

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00164954.</p> <p>Complaint IN00164954- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey date: February 16, 17, and 18, 2015</p> <p>Facility number: 004268 Provider number: 155735 AIM number: 200504460</p> <p>Team: Chuck Stevenson, RN-TC</p> <p>Census bed type: SNF: 21 SNF/NF: 36 Total: 57</p> <p>Census payor type: Medicare: 19 Medicaid: 19 Other: 19 Total: 57</p> <p>Sample: 4</p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D Bldg. 00	<p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.3-1.</p> <p>Quality review completed on February 22, 2015 by Cheryl Fielden, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 develop health care plans for residents who had chosen Do Not Resuscitate code status (Residents B, C, D, and E), and failed to develop health care plans for diabetic care and</p>	F 279	<p><b>F 279 Develop of care plans</b> <b>Corrective actions</b> <b>accomplished for those</b> <b>residents found to be affected</b> <b>by the alleged deficient</b> <b>practice:</b> Residents #B,#C #D and # E are confidential as part of</p>	03/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>respiratory care for a resident who was diabetic and whose primary admitting diagnosis was upper respiratory infection, and following hospitalization for pulmonary effusion (excess fluid in the lung) (Resident D). 4 of 4 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 2/16/15 at 1:00 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, arteriosclerotic heart disease (hardening of the coronary arteries), atrial fibrillation, peripheral vascular disease, and congestive heart failure.</p> <p>A 5 Day Minimum Data Set assessment dated 1/14/15 indicated Resident B was not cognitively impaired, had no behavior issues, required limited to extensive assistance for activities of daily living, did not ambulate out of her room, and was continent of bowel and bladder.</p> <p>Resident B was originally admitted to the facility on 5/21/07. She was discharged to home on 8/15/13, and readmitted on 1/07/15. At readmission her code status was noted to be Do Not Resuscitate. A properly completed Do Not Resuscitate</p>		<p>the complaint survey</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Audit of all residents identified as a Do Not Resuscitate Code Status, have a diagnosis of Diabetes and respiratory infection to ensure care plans have been developed.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Staff will be re educated on the developing comprehensive careplan for residents Do Not Resuscitate status, Diabetes and respiratory infection by the DHS and/or designee</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> New admissions, readmissions and residents with a change to Do Not Resuscitate, have a diagnosis of Diabetes and respiratory infection will be reviewed daily during the Clinical Care Meeting 5 days a week x 4 weeks, then monthly x 6 months to ensure residents</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>form was in the medical record.</p> <p>Resident B's record contained no Health Care Plan for a code status of Do Not Resuscitate including, but not limited to, end of life care directions, family notification instructions, or funeral contact information.</p> <p>2. The record of Resident C was reviewed on 2/17/15 at 2:00 P.M. Diagnoses included, but were not limited to, a history of influenza A, dementia, renal insufficiency, small vessel ischemic disease, labile hypertension, and anorexia.</p> <p>A 14 Day Minimum Data Set assessment dated 1/21/15 indicated Resident C was cognitively impaired, required staff assistance for all activities of daily living, and was occasionally incontinent of bowel and bladder.</p> <p>Resident C was readmitted to the facility on 1/07/15 following a hospitalization for respiratory distress, including Influenza A. Resident C's readmission record contained a "Do Not Resuscitate Declaration and Order" form dated 1/06/15, and her code status was noted to be Do Not Resuscitate.</p> <p>Resident C's record contained no Health</p>		<p><b>with Do Not Resuscitate orders have a care plan developed to address their Do Not Resuscitate status by the DHS and or designee.</b></p> <p><b>Completion Date: 3/20/15</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Care Plan for a code status of Do Not Resuscitate including, but not limited to, end of life care directions, family notification instructions, or funeral contact information.</p> <p>3. The record of Resident D was reviewed on 2/17/15 at 9:30 A.M. Diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's Disease, hypertension, gastro esophageal reflux disease, pyelonephritis, anemia, and hypercholesterolemia.</p> <p>A 5 Day Minimum Data Set assessment dated 2/03/15 indicated Resident D was severely cognitively impaired, required extensive staff assistance for all activities of daily living, had limited ambulation abilities, and was frequently incontinent of bowel and bladder.</p> <p>A hospital History and Physical form dated 1/23/15 indicated "Chief complaint: Increased dyspnea (shortness of breath)...History of present illness...a large right pleural effusion was also discovered on X-ray. Code status: I spoke with the patient's daughter about the pts' code status and they said...she does not want heroic measures used..."