughter educated on swallow strategies and risks of aspiration. Education also provided on patient being up in chair or wheel chair for meals and eating in the dining room r/t supervision...Patient Response: Patient did not meet goals. Patient and patients family reports that her dysphagia is premorbid and do not want repeat MBS or thickened liquids...."</p> <p>A care plan, with the target date of 12/10/15, indicated the focus included "recommended thickened liquids - refused." The interventions included: to observe for nausea / vomiting, abdominal distention, diarrhea and constipation, teach reason for diet and involve resident in meal planning. There was no documentation to address approaches/interventions for the resident's need for supervision while eating or the risk of aspiration.</p> <p>A Nursing Progress Note, dated 9/12/15 at 12:58 P.M., indicated "... Res. [resident] continues to request water thin liquids despite recommendations for other wise. Res. states that she will not drink the thickened liquids that she "hates them." Res. advised of possible illness,</p>			

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	<p>and even death should she aspirate the fluids. Res. states " I understand" daughter present and is also requesting thin liquids "whatever mom wants." Daughter aware and acknowledges risk. Daughter does not want to sign waiver at this time. States that she doesn't want her mother refused thin liquids but wants to wait until Monday until speech therapist is in. Res. observed swallowing, no cough noted, however approx. [approximately] 15 - 20 seconds after drinking thin water res. vomited clear fluid up small amount. Res. states that was "the pills," however there was [sic] no pills, applesauce noted in emesis. Res. continued to be encouraged to use thickened liquids but is refusing at this time...."</p> <p>A Late Entry Therapy Department Note, dated 9/14/15 at 11:33 A.M., indicated "... Order written this date for mechanical soft diet with thin liquids d/t patient's daughter request and patient refusal of nectar thickened liquids. Patient and Patient's daughter were both educated on aspiration and patient being at risk for aspiration...."</p> <p>A Speech Therapy Daily Note, dated 9/16/15 at 11:16 A.M., indicated "... Patient seen during breakfast...Patient required mod [moderate] verbal cues</p>			

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	<p>[reminders] to utilize chin tuck with liquids...Patient reported that yesterday she coughed after she took a water and then vomited...Educated patient on the risks of aspiration and patient stated "I can swallow just fine. I don't need that thick stuff...."</p> <p>A Speech Therapy Daily Note, dated 9/17/15 at 2:23 P.M., indicated "... Educated patient on risks of aspiration but patient continues to refuse thickened liquids. Also educated patient on the importance of using chin tuck and not utilizing straws. Patient remains at a high risk for aspiration, however per my conversation with patient's daughter, she doesn't want a repeat MBS completed or want her mother on thickened liquids...."</p> <p>A Nutrition Progress Note, dated 9/16/15 at 5:47 P.M., indicated, "...RD [Registered Dietician] spoke to resident on this date who states she has no appetite, et [and] daughter wants resident to try pureed texture. Sample pureed texture provided for resident for dinner...."</p> <p>A Nutritional Progress Note, dated 9/17/15 at 10:35 A.M., indicated RD received return call from daughter [name of daughter] who states she does want resident to be downgraded to pureed</p>			

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	<p>texture consistent with resident request yesterday...."</p> <p>A Nurses Note, dated 9/17/15 at 7:11 P.M., indicated, "Patient Temp [Temperature] at 4:30 P.M., 102.0, P [pulse] 95, R [respirations] 20, BP [blood pressure] 132/71, Biox [a measure of the oxygen level in the blood] 91% on 2L [liter of oxygen] per nasal cannula, Patient alert, drowsy, stated that she felt ill, moist cough, productive of yellow sputum, L/S [lung sounds] diminished, tremors to bilat [bilateral] arms, patient unable to hold cup to take drink of water. Remains on ABT [antibiotic] for UTI [Urinary Tract Infection] ...daughter requested that Xanax [an antianxiety medication] be administered as ordered, Tylenol [a medication used for pain and increased temperature] also administered, this nurse offered to send patient to ER [Emergency Room] daughter appeared hesitant, did not want to drag patient out if it was "nothing"...Daughter thought Xanax would help with tremors, daughter requested that patient let rest [sic] and that she would return after she went home to change clothes, at 5:30 P.M., patient noted sitting up in bed, alert with eyes open, temp down 101.5, Biox remained 91-92 % at 2 L, Patient feeding self applesauce, assistance provided for patient to take drink of water, patient</p>			

