

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2015
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NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: August 10, 11, 12, 13, 14, 17, and 18, 2015.</p> <p>Facility number: 000391 Provider number: 15E247 AIM number: 100274990</p> <p>Census bed type: NF: 47 Residential: 39 Total: 86</p> <p>Census Payor Type: Medicaid: 25 Private: 22 Total: 47</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0157 SS=D Bldg. 00	<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</p>			

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>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 physician when a resident with a recent fractured wrist had swelling in one lower leg and complained of pain in the calf of the leg when the foot was flexed for 1 of 1 resident reviewed for timely physician notification of change in condition. (Resident #39)</p>	F 0157	Correction of deficient practice for cited resident- Facility response: Resident #39 has care plan in place for residents on anticoagulation therapy and for DVT. Resident's MD/POA/family are aware of resident's condition and will be informed of any change in condition/ change in meds or tx/ med error. Review of all residents who could be affected by deficient practice-	09/18/2015

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	<p>Findings include:</p> <p>The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities).</p> <p>An Admission Minimum Data Set (MDS) assessment completed 6/12/15, assessed the resident as having a BIMS (Brief Interview for Mental Status) of 6 out of 15, indicating severe cognitive impairment.</p> <p>A nursing progress note dated 6/24/15 at 10:00 p.m., indicated the resident's left lower leg was swollen and the resident complained of calf pain when the left foot was flexed. The left leg was elevated on a pillow and the resident was instructed to keep still and not move around. The progress note indicated the physician was faxed regarding the swollen leg and a call was placed to hospice.</p> <p>The next nursing progress note was dated 6/25/15 at 6:00 a.m., indicated the left lower extremity was swollen and the resident expressed discomfort when flexing the foot. The progress note lacked a response from the attending</p>		<p>Facility response: Immediate changes were implemented to track labs and anticoagulants for All residents receiving anticoagulation therapy through a tracking form for anticoagulation/lab therapy on MAR. All residents receiving anticoagulation therapy have care plan in place for anticoagulants and possible complications of same. Systemic changes to prevent deficient practices-</p> <p>Facility response: Reviewed with all nurses the need for immediate notification of MD's/ family/POA regarding change in tx/medication orders and any tx/med. errors. All nursing staff has been instructed to report in writing in the nurses' notes, responses obtained by phone or verbally from either the attending or hospice MD, lab, family/POA contact. Parameters for immediate notification of the doctor and laboratory were reviewed. Results are to be documented in nurses' notes. Reviewed with all nursing staff the s/s of DVT and the necessity of reporting any unusual bruising or bleeding to MD, Family/POA. All residents receiving an anticoagulant have/will have care plan in place within 8hrs of admission or receiving the new order. QA monitoring of systemic changes- Facility response: Triple check of new orders as per policy Double check of lab orders as per policy DON/ADON will monitor new orders and labs daily</p>		

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	<p>physician and the hospice physician regarding the change in condition.</p> <p>A hospice progress note dated 6/25/15 (time of note was not included), indicated the resident was seen for a routine visit. The resident's daughter was present during the visit and expressed concern about the the possibility of a blood clot in the left lower extremity. The hospice nurse assessed the left leg and indicated the swelling was due to an injury and not a blood clot. The note indicated the daughter was still concerned and the nurse collaborated with the facility nurse. The decision was made to have the resident assessed by the physician the next day and the daughter was informed. The note indicated resident did not complain of pain with manipulation of the leg, had no redness, and no warmth. The note lacked documentation of the hospice physician notification of the swelling of the leg.</p> <p>The next nursing progress note was dated 6/27/15 at 11:50 a.m. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) indicated the date of the entry was entered as 6/27/15, and should have been 6/26/15. The note indicated the resident was seen by the physician and an order was received for a venous doppler study of</p>		<p>Changes in meds will be shared in daily shift huddle with possible complications reviewed. Supporting documentation attached: In-service record –held 9/11/15 MD parameters Lab Parameters anticoagulant tracking sheet Care plan for DVTPolicy for notification of Family/POA</p>				

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	<p>the left lower leg. A venous doppler, a non-invasive procedure, checks the venous (veins) system for blood clots.</p> <p>The physician's progress note dated 6/26/15, indicated the resident had a swollen left leg with tenderness in the calf and a positive Homans sign. A positive Homans sign occurs when the resident experiences pain in the calf area with flexion of the foot and typically indicates a blood clot in the lower leg. The assessment indicated, "LLE edema [left lower extremity swelling], DVT [deep vein thrombosis, blood clot]...Plan: U/S LLE [Ultrasound left lower extremity]...."</p> <p>An ultrasound report, performed on 6/26/15, indicated Resident #39 had a left side deep vein thrombosis.</p> <p>The nursing progress notes dated 6/27/15 at 9:00 a.m., indicated the nurse practitioner (NP) was contacted by phone and informed of the ultrasound results. New orders were received for anticoagulants (a medication used to prevent or treat blood clots) Lovenox 60 mg (milligrams) subcutaneously (under the skin) every 12 hours and Coumadin 4 mg daily. Laboratory (lab) monitoring of the medications 2 times a week while receiving the Coumadin was also</p>			

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	<p>ordered.</p> <p>During an interview with the DON on 8/18/15 at 2:45 p.m., the DON indicated faxing the physician at the time of the change in condition was a courtesy to the attending physician as the resident was admitted under hospice care and hospice had also been notified of the resident's change in condition. The DON indicated the resident was assessed by the hospice nurse on 6/25/15, but was not sure if the nurse had spoken with the hospice physician regarding the swelling in the lower leg. The DON and the ADON indicated the resident was seen by the attending physician on 6/26/15, 2 days after the swelling was first noted, and the attending physician ordered treatment for the resident.</p> <p>On 8/18/15 at 3:50 p.m., the DON provided an undated policy titled Physician Notification Summary When to call the Doctor, and indicated the policy was the one currently used by the facility for all of the physicians with residents in the facility. The policy indicated, "...Edema...Abrupt onset in one leg...Abrupt onset with tenderness and redness...Immediate (Call)...."</p> <p>3.1-5(a)(2)</p>			

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans with interventions were initiated prior to a resident developing a pressure ulcer (Resident #55), and a resident experiencing a fall and receiving anticoagulant therapy (Resident #39).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #55 was reviewed on 8/12/15 at 1:54 p.m. Diagnoses for the resident included, but</p>	F 0279	Correction of deficient practice for resident cited-Resident #55 is assessed weekly for skin breakdown. All residents are assessed weekly for skin breakdown. Resident #39 has a fall risk care plan in place. No specific additional residents were cited. All nursing staff has been instructed in the initiation of care plans within 8 hours of resident's initial admission or return from hospitalization or change in condition. Complete skin assessments are to be completed upon admission and a care plan with interventions addressing the potential for skin breakdown is to	09/18/2015	