</p> <p>A nurse's progress note dated 1/23/15 at 4:00 P.M., indicated "V.S. (vital signs)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>assessment included Tem (temperature) 97.4 BP (blood pressure) 76/48 P (pulse) 43 on third attempt. Notified (name of medical practice) and was instructed to send her to (name of acute care hospital). ER (emergency room) admitted pt (patient) with pulmonary effusion."</p> <p>A nurse's progress note dated 1/27/15 (untimed) indicated "Arrived from (name of acute care hospital) at 1600 (4:00 P.M.) Pt. is calm and recognized room. Daughter brought C-Pap (constant positive airway pressure; utilized for respiratory treatment) machine...PAO2 (a measure of oxygen in the blood) was unable to register..."</p> <p>A nurse's progress note dated 2/06/15 at 12:45 P.M. indicated "Spoke (symbol for "with") daughter...informed her of appt. (appointment) with (name of Pulmonologist) Feb. (February) 16..."</p> <p>An office visit information form dated 2/16/15 and signed by the Pulmonologist on that date indicated "Dx: (diagnosis) Rt (right) effusion." An accompanying Physician's Progress Note of that same date indicated "Recommend: Auto titrating C-Pap; Sleep study; To prevent repeat hospital admissions or Hospice/ Palliative care."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident D's record included a health care plan for ADLS (activities of daily living ) that included "Nursing to administer my oxygen as ordered-see my current orders." It did not include any other health care plans related to respiratory status, including, but not limited to, assessment, use of C-Pap machine, or other interventions.</p> <p>Resident D's diagnoses included diabetes mellitus. A physician's recapitulation of orders for February 2015 indicated Resident D had a standing order for Lantus insulin 8 units to be administered at bedtime, and an order for blood sugar testing twice a day, with Novolog insulin to be administered according to a sliding scale.</p> <p>Resident D's record did not include health care plans related to diabetes mellitus status, including, but not limited to, assessment, insulin therapy, signs and symptoms of low or high blood sugar, or other interventions, including emergency interventions in the event of hypoglycemic crisis.</p> <p>Resident D's record contained an "Indiana Physician Orders for Scope of Treatment" dated 1/27/15. It indicated "Cardiopulmonary Resuscitation (CPR): Do Not Attempt Resuscitation (DNR)."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident D's record contained no Health Care Plan for a code status of Do Not Resuscitate including, but not limited to, end of life care directions, family notification instructions, or funeral contact information.</p> <p>4. Resident E's record was reviewed on 2/17/15 at 12:30 P.M. Diagnoses included, but were not limited to, Parkinson's Disease, pneumonia, encephalitis, febrile illness with leukocytosis, seizures, rhabdomyolysis, heart murmur, and aortic stenosis.</p> <p>An annual Minimum Data Set assessment dated 1/13/15 indicated Resident E was cognitively impaired, required staff assistance for all activities of daily living, did not ambulate, and was occasionally incontinent of bladder.</p> <p>Resident E's record contained a "Living Will Declaration" form dated 12/12/95 which indicated "I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me."</p> <p>Nurse's progress note dated 11/10/14 at 11:30 A.M., indicated "Meeting held with family. Code status (symbol for "changed") to DNR."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>Resident E's record contained an "Indiana Physician Orders for Scope of Treatment" dated 11/10/14. It indicated "Cardiopulmonary Resuscitation (CPR): Do Not Attempt Resuscitation (DNR)."</p> <p>A physician's order dated 2/09/15 indicated "Admit to (name of hospice service provider.)"</p> <p>A health care plan for Resident E titled "Acute Care Needs" included "2/11/2015 Hospice." Resident E's record contained no other health care plan related to code status including, but not limited to, end of life care directions, family notification instructions, hospice services to be provided, or funeral contact information.</p> <p>A facility policy titled "Interdisciplinary Team Care Plan Guideline dated 1/08 received from the Director of Health Services on 2/17/15 at 11:30 A.M., indicated "Purpose: to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines.... Care plan interventions should be reflective of the impact the risk area(s) disease process(es) have on the individual resident...New</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D Bldg. 00	<p>problem areas should be printed and added to the existing care plans."</p> <p>3.1-35(a) 3.1-35 (b)(1)</p> <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. Based on record review and interview, the facility failed to ensure a resident with a documented history of respiratory difficulty, including a hospitalization for upper respiratory infection and a pleural effusion, and who required supplemental oxygen therapy, received regular respiratory assessments to monitor status and maintain the highest practicable level of functioning (Resident D.) 1 resident of 4 reviewed for appropriate care and assessment.