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	<p>refused this nurses offer to feed her, patient to be monitored...."</p> <p>A Nursing Progress note, dated late entry 9/17/15 at 08:27 P.M., indicated, Resident B was unresponsive and was sent to the hospital on 9/17/2015 at 8:27 P.M.</p> <p>A Nurses Note, dated 9/18/15 at 06:02 A.M., titled Health Status Late Entry indicated, "... Called to resident's room noticed resident unresponsive, b/p [blood pressure] 114/57, p [pulse] 78, r [respirations] 20, t [temperature] 100.6 biox 94%, daughter here 911 notified, don aware, and md [medical doctor] aware...."</p> <p>The hospital History and Physical Exam, dated 9/19/15, indicated "...For the past five days, the patient has been regurgitating and aspirating at the nursing home, had a fever of 100.5, shaking chills, tremor, became unresponsive. 911 was called at the nursing home."</p> <p>On 10/1/15 at 3:33 P.M., a Incident Report, provided by the Executive Director and dated 9/18/15 at 4:45 P.M., was reviewed. The Incident Report indicated, "...Brief Description of Incident: 9/18/15 Residents' daughter reports the facility neglected her mother</p>			

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	<p>by not providing her with a puree diet...Immediate action taken: 9/18/15...1. Resident sent to the hospital at the request of the family...Follow Up: Preventative Measures Includes: Upon review and investigation of the clinical record, hospital records and investigation completion, it was determined that the allegation of failing to provide puree foods was deemed unsubstantiated, Resident was on speech therapy, was trialed w [with] /a puree diet, had an active order for mechanical soft w/nectar thick liquids, there is multiple notations of resident and resident's daughter refusing the thickened liquids as recommended by the speech therapist...Speech therapist discontinued skilled services d [due] / t [to] resident and resident's daughter refusing recommendations....In servicing for licensed therapist regarding residents who are non-compliant w[with]/recommendations, education on reporting change of conditions to the Director of Nursing for follow up...."</p> <p>On 10/1/15 at 3:57 P.M., an interview was conducted with the Speech Therapist (ST). The ST indicated she evaluated Resident B because the DON had requested it d/t patient coughing with breakfast on 9/11/15. ST further indicated she recommended a regular diet, she</p>			

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	<p>further indicated Resident B had been trialed with a puree diet, a soft diet and regular diet and in her opinion she tolerated the regular diet. '...ST indicated over that weekend the nurses had told her the family brought her in liquids that were not nectar consistency and the patient was refusing nectar thick liquids so I went and talked to the patient related to the risks of aspiration and the patient continued to refuse the nectar thick liquids so at that point I trialed her with thin liquids but asked her to tuck her chin when she swallowed. Chin tuck was helpful but she would only take like 2 sips and then she was done so at that point I called the patient's daughter and told her what I'd observed with her mother that day. The patient's daughter agreed that she was refusing and had brought her in whole milk and milkshakes because they were thicker, I explained to the daughter those are still considered thinner than nectar. I educated the daughter on risks of aspiration as well but daughter stated she wanted her mother on a soft diet with regular liquids. I changed her to Mechanical Soft diet with thin liquids per her daughters request. I talked to the Rehab Manager and the Director of Nurses. I did not talk to the doctor but he signed the order for the diet change. I recommended the patient take small sips and to alternate</p>			
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	<p>bites and sips. I talked to the nurse and gave recommendations but i did not do an in service with the staff. The resident preferred to eat her meals in her room and she was able to feed herself. I recommended she go to the dining room to eat her meals but she did not want to. I believe I documented that but I'm not sure. I wrote a telephone order with those swallowing precautions as well, it would just need passed on to the next shift...."</p> <p>On 10/1/15 at 4:40 P.M., an interview was conducted with LPN # 8. LPN #8 indicated she took over care for Resident B around 3 P.M. on 9/17/15. At 4:00 P.M., she indicated she noted Resident B was tremoring in her hands and Resident B told her she felt ill. LPN #8 indicated vitals were assessed and the resident's vitals were found to be over 102.0 F [Fahrenheit] LPN #8 indicated she mentioned to Resident B's daughter that she could be septic but LPN #8 felt the daughter was more concerned with her tremors, LPN #8 indicated, "... I explained we should send to ER they would get faster results than having blood work drawn here. The daughter wanted me to give her anxiety medication and the daughter did not want her sent out at that time she was going to go home and change her clothes. I checked her at 6:00 P.M. r/t she had a tray on her table. No</p>			