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	<p>were not limited to, multiple sclerosis.</p> <p>An admission nursing assessment, dated 5/22/15, indicated Resident #55's skin was, "clean, dry intact." There was no documentation of wounds or open areas.</p> <p>A nurse's note dated 5/26/15 at 7:00 p.m., indicated Stage 1 pressure ulcers on the resident's left inner buttock and on the coccyx. A Stage 1 pressure ulcer presents with an intact, often reddened or warm area of skin.</p> <p>A physician's order dated 5/26/15, indicated a treatment for Stage 1 areas on the resident's left inner buttock and on her coccyx.</p> <p>An admission Minimum Data Set assessment, dated 6/1/15, indicated the resident was at risk for developing pressure ulcers, had 2 Stage 2 pressure ulcers which were not present on admission, and a care plan with interventions would be written. A Stage 2 pressure ulcer presents a partial loss of the thickness of the skin, a shallow, open crater.</p> <p>A care plan which addressed the resident's risk for developing a pressure ulcer was not initiated until 6/8/15.</p>		<p>be included in the initial care plan. Braden scale for predicting pressure score risk is utilized All nursing staff has been instructed that a fall risk assessment is to be conducted at the time of admission and included in initial care plan with interventions. All nursing staff has been instructed that any resident receiving anticoagulant therapy will have a care plan in place with interventions for monitoring lab values and changes in dosage. Signs/ symptoms of DVT were reviewed and a care plan with interventions for treatment of the same are in place. Section C of our interim care plan contains a section for fall risk. Supporting documentation attached: In-service record -9/11/15 Initial care plan form/assessment form Policy for anticoagulation therapy Monitoring form for anticoagulation therapy Care plan for DVT</p>		

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	<p>A skin assessment, dated 6/17/15, indicated the resident's pressure ulcers had healed and preventative treatment was now indicated.</p> <p>On 8/14/15 at 10:32 a.m., the Director of Nursing indicated a care plan should have been put in place at the time of Resident #55's admission to the facility to help prevent the development of her pressure ulcers.</p> <p>2.a. The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities). Resident #39 was admitted to the facility on 6/4/15.</p> <p>A Discharge Summary/Transition of Care Note dated 6/4/15, indicated the resident had a history of falls and had experienced a fall with a resulting fracture of the right forearm. The cast was removed from the right arm on 6/4/15, and a splint was placed prior to discharge from the hospital. The summary indicated the resident had a mild compression fracture of the lumbar spine.</p> <p>A nursing progress note dated 6/5/15 at 6:00 a.m., indicated the resident was</p>			

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	<p>confused to time and place, and had been found with feet off of the bed and resting on the floor several times during the shift.</p> <p>On 6/6/15 at 8:20 a.m., the resident was found on the floor by the bed. The resident indicated a need to go to the bathroom.</p> <p>A progress note dated 6/7/15 at 1:00 a.m., indicated the resident was independent in bed mobility and had a personal safety alarm (PSA) in place.</p> <p>A nursing progress note dated 6/8/15 at 8:50 p.m., indicated the resident was found on the floor yelling for help.</p> <p>Nursing progress notes 6/9/15 at 2:30 a.m. and 6:00 a.m., indicated the resident's PSA was in place for safety, was in and out of bed, and was found laying sideways in bed with feet on the floor.</p> <p>A review of the written plans of care indicated the resident did not have a fall prevention plan of care in place until 6/11/15, after 2 falls and repeated attempts to get out of bed unassisted.</p> <p>During an interview with the Director of Nursing (DON) on 6/14/15 at 4:27 p.m., the DON indicated no fall prevention</p>			

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F 0280 SS=D Bldg. 00	<p>care plans were initiated for the resident until 6/11/15, 7 days after admission.</p> <p>b. On 6/26/15, Resident #39 was diagnosed with a deep vein thrombosis (DVT, a blood clot) in the left lower leg and was started on anticoagulant (a medication used to prevent or treat a blood clot) therapy. A review of the written plans of care lacked a care plan for the treatment of the blood clot.</p> <p>During an interview with the Director of Nursing (DON) on 8/14/15 at 4:27 p.m., the DON indicated the resident did not have a care plan implemented for the treatment of the diagnosed DVT nor the anticoagulant therapy including monitoring of the lab values.</p> <p>3.1-35(b)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes</p>						

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	<p>the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the care plan of a resident with a left hand contracture was updated to reflect the resident was not currently receiving PROM exercises on her left hand. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record of Resident #21 was reviewed on 8/13/15 at 10:22 a.m. Diagnoses for the resident included, but were not limited to, stroke and left hemiparesis (muscular weakness or paralysis affecting one side of the body).</p> <p>An observation on 8/10/15 at 3:14 p.m., indicated Resident #21's left hand and fingers were contracted. A contraction is a shortening of muscle tissue which makes the joint very resistant to stretching.</p> <p>A care plan for Resident #21, dated 6/2/15 and current through 8/20/15, indicated the resident was at risk for</p>	F 0280	<p>Correction of deficient practice for cited resident:Immediate corrections were made to the restorative orders for resident #21.A revised restorative care flow sheet has been instituted.Care plan for residents receiving restorative treatments is in place.No additional residents were cited.Systemic changes to prevent recurrence of deficiency-Staff response:All nursing staff instructed in the need to update care plans after hospitalization and with each change in the resident's condition. Recommendations for restorative staff are to be received in writing from therapists and residents receiving restorative care are to be reviewed at least bi-weekly with therapy staff or licensed nurse. Policy for receiving new orders reviewed.Documentation for restorative nursing interventions reviewed.Monitoring of systemic change:New orders reviewed as per policyAt least bi-weekly meetings of restorative CNA's/ therapy and licensed nurse.Initial care plan after hospitalization monitored by DON/ADON/MDS</p>	09/18/2015

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	<p>activity intolerance related to left hemiparesis. The goal was she, "will have no complaints of discomfort, difficulty in movement or rest periods needed as seen by participating in PROM [passive range of motion] 6 out of 7 days by doing 5-10 sets and 5-10 repetitions with her left upper extremity within the next 90 days." Interventions included, "The Restorative Aides and CNA's [Certified Nursing Assistants] will encourage and assist [name of resident] with PROM with her left upper extremity. They will document [name of resident] participation on the Restorative Care Flow Sheet daily..."</p> <p>Review of the Restorative Care Flow Sheet for August 1 - 13, 2015, did not indicate any PROM minutes were performed for Resident #22.</p> <p>During an interview with Physical Therapist (PT) #2 on 8/14/15 at 1:22 p.m., she indicated the therapy department provides instruction to the restorative aides after a resident has met their goals and is discharged from the therapy department. PT #2 provided an instruction sheet for Resident #21, dated 2/24/15, which indicated PROM to the resident's left upper extremity was recommended daily. Physical Therapist #1 indicated the resident had been</p>		<p>coordinator. Supporting documentation: In-service record for nursing – 9/11/15 In-service record for restorative staff Initial care plan form Restorative flow sheet Restorative Nursing Documentation Policy</p>		

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F 0282 SS=D Bldg. 00	<p>hospitalized since then, returned to the facility on 5/22/15, and was still being treated in the therapy department. Instructions to resume PROM on the resident's left upper extremity had not yet been given to the restorative aides.</p> <p>On 8/14/15 at 1:41 p.m. the Director of Nursing indicated if a resident was receiving restorative care, went into the hospital and returned to the facility, the restorative care aides would not resume treatment until given given instructions from the therapy department and the resident's care plan had not been updated to reflect the resident was not currently receiving PROM exercises on her left hand.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to discontinue an anticoagulant (blood thinner) medication as ordered (Resident #39), failed to obtain laboratory (lab)</p>	F 0282	Correction of deficient practice for cited residents- Facility response- Resident #39 has an anticoagulant/lab tracking form in place on the MAR. Resident #33 and 39 have revised restorative	09/18/2015			