</p> <p>Findings include:</p> <p>The record of Resident D was reviewed on 2/17/15 at 9:30 A.M. Diagnoses included, but were not limited to,</p>	F 309	<p><b>F 309</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #D is confidential as part of the complaint survey</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Audit all residents with Respiratory difficulty/or hx of will be conducted to ensure they have respiratory assessments every</p>	03/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>diabetes mellitus, Alzheimer's Disease, hypertension, gastro esophageal reflux disease, pyelonephritis, anemia, and hypercholesterolemia.</p> <p>A 5 Day Minimum Data Set Assessment dated 2/03/15 indicated Resident D was severely cognitively impaired, required extensive staff assistance for all activities of daily living, had limited ambulation abilities, and was frequently incontinent of bowel and bladder.</p> <p>During an interview on 2/17/15 at 10:50 A.M., the Director of Health Services indicated that each resident's assessment status was determined by the primary admitting diagnosis, and the Skilled Charting Evaluation form pertinent to that diagnosis would be used for that resident. She indicated Resident D's primary admitting diagnosis was upper respiratory infection, and the charting form for that diagnosis was in use for Resident D.</p> <p>A nurse's progress note dated 1/23/15 at 4:00 P.M., indicated "V.S. (vital signs) assessment included Tem (temperature) 97.4 BP (blood pressure) 76/48 P (pulse) 43 on third attempt. Notified (name of physician's practice) and was instructed to send her to (name of acute care hospital). ER (emergency room) admitted</p>		<p>shift to monitor status and maintain their highest practible level of functioning by the DHS and/or designee</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Nurses will be reeducated on conducting regular respiratory assessments to monitor status by the DHS and/or designee</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Random weekly audits of residents with respiratory difficulty will be conducted for 8 weeks via the daily clinical care meeting, then monthly x 4 months to ensure residents with respiratory difficulty have regular respiratory assessments. Conducted by the DHS and/or designee.</p> <p>Completion date: 3/20/15</p> <p><b><i>The results of the audit observations will be reported,</i></b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>pt (patient) with pulmonary effusion."</p> <p>A hospital History and Physical form dated 1/23/15 indicated "Chief complaint: Increased dyspnea (shortness of breath)...History of present illness...a large right pleural effusion was also discovered on X-ray..."</p> <p>A nurse's progress note dated 1/27/15 (untimed) indicated "Arrived from (name of acute care hospital) at 1600 (4:00 P.M.) Pt. is calm and recognized room. Daughter brought C-Pap (constant positive airway pressure; utilized for respiratory treatment) machine...PAO2 (a measure of oxygen in the blood) was unable to register..."</p> <p>A nurse's progress note dated 2/06/15 at 12:45 P.M. indicated "Spoke (symbol for "with") daughter...informed her of appt. (appointment) with (name of Pulmonologist) Feb. (February) 16..."</p> <p>An office visit information form dated 2/16/15 and signed by the Pulmonologist on that date indicated "Dx: (diagnosis) Rt (right) effusion." An accompanying Physician's Progress Note of that same date indicated "Recommend: Auto titrating C-Pap; Sleep study; To prevent repeat hospital admissions or Hospice/ Palliative care."</p>		<p><b>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Skilled Charting Evaluation- Infection" forms for Resident D indicated:</p> <p>1/28/15 "Infection type: URI (upper respiratory infection) O2 sats (blood oxygen saturation) unable to obtain. O2 (supplemental oxygen) (symbol for "at") 2LPM/NC (2 liters per minute by nasal cannula). Color of nail beds: blue."</p> <p>1/29/15 10-6 "Infection type: URI O2 sats 96%. O2 2LPM/CPAP"</p> <p>1/29/15 6-2 "Infection type: Pneumonia. Lung sounds diminished. O2 2L."</p> <p>1/29/15 2200 "Infection type: URI O2 sats 95%. Diminished lung sounds. O2 2L NC/CPAP "</p> <p>1/31/15 "Infection type: URI O2 sats 93%. Diminished all fields. 2L NC."</p> <p>2/1/15 "Infection type: URI O2 sats unable to obtain. Diminished all fields. 2L NC Color of nail beds: blue."</p> <p>2/2/15 "Infection type: Resp. (respiratory) O2 sats 97%. O2 2L."</p> <p>2/3/15 "Infection type: URI Lung sounds diminished. O2 sats 92% via CPAP."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2/5/15 "Infection type: Pneumonia O2 sats 94%. O2 2L."</p> <p>2/7/15 "Infection type: URI O2 sats 93%. 2L per NC."</p> <p>2/8/15 "Infection type: URI O2 sats 96%. 2L NC."</p> <p>2/12/15 2/8/15 "Infection type: URI O2 sats 96%. 2L NC."</p> <p>2/13/15 "Infection type: URI O2 sats 91%. 2L NC."</p> <p>Resident D's record did not contain Skilled Charting Evaluation- Infection forms for 1/30/15, 2/04/15, 2/06/15, 2/09/15, 2/10/15, 2/11/15, 2/14/15, or 2/16/15.</p> <p>During an interview on 2/18/15 at 11:10 A.M. the Director of Health Services indicated there was no documentation of any respiratory assessments for Resident D other than on the Skilled Charting Evaluation- Infection forms noted above.</p> <p>3.1-37(a)</p>			