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	<p>one was with her when she was eating. She was eating yogurt or applesauce or something like that her temp. was around 101 then I was giving report at 6:30 P.M. when her other daughter reported she needed help in the hallway she (Resident B) was not responding... I did not notify the doctor prior to her unresponsive episode I was waiting for the daughter who was changing her clothes to get back. I was not aware she was an aspiration risk...Now we have blue bands to indicate a risk for aspiration, thickened liquid. I think this went into effect last Thursday...."</p> <p>On 10/2/15 between 12:30 P.M. and 1:30 P.M., an interview was conducted with the facility Medical Director. The Medical Director indicated had not been fully informed of the residents condition at the time the ST recommended a mechanical soft diet with thin liquids and further indicated had he known of the residents condition he would have met with the family and discussed options for care such as an educational meeting between himself and the Interdisciplinary team of the facility to properly educate of risks and consequences involved with non- compliance with ST recommendations. He further indicated that he would have discussed with the family alternative options such as</p>			

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	<p>Hospice care...."</p> <p>On 10/2/15 at 3:07 P.M., an interview was conducted with QMA #10. QMA #10 indicated he thought Resident B received thickened liquids but was unsure. He indicated she mostly ate in her room, she as well as the family were private but that her daughters would come visit her...."</p> <p>On 10/5/15 at 4:00 P.M., an interview was conducted with the Director of Nurses and the Executive Director. The Executive Director indicated that each morning they have a meeting where they discuss the previous days events, if the residents have new orders and if they have special needs. The Executive Director pulled up the minutes for those meetings in reference to 9/11/15's orders but because Resident B was discharged from facility, her data no longer populated on the report. The Director of Nurses indicated at that time that nursing had not been informed of the residents specific swallowing precautions.</p> <p>3.1-37(a)</p>				

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F 0333 SS=D Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to implement a system to identify and prevent medication errors and ensure residents were free from significant medication errors related to the administration of a Fentanyl (a narcotic pain medication) patch when a previous patch could not be located on the residents body for 1 of 8 residents reviewed for medications. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/1/15 at 9:00 A.M. The clinical record indicated Resident B was admitted to the facility on 9/9/15. The diagnoses included, but were not limited to, unspecified generalized pain, unspecified debility and other pulmonary insufficiency nec (not elsewhere classified).</p> <p>A SNF (Skilled Nursing Facility) Order Summary Report (a physician's order</p>	F 0333	<p>1. Resident B was not identified in the sample, however the facility was fully aware of who the residents identified were. Resident B has since discharged from the facility. A medication error report was completed by the Director of Nursing for resident B.</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> · Residents with active orders for Fentanyl patches have had their skin checked to ensure no patches were exposed on the body, there were no additional findings. · A new Fentanyl Patch procedure has been implemented that includes two nurses indicating the location of the fentanyl patch and verification by signature on the fentanyl patch log located in the narcotic count sheets, <p>3. The nursing department has been educated by 10/30/15 on the Fentanyl Procedure by the Director of Nursing, in the event a resident with a fentanyl patch</p>	11/02/2015

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	<p>summary), dated 9/9/15, indicated, "... Fentanyl (a narcotic pain medication) patch (a medicated adhesive pad that is placed on the skin) 72 hour (period of time the medicated patch is worn) 25 MCG (microgram)/HR (per hour) Apply 1 patch transdermally (a method by which a medicated adhesive pad is placed on the skin to deliver a timed-release dosage of medication through the skin into the bloodstream) in the morning every 3 day(s) for pain...."</p> <p>A Medication Administration Record (MAR), dated 9/1/15 through 9/30/15, indicated Resident B had a Fentanyl Patch applied on 9/11/15, 9/14/15 and 9/17/15.</p> <p>A Nursing Progress note, dated late entry 9/17/15 at 08:27, indicated, Resident B was unresponsive and sent to the hospital.</p> <p>On 10/1/15 at 3:33 P.M., a Incident Report, provided by the Executive Director and dated 9/18/15 at 4:45 P.M., was reviewed. The Incident Report indicated, "...Brief Description of Incident: 9/18/15 Residents' daughter reports the facility was [sic] over medicating her mother (with Fentanyl patches) during her stay here...Immediate action taken: 9/18/15...1. Resident sent to</p>		<p>order is found with out a patch on the body, a medicationerror report will be initiated.</p> <p>4. The Director of Nursing will conduct Weeklyaudits for a period of 6-months the results of these audits will be forwarded to the QA&A committee for review, These audits will bereported monthly for a period of 6-months until compliance is achieved.</p>	