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	<p>tests as ordered by the physician (Resident #39 and Resident #33), failed to perform range of motion (ROM) exercises (Resident #33), and failed to apply and remove splints (Resident #33) as indicated by the written plans of care.</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities).</p> <p>On 6/30/15, the Nurse Practitioner (NP) wrote an order indicating, "...OK to DC [discontinue] lovenox [sic] today." The order was received by the Assistant Director of Nursing (ADON) at 2:00 p.m.</p> <p>A review of the Medication Administration Record (MAR) for June 2015, indicated the resident received 1 dose of Lovenox on 6/30/15 at 9:00 p.m. The MAR for July 2015, indicated the resident received 2 doses of Lovenox on 7/1/15 and 7/2/15, and one dose on 7/3/15.</p> <p>A nursing progress note dated 7/2/15 at 12:00 p.m., indicated Resident #39 had purple bruising on the left side of the</p>		<p>nursing flow sheets in place. Orders for Labs for residents #33 and 39 have been reviewed and are checked as per facility policy. Review of all residents potentially affected by deficient practice- Facility response: All residents on anticoagulant therapy have lab tracking sheets in MAR. All residents receiving restorative therapy have revised restorative flow sheets in place. All new orders are triple checked as per policy. New lab orders are checked as per policy. Restorative orders are reviewed at least bi-weekly with therapy, restorative CNA and licensed nurse. Systemic changes made to prevent recurrence- Facility response: All nursing staff has been instructed in the policy regarding checking of new orders. Three checks of new orders have been instituted. Two checks of new lab orders have been instituted. All nursing staff has been instructed in the policy for weekly lab draws for all residents receiving anticoagulant therapy. All nursing staff has been instructed in the policy for monitoring anticoagulant and use of the Coumadin tracking forms. All nursing staff have been instructed in the immediate reporting of med errors to MD (including hospice), DON, administrator and POA/family. Restorative orders are reviewed at least bi-weekly with therapy, restorative CNA's and licensed</p>		

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	<p>chest and underarm area. The next nursing progress note 7/2/15 at 9:00 p.m., indicated the PT/INR (Prothrombin time/international normalized ratio, a laboratory test used to determine how long it takes blood to clot) was scheduled to be drawn on 7/3/15.</p> <p>A nursing progress note dated 7/3/15 at 3:30 a.m., indicated the resident expressed soreness to the left rib area and had extensive purple bruising to the rib area, the lateral side of the breast, and into the underarm area.</p> <p>On 7/3/15 at 12:30 p.m., the nursing progress notes indicated critical lab values of an INR greater than 10.0 had been received and the physician was faxed and called regarding the results. New orders were received to administer Vitamin K 5 mg, discontinue the Lovenox, hold the Coumadin, and to recheck the PT/INR in 3 days. Vitamin K helps the blood to clot.</p> <p>During an interview with the Director of Nursing (DON) on 8/14/15 at 3:30 p.m., the DON indicated the order received on 6/30/15, to discontinue the Lovenox, was missed at the time the order was received and was not removed from the MAR, resulting in the resident receiving the medication for 4 additional doses and</p>		<p>nurse and MDS coordinator. All nursing and restorative staff has been instructed in the use of the restorative flow sheet and the policy for restorative documentation and reporting. Initial care plans will be on resident's chart no more than eight hours after admission or re-admission. QA for systemic changes- DON/ADON/MDS coordinator will review initial care plans for new admissions/re-admissions. New orders will be reviewed as per policy, and Lab orders will be reviewed as per policy. Supporting documentation attached: In-service record for nursing – 9/11/15 In-service record for restorative nursing staff Policy for receiving and checking of new orders Policy for receiving new lab orders and monitoring for completion of ordered labs. Coumadin tracking form Policy for anticoagulants and weekly INR lab draws Lab parameters Restorative flow sheet</p>	

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	<p>requiring the use of Vitamin K to correct the increased time for blood to clot.</p> <p>2.a. The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities).</p> <p>A physician's order dated 6/27/15, indicated, "...PT/INR [Prothrombin time/international normalized ratio, a laboratory test used to determine how long it takes blood to clot] Mon [Monday] & [and] Thursday q wk [every week] while on Coumadin...."</p> <p>A nursing progress note dated 7/2/15 at 12:00 p.m., indicated Resident #39 had purple bruising on the left side of the chest and underarm area. The note also indicated the lab company was notified of the failure to draw the INR test as ordered for that date. The next nursing progress note 7/2/15 at 9:00 p.m., indicated the PT/INR was scheduled to be drawn on 7/3/15.</p> <p>On 7/3/15 at 12:30 p.m., the nursing progress notes indicated critical lab values of an INR greater than 10.0 had been received, and the physician was faxed and called regarding the results.</p>			

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	<p>New orders were received to administer Vitamin K 5 mg, discontinue the Lovenox, hold the Coumadin, and to recheck the PT/INR in 3 days. Vitamin K helps the blood to clot.</p> <p>During an interview with the DON (Director of Nursing) on 8/14/15 at 3:30 p.m., the DON indicated the facility nurse could have ordered a stat (immediate) check of the lab when the error was discovered and was not sure why the lab was not checked until the next day. The DON also indicated the facility was in the process of changing lab companies as the company used at the time of the missed lab was not reliable in obtaining labs as ordered.</p> <p>2.b. The clinical record review for Resident #33 was reviewed on 8/12/15 at 2:30 PM. Diagnoses included, but were not limited to, dementia and muscle weakness.</p> <p>A review of the recapitulation of physician orders for Resident #33 for 8/1/15 through 8/31/15, indicated an order for a BMP (basic metabolic panel) lab every 3 months, started 3/20/15.</p> <p>A review of Resident # 33's lab results, indicated a BMP was completed on 4/24/15.</p>			

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	<p>No BMP lab results for July 2015, were found in the record review for Resident #33.</p> <p>During an interview on 8/14/15 at 3:57 PM, the DON (Director of Nursing) indicated a BMP should have been completed for Resident #33 in July 2015, but it was missed. The DON indicated a STAT BMP lab order was placed this day (8/14/15).</p> <p>3. The clinical record review for Resident #33 was reviewed on 8/12/15 at 2:30 PM. Diagnosis included, but were not limited to, dementia and muscle weakness.</p> <p>A careplan for Resident #33 dated 6/23/15, indicated resident has bilateral ankle contractures. Interventions included, but were not limited to, "...The RNA (restorative nurse aide) will apply the AFO splints in the morning for 3 hours while in bed, remove them after 3 hours. The RNA will do passive ROM to resident's feet and ankles. The RNA will check the splints to make sure they are not causing irritation to the skin underneath and they are in the correct position before and after placement. In the afternoon the RNA will apply the AFO splints for 3 hours and repeat the</p>			

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	<p>passive ROM after removing the splints...."</p> <p>A Physical Therapy Discharge Summary dated 6/19/15, indicated "...Discharge Recommendations....to continue with RNP [restorative nursing program] for bilat [bilateral] ankle ROM [range of motion], stretch, and AFO [ankle foot orthosis] use....Appropriate wear schedule established and RNA educated on wear schedule and how to properly donn/doff, apply straps in appropriate order...."</p> <p>A review of Restorative Nursing Care Program - Physical Therapy dated 6/15/15, indicated "...the following splint - AFO schedule should be followed: 3hrs [hours], 2x [2 times] throughout day...."</p> <p>A review of Restorative Care Flow Sheet for 6/1/15 through 6/30/15, did not indicated ROM (range of motion) services had been provided according to plan of care for Resident #33 on June 20, 21, 23, 24, 25, 29 and June 30, 2015.</p> <p>A review of Restorative Care Flow Sheet for 7/1/15 through 7/31/15, did not indicated ROM (range of motion) services had been provided according to plan of care for Resident #33 on July 1, 2, 3, 4, 5, 13, 16, 21, 22, 23 and July 27,</p>			

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	<p>2015.</p> <p>A review of Restorative Care Flow Sheet for 8/1/15 through 8/16/15, did not indicated ROM (range of motion) services had been provided according to plan of care for Resident #33 on August 1, 2, 6 and August 11, 2015.</p> <p>During an interview on 8/14/15 at 5:19 PM, the DON (Director of Nursing) indicated the days with no documentation on the Restorative Care Flow Sheet was due to the RNA forgetting to document or the ROM and application of AFO splints was not completed.</p> <p>4. The clinical record review for Resident #33 was reviewed on 8/12/15 at 2:30 PM. Diagnosis included, but were not limited to, dementia and muscle weakness.</p> <p>A review of Restorative Care Flow Sheets for June, July and August 2015, did not indicate Resident #33's AFO (ankle foot orthosis) splints were applied for 3 hours in the morning and 3 hours in the afternoon according to plan of care..</p> <p>A careplan for Resident #33 dated 6/23/15, indicated resident has bilateral ankle contractures. Interventions included, but were not limited to, "...The</p>			

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	<p>RNA (restorative nurse aide) will apply the AFO splints in the morning for 3 hours while in bed, remove them after 3 hours. The RNA will do passive ROM to resident's feet and ankles. The RNA will check the splints to make sure they are not causing irritation to the skin underneath and they are in the correct position before and after placement. In the afternoon the RNA will apply the AFO splints for 3 hours and repeat the passive ROM after removing the splints...."</p> <p>A Physical Therapy Discharge Summary dated 6/19/15, indicated "...Discharge Recommendations....to continue with RNP [restorative nursing program] for bilat [bilateral] ankle ROM [range of motion], stretch, and AFO [ankle foot orthosis] use....Appropriate wear schedule established and RNA educated on wear schedule and how to properly donn/doff, apply straps in appropriate order...."</p> <p>A review of Restorative Nursing Care Program - Physical Therapy dated 6/15/15, indicated "...the following splint - AFO schedule should be followed: 3hrs [hours], 2x [2 times] throughout day...."</p> <p>During an interview on 8/17/15 at 11:45 AM, RNA #1 (restorative nurse aide)</p>			

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	<p>indicated the AFO splints are applied in the morning and left on Resident #33 for 6 hours straight and removes the AFO splints before shift ends. RNA #1 indicated the AFO splints are not removed throughout the day and skin integrity is not checked throughout the day. RNA #1 indicated the "15" documented in the row titled "b AFO splints" indicated 15 minutes of ROM was completed to Resident #33's bilateral ankles/feet and AFO splints were applied to bilateral ankles/feet for 6 hours.</p> <p>On 8/17/2015 at 10:09 AM the Director of Nursing provided an undated policy titled Restorative Nursing Documentation, and indicated it was the current policy used by the facility. The policy indicated "...3. A facility approved documentation form will be used to document restorative nursing interventions as follows: a. Daily participation b. Time required to provide the service in minutes c. Distance ambulated in feet, number of repetitions for ROM, body part exercised, and other measurements in accordance with the goal(s) as written on the plan of care...."</p> <p>3.1-35(g)(2)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to promptly assess and notify the physician of the resident's swollen and painful lower leg, failed to discontinue an anticoagulant (blood thinner) medication as ordered by the physician and the resident experienced a critically high PT/INR result, (Prothrombin time/international normalized ratio, a laboratory test used to determine how long it takes blood to clot) and required medical management to correct the levels. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities).</p> <p>An Admission Minimum Data Set</p>	F 0309	<p>To correct deficient practice for resident #39- Facility response: Resident has care plan in place for monitoring of anticoagulant therapy and for potential of DVT. Monitoring form for anticoagulants and for PT/INR in place in MAR. MD/ family/POA aware of resident's condition (resident removed from hospice on 8/21/15). Review of all residents with potential to be affected - Facility response: All residents currently receiving anticoagulant therapy have had medication orders and lab orders reviewed. Anticoagulant/lab tracking forms are in place for each in the MAR. Systemic changes made to prevent recurrence of deficient practice- Facility response: All nursing staff has been instructed in the policy for receiving new orders. All nursing staff has been instructed in the parameters for calling and MD, including hospice MD. Instructed to inform family/POA of changes in condition, changes in meds/tx., med errors. All nursing</p>	09/18/2015

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	<p>(MDS) assessment completed 6/12/15, assessed the resident as having a BIMS (Brief Interview for Mental Status) of 6 out of 15, indicating severe cognitive impairment.</p> <p>A nursing progress note dated 6/24/15 at 10:00 p.m., indicated the resident's left lower leg was swollen and the resident complained of calf pain when the left foot was flexed. The left leg was elevated on a pillow and the resident was instructed to keep still and not move around. The progress note indicated the physician was faxed regarding the swollen leg and a call was placed to hospice.</p> <p>The next nursing progress note was dated 6/25/15 at 6:00 a.m., indicated the left lower extremity was swollen, and the resident expressed discomfort when flexing the foot. The progress note lacked a response from the attending physician and the hospice physician regarding the change in condition.</p> <p>A hospice progress note dated 6/25/15, (time of note was not included) indicated the resident was seen for a routine visit. The resident's daughter was present during the visit and expressed concern about the the possibility of a blood clot in the left lower extremity. The hospice</p>		<p>staff has been instructed in the parameters for calling the lab. All nursing staff has been instructed in the how to confirm that ordered labs have been completed. All nurses instructed in the s/s of DVT. QA program: Monitoring of labs as per policy. Monitoring of new medication orders as per policy Supporting documentation attached: In-service record –9/11/15 Policy for receiving new orders Parameters for calling MD Parameters for calling lab Procedure for confirming ordered lab draws Care plan for DVT Policy for notification of family</p>	

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	<p>nurse assessed the left leg, and indicated the swelling was due to an injury and not a blood clot. The note indicated the daughter was still concerned, and the nurse collaborated with the facility nurse. The decision was made to have the resident assessed by the physician the next day and the daughter was informed. The note indicated resident did not complain of pain with manipulation of the leg, had no redness, and no warmth. The note lacked documentation of the hospice physician notification of the swelling of the leg.</p> <p>The next nursing progress note was dated 6/27/15 at 11:50 a.m. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) indicated the date of the entry was entered as 6/27/15, and should have been 6/26/15. The note indicated the resident was seen by the physician and an order was received for a venous doppler study of the left lower leg. A venous doppler, a non-invasive procedure, checks the venous system for blood clots.</p> <p>The physician's progress note dated 6/26/15, indicated the resident had a swollen left leg with tenderness in the calf and a positive Homans sign. A positive Homans sign occurs when the resident experiences pain in the calf area</p>			

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	<p>with flexion of the foot and typically indicates a blood clot in the lower leg. The assessment indicated, "LLE edema [left lower extremity swelling], DVT [deep vein thrombosis, blood clot]...Plan: U/S LLE [Ultrasound left lower extremity]...."</p> <p>An ultrasound report, performed on 6/26/15, indicated Resident #39 had a left side deep vein thrombosis.</p> <p>The nursing progress notes dated 6/27/15 at 9:00 a.m., indicated the Nurse Practitioner (NP) was contacted by phone and informed of the ultrasound results. New orders were received for anticoagulants (a medication used to prevent or treat blood clots) Lovenox 60 mg (milligrams) subcutaneously (under the skin) every 12 hours a Coumadin 4 mg daily. Laboratory (lab) monitoring of the medications 2 times a week while receiving the Coumadin was also ordered.</p> <p>A nursing progress note dated 6/29/15 at 3:00 p.m., indicated PT/INR results of 21.6/1.9 were faxed to the physician's office. A reported range for the results would be 9.5 - 11.6 seconds/0.9 - 1.1.</p> <p>On 6/30/15, the NP wrote an order indicating, "Please get venous doppler</p>				