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	<p>the hospital at the request of the family...2. Resident's receiving Fentanyl [sic] Patches have been reviewed and their skin checked to ensure no patches were exposed on the body. There were no additional findings...Follow Up: Preventative Measures Includes: Implementation of Fentanyl Procedure, In serviced licensed staff on application and removal of fentanyl patches, resident w/active orders for fentanyl patches had body's checked for placement, no discrepancies were noted or found, Medication Error Incidents completed, Action plans initiated as it relates to controlled substances and fentanyl patches...."</p> <p>On 10/1/15 at 3:34 P.M., an interview was conducted with the Director of Nurses (DON). The DON indicated that Resident B's daughter alleges Fentanyl patches were still on when Resident B was taken to the hospital and that EMS [Emergency Medical Services] had told her the patches were present. The DON further indicated that during her investigation she determined the nurse that applied the Fentanyl patch on 9/11/15, documented she placed it on the resident's chest. When she interviewed the nurse who applied the Fentanyl patch on 9/14/15, the nurse indicated she looked and palpated the chest of Resident</p>			

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	<p>B on 9/14/15 but could not locate the patch so another patch was applied. The DON indicated what had been determined was that the nurse who applied the Fentanyl patch on 9/14/15 failed to document the incident as a medication error so that herself and the Executive Director could be notified and investigate the incident.</p> <p>On 10/1/15 at 3:35 P.M., an interview was conducted with LPN # 5. LPN #5 indicated that she applied the Fentanyl patch for Resident B on 9/11/15 and 9/17/15. She further indicated she removed the 9/14/15 patch and reapplied a patch on Resident B's chest but she could not remember which side of Resident B's chest she applied it to. LPN #5 indicated nurses document in Point Click Care [electronic charting system] the location of the patch such as the chest or back but not which side it is located on.</p> <p>On 10/2/15 at 12:00 P.M., a [name of fire department] Patient Care Record received from [name of hospital] on 10/2/15 at 11:00 A.M., was reviewed. The record indicated, "...Upon further examination it was noted there were 2 Fentanyl patches on pt's upper L [left] chest. One is dated 09/11 and the other is dated 09/17. Pt.'s [patient's] pupils are approximately 4mm</p>			

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NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544
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	<p>[millimeter] bilaterally [on both sides] but sluggish to respond... Pt. given 1mg [milligram] of Narcan [a medication used to reverse the effects of narcotic medication]. Pt.'s mental status immediately improves. Pt. opens eyes and is now able to talk and follow commands...Fentanyl patches removed and wiped with towel. Pt. states she feels much better...."</p> <p>On 10/2/15 at 12:10 P.M., a [name of hospital] History and Physical Exam electronically signed and dated 9/19/15 at 22:58 received from [name of hospital] on 10/2/15 at 11:00 A.M., was reviewed. The History and Physical indicated, "...911 was called at the nursing home. They found her to have 2 fentanyl patches on her body unfortunately. She was given some Narcan and her mental status improved tremendously with the Narcan. She became somnolent [sleepy] again and again was given Narcan and that helps with her mental status again...She has quite a bit of respiratory distress...Impression:1. Aspiration pneumonia...8. Lumbar spine disk disease...."</p> <p>On 10/2/15 between 12:30 P.M. and 1:30 P.M., an interview was conducted with the facilities Medical Director. The Medical Director indicated the "old pain</p>			

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	<p>patch" for Resident B had not been removed and the facilities system for administration/application of Fentanyl patches had failed to prevent an incident like the one that occurred with Resident B from happening, but the likelihood of a 5 day old Fentanyl patch being the source of Resident B's respiratory depression was very low as the medication would have already been absorbed from the patch dated 9/11/15.</p> <p>On 10/5/15 at 3:52 P.M., an interview was conducted with LPN # 6. LPN #6 indicated she applied Resident B's Fentanyl patch on 9/14/15. LPN #6 indicated she did not find the patch for 9/11/15, she described how she checked Resident B's chest and back by rubbing her hands across the area described and when she did not find the patch she assumed that it had fallen off and she applied a new patch. LPN #6 further indicated at the time, she did not know that if a patch had fallen off and you couldn't find it, that it was considered a med error, "...I assumed that if it [Fentanyl patch] had fallen off it was at the 72 hour point so I applied a new one..." she further indicated that since the incident occurred the DON has put out books and inserviced that two nurses have to sign that they see the patch and that it is removed. She indicated she now</p>			

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	<p>knows if she cannot find a Fentanyl patch it is considered a medication error.</p> <p>On 10/5/15 at 4:00 P.M., a second interview was conducted with the DON. The DON indicated LPN #6 had failed to recognize that not being able to locate a previously applied Fentanyl patch was considered a medication error. The DON further indicated that all nurses were inserviced regarding medication errors and the new system for verification of Fentanyl patches. The DON indicated that prior to the incident on 9/17/15 the facility did not have a policy or procedure for the application or removal of Fentanyl patches.</p> <p>This Federal tag relates to Complaint IN00183034.</p> <p>3.1-48(c)(2)</p>			