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	<p>report on chart OK to DC [discontinue] lovenox today." The order was received by the Assistant Director of Nursing (ADON) on 6/30/15 at 2:00 p.m.</p> <p>A review of the Medication Administration Record (MAR) for June 2015, indicated the resident received 2 doses of Lovenox on 6/30/15, one at 9:00 a.m., and one at 9:00 p.m. The MAR for July 2015, indicated the resident received 2 doses of Lovenox on 7/1/15 and 7/2/15, and one dose on 7/3/15.</p> <p>A nursing progress note dated 7/2/15 at 12:00 p.m., indicated Resident #39 had purple bruising on the left side of the chest and underarm area. The note also indicated the lab company was notified of the failure to draw the INR test as ordered for that date. The next nursing progress note 7/2/15 at 9:00 p.m., indicated the PT/INR was scheduled to be drawn on 7/3/15.</p> <p>A nursing progress note dated 7/3/15 at 3:30 a.m., indicated the resident expressed soreness to the left rib area and had extensive purple bruising to the rib area, the lateral side of the breast, and into the underarm area.</p> <p>On 7/3/15 at 12:30 p.m., the nursing progress notes indicated critical lab</p>			

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F 0314 SS=D	<p>values of an INR greater than 10.0 had been received, and the physician was faxed and called regarding the results. New orders were received to administer Vitamin K 5 mg, discontinue the Lovenox, hold the Coumadin, and to recheck the PT/INR in 3 days. Vitamin K helps the blood to clot.</p> <p>During an interview with the DON on 8/14/15 at 3:30 p.m., the DON indicated the order received on 6/30/15, to discontinue the Lovenox, was missed at the time the order was received and was not removed from the MAR, resulting in the resident receiving the medication for 3 additional days, and requiring the use of Vitamin K to correct the increased time for the blood to clot. The DON indicated the facility nurse could have ordered a stat (immediate) check of the lab when the error was discovered, and was not sure why the lab was not checked until the next day. The DON also indicated the facility was in the process of changing lab companies as the company used at the time of the missed lab was not reliable in obtaining labs as ordered.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL</p>			

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Bldg. 00	<p>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 record review and interview, the facility failed to ensure a resident who was admitted without a pressure ulcer did not develop one, for 1 of 12 residents who met the criteria for review of developing a pressure ulcer after admission. (Resident #55)</p> <p>Findings include:</p> <p>The clinical record of Resident #55 was reviewed on 8/12/15 at 1:54 p.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis.</p> <p>An admission nursing assessment, dated 5/22/15, indicated Resident #55's skin was, "clean, dry intact." There was no documentation of wounds or open areas.</p> <p>A nurse's note dated 5/26/15 at 7:00 p.m. indicated Stage 1 pressure ulcers on the resident's left inner buttock and on the coccyx. A Stage 1 pressure ulcer presents</p>	F 0314	<p>Correction of deficient practice for resident cited: Resident #55 has a care plan in place for potential of skin breakdown. Weekly skin assessments are completed. Treatment of skin breakdown is recorded in TAR. Review of all residents who could be affected by deficient practice- Facility response: All residents receive a weekly skin assessment. Care plans are in place for all residents with potential for skin breakdown. Treatment for skin breakdown is recorded in the TAR. Systemic changes to prevent deficient practice - Facility response: All nursing staff has been instructed in the initiation of care plans within 8 hours of resident's admission. Complete skin assessments are to be completed upon admission and a care plan with interventions addressing the potential for skin breakdown is to be included in the initial care plan. Weekly skin assessments on all residents are completed. Monitoring to ensure deficient practice does not recur-</p>	09/18/2015

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	<p>with an intact, often reddened or warm area of skin.</p> <p>A physician's order dated 5/26/15 indicated a treatment for Stage 1 areas on the resident's left inner buttock and on her coccyx.</p> <p>An admission Minimum Data Set assessment, dated 6/1/15, indicated the resident was at risk for developing pressure ulcers, had 2 Stage 2 pressure ulcers which were not present on admission, and a care plan with interventions would be written. A Stage 2 pressure ulcer presents a partial loss of the thickness of the skin, a shallow, open crater.</p> <p>A care plan which addressed the resident's risk for developing a pressure ulcer was not initiated until 6/8/15.</p> <p>A skin assessment, dated 6/17/15, indicated the resident's pressure ulcers had healed and preventative treatment was now indicated.</p> <p>On 8/14/15 at 10:32 a.m., the Director of Nursing indicated a care plan should have been put in place at the time of Resident #55's admission to the facility to help prevent the development of her pressure ulcers.</p>		<p>DON/ADON/MDS coordinator will monitor new admissions to ensure that care plans are in place within 8 hours of admission. Skin assessments will be monitored at time of admission for potential of skin breakdown and care plans reviewed for inclusion of interventions. New care plans and/or changes in care plans will be shared at shift huddles. Supporting documentation: In-service record for nursing – 9/11/15 Initial care plan form/assessment including Braden scale for predicting pressure sore risk.</p>				

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F 0318 SS=D Bldg. 00	<p>3.1-40(a)(1)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview and record review, the facility failed to ensure a resident (Resident #33) with a contracture received treatment and services as ordered by the physician to prevent further decrease in range of motion.</p> <p>Findings include:</p> <p>The clinical record review for Resident #33 was reviewed on 8/12/15 at 2:30 PM. Diagnosis included, but were not limited to, dementia and muscle weakness.</p> <p>A careplan for Resident #33 dated 6/23/15, indicated resident had bilateral ankle contractures. Interventions included, but were not limited to, "...The RNA (restorative nurse aide) will apply the AFO splints in the morning for 3 hours while in bed, remove them after 3</p>	F 0318	<p>Correction of deficient practice for cited resident- Resident #33 has flow sheet up-dated to reflect current interventions. Orders have been reviewed for accuracy. Review of all residents who could be affected by deficient practice- Facility response: All residents receiving restorative therapy have had orders reviewed for accuracy. New restorative flow sheets have been instituted for each resident receiving restorative therapy. Care plans are in place for all residents receiving restorative therapy. Systemic changes to prevent recurrence of deficient practice- Facility response: Recommendations for restorative staff are to be received in writing from therapists and residents receiving restorative care are to be reviewed at least bi- weekly with therapy staff or licensed nurse and MDS coordinator. All</p>	09/18/2015	

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	<p>hours. The RNA will do passive ROM to resident's feet and ankles. The RNA will check the splints to make sure they are not causing irritation to the skin underneath and they are in the correct position before and after placement. In the afternoon the RNA will apply the AFO splints for 3 hours and repeat the passive ROM after removing the splints...."</p> <p>A Physical Therapy Discharge Summary dated 6/19/15, indicated "...Discharge Recommendations....to continue with RNP [restorative nursing program] for bilat [bilateral] ankle ROM [range of motion], stretch, and AFO [ankle foot orthosis] use....Appropriate wear schedule established and RNA educated on wear schedule and how to properly donn/doff, apply straps in appropriate order...."</p> <p>A review of Restorative Nursing Care Program - Physical Therapy dated 6/15/15, indicated "...the following splint - AFO schedule should be followed: 3hrs [hours], 2x [2 times] throughout day...."</p> <p>A review of Restorative Care Flow Sheet for 6/1/15 through 6/30/15, contained no documentation for completion of ROM (range of motion) and application of AFO (ankle foot orthosis) splints for Resident</p>		<p>nursing and restorative staff has been instructed in the use of the restorative flow sheet. Restorative flow sheet has been revised. Restorative staff has been in-serviced in need for accuracy in recording times for splints, feet ambulated, skin issues, etc. Monitoring of systemic changes- Facility response: Meetings at least bi-weekly with therapy, restorative CNA's and licensed nurse and MDS coordinator. Triple check of new physician orders received as per policy. Supporting documentation: In-service record for nursing – 9/11/15 In-service record for restorative staff Policy for receiving new orders. Policy for Restorative Nursing Documentation Restorative nursing flowsheet</p>	

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	<p>#33 on June 20, 21, 23, 24, 25, 29 and June 30, 2015.</p> <p>A review of Restorative Care Flow Sheet for 7/1/15 through 7/31/15, contained no documentation for completion of ROM and application of AFO splints for Resident #33 on July 1, 2, 3, 4, 5, 13, 16, 21, 22, 23 and July 27, 2015.</p> <p>A review of Restorative Care Flow Sheet for 8/1/15 through 8/16/15, contained no documentation for completed of ROM and application of AFO splints for Resident #33 on August 1, 2, 6 and August 11, 2015.</p> <p>During an interview on 8/17/15 at 11:45 AM, RNA #1 (restorative nurse aide) indicated the AFO splints are applied in the morning and left on Resident #33 for 6 hours straight and removes the AFO splints before shift ends. RNA #1 indicated the AFO splints are not removed throughout the day and skin integrity is not checked throughout the day. RNA #1 indicated the "15" documented in the row titled "b AFO splints" indicated 15 minutes of ROM was completed to Resident #33's bilateral ankles/feet and AFO splints were applied to bilateral ankles/feet for 6 hours.</p> <p>During an interview on 8/14/15 at 5:19</p>			

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F 0323 SS=D Bldg. 00	<p>PM, the DON (Director of Nursing) indicated the days with no documentation on the Restorative Care Flow Sheet was due to the RNA forgetting to document or the ROM and application of AFO splints was not completed.</p> <p>An undated policy for "Restorative Nursing Documentation" was provided by the Director of Nursing on 8/17/15 at 10:09 AM. The policy indicated "...3. A facility approved documentation form will be used to document restorative nursing interventions as follows: a. Daily participation b. Time required to provide the service in minutes c. Distance ambulated in feet, number of repetitions for ROM, body part exercised, and other measurements in accordance with the goal(s) as written on the plan of care...."</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to</p>	F 0323	Correction of deficient practice for resident cited- Facility response: Resident #39 has a fall risk care	09/18/2015			

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	<p>implement fall prevention interventions at the time of admission for a resident admitted with a history of falls with fractures for 1 of 3 residents reviewed for accident prevention. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities). Resident #39 was admitted to the facility on 6/4/15.</p> <p>A Discharge Summary/Transition of Care Note dated 6/4/15, indicated the resident had a history of falls and had experienced a fall with a resulting fracture of the right forearm. The cast was removed from the right arm on 6/4/15, and a splint was placed prior to discharge from the hospital to the facility. The summary indicated the resident had a mild compression fracture of the lumbar spine.</p> <p>A nursing progress note dated 6/5/15 at 6:00 a.m., indicated the resident was confused to time and place, and had been found with feet off of the bed and resting on the floor several times during the shift.</p> <p>On 6/6/15 at 8:20 a.m., the resident was</p>		<p>plan in place. Review of all residents who could be affected by deficient practice- Facility response: Fall risk has been reviewed for all residents and fall risk care plan is in place with interventions where indicated. Review of fall risk is reviewed in shift huddles. Systemic changes to ensure that deficient practice does not recur- Facility response: All nursing staff has been instructed in the initiation of care plans within 8 hours of resident's admission. All nursing staff has been instructed that a fall risk assessment is to be conducted at the time of admission and included in initial care plan with interventions. Care plans are reviewed and investigated and up-dated with any subsequent fall. Care plans including fall risk are reviewed quarterly. Monitoring of systemic changes: All falls are reviewed during monthly QA meeting and new interventions explored with the committee. DON/ADON review all new admissions for completion of initial care plan within eight hours - including fall risk assessment and interventions. Supporting documentation: In-service record for nursing – 9/11/15 Fall assessment Skin assessment</p>		

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	<p>found on the floor by the bed. The resident indicated a need to go to the bathroom.</p> <p>A progress note dated 6/7/15 at 1:00 a.m., indicated the resident was independent in bed mobility and had a personal safety alarm (PSA) in place.</p> <p>A nursing progress note dated 6/8/15 at 8:50 p.m., indicated the resident was found on the floor yelling for help.</p> <p>Nursing progress notes 6/9/15 at 2:30 a.m. and 6:00 a.m., indicated the resident's PSA was in place for safety, was in and out of bed, and was found laying sideways in bed with feet on the floor.</p> <p>A nursing progress note on 6/11/15 at 12:20 p.m., indicated the resident was found sitting on the floor with the PSA attached and had non skid socks on feet.</p> <p>A review of the written plans of care indicated the resident did not have a fall prevention plan of care in place until 6/11/15, after the resident had experienced 2 falls and numerous attempts to get out of bed unassisted. Interventions included checking resident during rounds and anticipating needs, a tab alarm to remind resident not to get up</p>			

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	<p>without assistance, bed in low position, call light in reach, and non slip socks when in bed.</p> <p>The Fall Risk Assessment completed on 6/12/15, 8 days after admission, assessed the resident with a score of 18. A score higher than 10 indicated a high risk for falls.</p> <p>A nursing progress note on 6/14/15 at 7:40 p.m., indicated the resident was observed sitting on the side of the bed and suddenly rolled off of the bed and onto the floor. The resident indicated the right wrist "felt funny" but didn't hurt.</p> <p>An x-ray of the right arm was obtained on 6/15/15, and indicated the resident had an acute fracture of the wrist.</p> <p>On 8/14/15 at 11:41 a.m., the resident was observed being propelled in a wheelchair into the dining room by staff. An alarm was clipped to the collar of the resident's shirt and was attached to the handle on the chair.</p> <p>During an interview with Certified Nursing Assistant (CNA) #3 on 8/14/15 at 1:35 p.m., CNA #3 indicated the resident was now able to stand and assist with transfers and would frequently remove the PSA (personal safety alarm)</p>			

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F 0329 SS=D Bldg. 00	<p>and attempt to get up without help. The CNA indicated the staff moved the PSA from the bed to the chair when the resident was gotten up in the chair and then moved the PSA from the chair to the bed when the resident went to bed. CNA #3 indicated the resident's bed was kept in a low position with a mat beside the bed to help prevent injuries.</p> <p>During an interview with the Director of Nursing (DON) on 8/14/15 at 4:27 p.m., the DON indicated no care plans were initiated for the resident until 6/11/15, 7 days after admission, including fall prevention interventions.</p> <p>On 8/12/15 at 1:57 p.m., the DON provided the Fall Prevention Policy dated 11/8/2006, and indicated the policy was the one currently used by the facility. The policy indicated, "...3. An initial fall risk assessment will be completed by the MDS (Minimum Data Set) coordinator upon admission. Based on scores all residents will be placed in categories classified as high, moderate, and low..."</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free</p>				

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	<p>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 laboratory tests as ordered by the physician for a resident receiving anticoagulant medications for 1 of 5 residents reviewed for unnecessary medication use. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities).</p>	F 0329	<p>Correction of deficient practice for cited resident- Facility response: Resident #39 has care plan in place for monitoring anticoagulant therapy and lab draws. Resident #39 has anticoagulant/lab tracking sheet in MAR. Review of residents potentially affected by deficient practice- Facility response: All residents on anticoagulant therapy have had orders reviewed and care plans in place for the same. New Orders are received as per policy with triple checks. Routine PT/INR labs are drawn as per facility policy and labs are checked daily as per policy. All residents receiving anticoagulant therapy have anticoagulant/lab tracking</p>	09/18/2015

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NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
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	<p>A physician's order dated 6/27/15, indicated, "...PT/INR [Prothrombin time/international normalized ratio, a laboratory test used to determine how long it takes blood to clot] Mon [Monday] & [and] Thursday q wk [every week] while on Coumadin 4 mg [milligrams] daily...."</p> <p>On 6/30/15, the NP wrote an order indicating, "Please get venous doppler report on chart OK to DC [discontinue] lovenox [sic] today."</p> <p>A nursing progress note dated 7/2/15 at 12:00 p.m., indicated Resident #39 had purple bruising on the left side of the chest and underarm area. The note also indicated the lab company was notified of the failure to draw the INR test as ordered for that date. The next nursing progress note 7/2/15 at 9:00 p.m., indicated the PT/INR was scheduled to be drawn on 7/3/15.</p> <p>A nursing progress note dated 7/3/15 at 3:30 a.m., indicated the resident expressed soreness to the left rib area and had extensive purple bruising to the rib area, the lateral side of the breast, and into the underarm area.</p> <p>On 7/3/15 at 12:30 p.m., the nursing</p>		<p>sheet in MAR. Systemic change to ensure deficient practice does not recur- Facility response: All nursing staff has been instructed in the policy for weekly lab draws for all residents receiving anticoagulant therapy. All nursing staff has been instructed in the parameters for calling the MD and/or lab. All nursing staff has been instructed in how to confirm that ordered labs have been completed. All nursing staff has been instructed in the policy for monitoring anticoagulants and the use of the Coumadin tracking forms. All nursing staff has been instructed in the immediate reporting of med. errors to Administrator, DON, MD, POA/family. Policy for obtaining new med orders reviewed. Policy for obtaining and checking new lab orders reviewed. Medications are reviewed monthly by the consultant pharmacist. Monitoring of systemic change-Facility response: Triple check of all new orders as per policy Review of med errors at risk management meetings quarterly or immediately as needed. Monthly review of medications by consultant pharmacist. Supporting documentation: In-service record for nursing- 9/11/15 Parameters for calling lab Procedure for confirming ordered lab draws Coumadin tracking form Policy for anticoagulants and weekly INR lab draws Policy for obtaining and checking new</p>	

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F 0333 SS=G	<p>progress notes indicated critical lab values of an INR greater than 10.0 had been received, and the physician was faxed and called regarding the results. New orders were received to administer Vitamin K 5 mg, discontinue the Lovenox, hold the Coumadin, and to recheck the PT/INR in 3 days. Vitamin K helps the blood to clot.</p> <p>During an interview with the Director of Nursing (DON) on 8/14/15 at 3:30 p.m., the DON indicated the order received on 6/30/15, to discontinue the Lovenox, was missed at the time the order was received and was not removed from the MAR, resulting in the resident receiving the medication for 3 additional days, and requiring the use of Vitamin K to correct the PT/INR. The DON indicated the facility nurse could have ordered a stat (immediate) check of the lab when the error was discovered, and was not sure why the lab was not checked until the next day. The DON also indicated the facility was in the process of changing lab companies as the company used at the time of the missed lab was not reliable in obtaining labs as ordered.</p> <p>3.1-48(a)(3)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED</p>		orders. Policy for obtaining and checking new lab orders.		

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Bldg. 00	<p>ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to discontinue an anticoagulant (blood thinner) medication as ordered by the physician, the resident experienced a critically high PT/INR result (Prothrombin time/international normalized ratio, a laboratory test used to determine how long it takes blood to clot) and required medical management to correct the levels. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record review of Resident #39, completed on 8/12/15 at 1:27 p.m., indicated the resident had diagnoses including, but not limited to, peripheral vascular disease (decreased circulation in the extremities).</p> <p>An Admission Minimum Data Set (MDS) assessment completed 6/12/15, assessed the resident as having a BIMS (Brief Interview for Mental Status) of 6 out of 15, indicating severe cognitive impairment.</p> <p>The nursing progress notes dated 6/27/15 at 9:00 a.m., indicated the nurse practitioner (NP) was contacted by phone and informed of the ultrasound results.</p>	F 0333	<p>Correction of deficient practice for resident #39- Facility response: Resident #39 has in place a tracking sheet for anticoagulant therapy and labs. New orders are triple checked as per facility policy. Lab orders are double checked daily as per policy. MD/family/POA are informed of changes in condition changes in meds/labs. A care plan is in place for anticoagulant therapy. Care related to changes in medications or lab results are shared in daily shift huddles with alerts for potential problems related to anticoagulant therapy. PT/INR labs are drawn at least weekly as per facility policy. Review of all residents potentially affected by deficient practice: All residents receiving anticoagulant therapy have tracking sheet for anticoagulant/labs on MAR. All new orders are triple checked as per facility policy. All new lab orders are double checked as per facility policy. All medications are reviewed monthly by the consultant pharmacist. All residents receiving anticoagulant therapy have a care plan in place with interventions for related problems. Systemic changes to prevent recurrence- Facility response: All nursing staff has been instructed in the policy regarding checking of new orders. All nursing staff has</p>	09/18/2015	

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	<p>New orders were received for anticoagulants (a medication used to prevent or treat blood clots) Lovenox 60 mg (milligrams) subcutaneously (under the skin) every 12 hours a Coumadin 4 mg daily. Laboratory (lab) monitoring of the medications 2 times a week while receiving the Coumadin was also ordered.</p> <p>A nursing progress note dated 6/29/15 at 3:00 p.m., indicated PT/INR results of 21.6/1.9 were faxed to the physician's office. A reported range for the results would be 9.5 - 11.6 seconds/0.9 - 1.1.</p> <p>On 6/30/15, the NP wrote an order indicating, "Please get venous doppler report on chart OK to DC [discontinue] lovenox today." The order was received by the Assistant Director of Nursing (ADON) on 6/30/15 at 2:00 p.m.</p> <p>A review of the Medication Administration Record (MAR) for June 2015, indicated the resident received 1 doses of Lovenox on 6/30/15 at 9:00 p.m. The MAR for July 2015, indicated the resident received 2 doses of Lovenox on 7/1/15 and 7/2/15, and one dose on 7/3/15.</p> <p>A nursing progress note dated 7/2/15 at 12:00 p.m., indicated Resident #39 had</p>		<p>been instructed in the policy for weekly lab draws for all residents receiving anticoagulant therapy. All nursing staff has been instructed in the policy for monitoring anticoagulants use of the Coumadin tracking forms. All nursing staff has been instructed in the parameters for calling the MD and/or lab and family. All nursing staff has been instructed in the how to confirm that ordered labs have been completed. Monitoring of systemic changes- Facility response: DON/ADON responsible for monitoring triple check of new orders daily. DON/ADON responsible for monitoring double check of labs as per policy. Consultant pharmacist reviews all meds monthly. Risk management committee will investigate any discrepancies found in procedures of review as listed in policies. Supporting documentation: In-service record for nursing – 9/11/15 Policy for receiving new orders Parameters for calling lab Procedure for confirming ordered lab draws Coumadin tracking form Policy for anticoagulants and weekly INR lab draws</p>		

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	<p>purple bruising on the left side of the chest and underarm area. The note also indicated the lab company was notified of the failure to draw the INR test as ordered for that date. The next nursing progress note 7/2/15 at 9:00 p.m., indicated the PT/INR was scheduled to be drawn on 7/3/15.</p> <p>A nursing progress note dated 7/3/15 at 3:30 a.m., indicated the resident expressed soreness to the left rib area and had extensive purple bruising to the rib area, the lateral side of the breast, and into the underarm area.</p> <p>On 7/3/15 at 12:30 p.m., the nursing progress notes indicated critical lab values of an INR greater than 10.0 had been received, and the physician was faxed and called regarding the results. New orders were received to administer Vitamin K 5 mg, discontinue the Lovenox, hold the Coumadin, and to recheck the PT/INR in 3 days. Vitamin K helps the blood to clot.</p> <p>During an interview with the DON on 8/14/15 at 3:30 p.m., the DON indicated the order received on 6/30/15, to discontinue the Lovenox, was missed at the time the order was received and was not removed from the MAR, resulting in the resident receiving the medication for</p>			

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F 0365 SS=D Bldg. 00	<p>4 additional doses and requiring the use of Vitamin K to increase the time for the blood to clot.</p> <p>3.1-48(c)(2)</p> <p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident #13) received food prepared in a form designed to meet individual needs for 1 of 3 residents reviewed for weight loss out of a sample of 10 residents.</p> <p>Findings Include:</p> <p>The clinical record for resident #13 was reviewed on 8/13/15 at 1:07 PM. Diagnoses included, but were not limited to, confusion and moderate dementia.</p> <p>A review of recapitulation of physician orders for 5/1/15 through 5/31/15, for Resident #13, indicated a regular diet with chopped meat.</p>	F 0365	<p>Correction for resident cited for deficient practice-Survey response:The correct consistency was provided for resident #13. Tray for resident #13 will be monitored for accuracy three times each week and any issues will be documented for correction.No other residents were cited during this survey.Systemic changes to prevent recurrence of the deficient practice-Facility response:A new policy and procedure has been written and implemented regarding mechanically altered diets. The dietary manager and dietary supervisor in-serviced the kitchen staff on mechanically altered diets and policy and procedure on 9/1/15. All medical records were reviewed on 8/25/15 to assure all mechanically altered diets were</p>	09/18/2015

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F 0441 SS=D Bldg. 00	<p>During an observation on 8/17/15 at 12:16 PM, Resident #13 was consuming the meal independently. Resident #13's plate contained a beef kabob.</p> <p>During an interview on 8/17/15 at 2:23 PM, the Dietary Manager indicated the beef kabob served for the lunch meal was not ground or chopped meat. The Dietary Manager indicated Resident #13 should have had ground meat.</p> <p>A review of the Menu Guide Report for August 17, 2015, provided by the Dietary Manager on 8/17/15 at 2:45 PM, indicated ground beef tips was to be served for regular ground and mechanical soft diets.</p> <p>A review of the tray ticket dated 8/17/15, provided by the Dietary Manager on 8/17/15 at 2:45 PM, indicated Resident #13's diet order was regular, chopped meat.</p> <p>3.1-21(a)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>		<p>identified. QA to monitor systemic changes-Facility response: A revised kitchen monitoring form has been implemented. The dietary manager/dietary supervisor will provide random monitoring weekly to ensure proper diet consistencies are being provided and policy is being followed. This monitoring will be on-going. Supporting documentation: Dietary In-service record Policy for mechanically altered diets Trayline checklist</p>		

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	<p>development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to isolate a resident who had a urinary tract infection (UTI) with the organism extended-spectrum beta-lactamase (ESBL). (Resident #44)</p> <p>Findings include:</p>	F 0441	Correction of deficient practice for cited resident- Facility response: Resident #44 was placed immediately in contact isolation in a private room. Care plan for resident in isolation initiated. Vacated room, including roommates space, was cleaned with appropriate antibacterial	09/18/2015

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	<p>During a review of the Infection Control Log for June 2015 and July 2015, multiple residents were listed on the log as having had an infection, but the organism was not listed with the culture results.</p> <p>The clinical record review of Resident #44, completed on 8/17/15 at 10:45 a.m., indicated the resident had diagnoses including, but not limited to, dementia and an enlarged prostate with urinary obstruction.</p> <p>On 7/23/15, the resident complained of difficulty urinating and a physician's order was received for a urinalysis and culture of the urine to rule out a urinary tract infection (UTI).</p> <p>A nursing progress note dated 7/26/15 at 1:45 p.m., indicated the culture results were received, the physician was notified of the results, and a new order was received for Macrobid (an antibiotic medication) 100 mg (milligrams) twice a day for the treatment of UTI. The culture result indicated the organism was Escherichia coli ESBL, a multidrug resistant organism, and recommended caution and monitoring of the resident during and after therapy.</p>		<p>agents. Curtains and bedding were also laundered with appropriate agents. Protection of all residents who potentially could be affected- Staff response: All residents with applicable dx. currently have been placed in isolation as required and appropriate cleaning done. All residents in isolation have a care plan in place for the same. Systemic changes- Facility response: All staff instructed in policy and procedure for establishing isolation with emphasis on resistant organisms. Housekeeping staff consults with nursing to maintain cleaning of infected areas and proper handling of linens. DON and administrator are on CDC list serve to obtain current parameters for isolation. All nursing staff instructed on how to determine from lab results the need for isolation. All nursing staff instructed in measures to prevent spread of disease by direct contact or applicable measures. All staff instructed in handwashing after contact with infected resident as indicated by professional standards. QA monitoring of facility response- DON maintains a record that tracks infection by type/ location/tx. Follow-up labs are obtained at the appropriate time following completion of tx.as per policy. Infection tracking record is reviewed in QA and interventions are explored. Supporting</p>	

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	<p>During an interview with the Director of Nursing (DON) on 8/17/15 at 10:13 a.m., the DON indicated the lab provided a complete listing of the cultures performed including the organisms and the listing was included in the infection control book with the log. During a review of the log and list with the DON, a resident was noted to have a urine culture result of ESBL. The DON indicated the resident shared a room with another resident and was not placed into isolation as the facility was unaware the organism required isolation.</p> <p>On 8/12/15 at 1:57 p.m., the DON provided the policy Infection Control Environmental Safety Policy dated 2000, and the Isolation/Precaution System Policy and Procedure dated 2001, and indicated the policies were the ones currently used by the facility. In the section under Contact Isolation the policy indicated, "...Contact isolation procedures will be implemented when a resident is diagnosed with any of the following diseases (not all inclusive):...j. Multi-resistant bacteria, infection or colonization with any of the following:...2. Other resistant bacteria if a special clinical and epidemiological significance...."</p> <p>3.1-18(a)</p>		documentation: In-service record for nursing – 9/11/15 Isolation policy Tracking record	

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 39 Sample: 7</p> <p>St. Paul Hermitage was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000		