

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902
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F0000	<p>This visit was for the Investigation of Compliant IN00103116 This visit resulted in a partially extended survey - immediate jeopardy</p> <p>Complaint IN00103116, Substantiated. Federal/State deficiencies related to the allegations are cited at F203, F282 and F309.</p> <p>Survey dates: February 1 and 2, 2012 Extended survey date: February 3, 2012</p> <p>Facility number: 000127 Provider number: 155222 AIM number: 100291430</p> <p>Survey team: Linn Mackey, RN- TC Toni Maley, BSW</p> <p>Census bed type: SNF: 97 Total: 97</p> <p>Census payor type: Medicare: 21 Medicaid: 58 Other: 18 Total: 97</p> <p>Sample: 9</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on February 7, 2012 by Bev Faulkner, RN</p>			
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F0203 SS=D	<p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and</p>						

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	<p>telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on interview and record review, the facility failed to ensure a resident was not involuntarily transferred from the facility without 30 days notice and documentation to support the reason for transfer for 1 of 3 residents reviewed for notice prior to discharge in a sample of 9. (Resident E) This practice resulted in Resident E being discharged from the facility without a place to reside.</p> <p>Findings Include:</p> <p>Resident E's closed record was reviewed on 2/1/12 at 1:30 p.m.</p> <p>Resident E's diagnoses included, but were not limited to, anxiety, chronic airway obstruction and congestive heart failure.</p> <p>Resident E had an 11/30/11, 1:50 p.m., "Resident Progress Note" which indicated "Smoking paraphernalia found on resident's possession in room which was</p>	F0203	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F203</p> <p>A) Information on Resident E was taken from a closed record review. Resident E no longer resides in the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>B) A review of all Transfer/Discharge paperwork that has been issued in the last 30 days has been completed to determine that all the required paperwork was given and completed in its entirety. No irregularities noted.</p> <p>C) Executive Director, nursing administrative staff(along with licensed staff), and social services department reviewed F 203 in detail, as to the importance of presenting the required Transfer/Discharge paperwork, (including i.e. Rights to appeal, etc.) and completed correctly, retaining a copy for the clinical chart. Residents who will be issued a transfer/discharge notice will have their form reviewed for completeness, and chart checked to validate presence of proper documentation at regular department manager meetings prior to</p>	02/29/2012	

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	<p>tobacco, cigarette roller which violated agreement [with] facility and has been given ordered immediate discharge from facility [home based hospice name] Hospice notified and resident and wife notified of order also."</p> <p>Resident E had an 11/30/11 Physician's Telephone order for "Discharge from facility." The order contained no discharge location.</p> <p>Resident E had an 11/30/11 "Notice Of Transfer Or Discharge" which indicated "Resident is being transferred to: Other (Please specify) Custody of Hospice [hospice name]. ...The safety of the individuals in the facility is endangered."</p> <p>Resident E record had a 10/5/11, "Smoking Policy" which indicated "Any resident who violates this policy will be given a discharge notice and be discharged from the facility."</p> <p>Resident E's record lacked:</p> <ul style="list-style-type: none"> a.) A 30 day discharge notice b.) Documentation of Resident E having any source of fire or flame on his person or on facility grounds. c.) Documentation of Resident E smoking on facility premises anytime after 10/13/11. d.) A discharge location which provided 		<p>discharge for the next 4 weeks. A PI tool has been developed to document findings of these reviews.</p> <p>D) The monitoring for compliance will be a joint effort between the ED/DNS/SSD, or designee, as they review each transfer/discharge for the next 4 weeks. Thereafter, the SSD/designee will conduct random checks monthly of at least 2 discharges, if applicable, for 6 months to ensure completeness of the required information. report of their findings will be presented at monthly Performance Improvement meetings with committee recommendation for continuation or discontinuation of the monitoring</p> <p>E) DOC-2-29-2012</p>				

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	<p>a residence/housing.</p> <p>Review of a 10/13/11, facility "Resident/Family Education Record", which was provided by the Administrator on 2/2/12 at 9:00 a.m., indicated "Resident found smoking in res [resident's] bathroom. Res immed [immediately] put out cig [cigarette]...Res O2 [oxygen] was not on during discussion."</p> <p>Resident E had an 11/30/11, 3:00 p.m., Resident Progress Note which indicated the resident and his wife left the facility without notifying staff and the home based hospice provider had called to say the resident had arrived.</p> <p>Review of an untitled, 10/13/11, facility document, which was provided by the Administrator on 2/2/12 at 9:00 a.m., indicated "Director informed resident he could leave facility with spouse to smoke, but make sure he signed himself or spouse signed him out."</p> <p>Review of a current, 4/28/10, facility policy title "Transfer & Discharge," which was provided by the Administrator on 2/1/12 at 3:25 p.m., indicated the following:</p> <p>"The resident is transferred or discharged</p>						

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	<p>only when:</p> <p>...4. The health of individuals in the center would be endangered;</p> <p>...The medical record must reflect the process by which the transfer/discharge was determined necessary due to safety reasons.</p> <p>...The resident and, if known, the family member, surrogate or legal representative, are notified at least 30 days prior to the transfer, unless transfer is effected when: notified at least 30 days prior to the transfer, unless the transfer is effected when:</p> <p>a. The resident's continued stay would be an endangerment to the health or safety of others in the center,</p> <p>...The written notice of transfer/discharge includes:</p> <p>...Location to which the resident is transferred/discharged."</p> <p>During a 2/1/12, 3:15 p.m. interview, the Social Services Director indicated Resident E was not given 30 days notice prior to discharge. Resident E was discharged immediately due to a violation of the smoking policy. She indicated possession of any smoking paraphernalia was a violation of the smoking policy. The resident had tobacco and a cigarette roller, but no flame or source of fire on the day of his 11/30/11 immediate discharge. She indicated the resident was</p>						

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	<p>discharged due to danger to self and others. She could not identify how the possession of smoking paraphernalia without a flame was danger. She indicated the resident had no documented episode of smoking or using a source of fire anywhere on the facility property anywhere after 10/13/11.</p> <p>The Social Service Director also indicated Resident E was discharged to a home based hospice service which was not a place of residence. The hospice provider had indicated hospice would work to find the resident a home. Hospice had placed Resident E in a shelter that same day. She indicated the resident's family could not provide a home for the resident because his wife was homeless. She indicated the resident and his wife had walked to the home based hospice office at the time of discharge. Additionally, the resident had walked to the hospice facility on other occasions.</p> <p>During a 2/1/12, 3:30 p.m., interview, the Director of Nursing indicated Resident E had not been given a 30 day notice due to his violation of the facility policy. She indicated the facility policy allowed the facility to discharge a resident immediately if a resident had smoking paraphernalia. She indicated Resident E did not have fire or flame of any kind and</p>			
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	<p>had not been smoking on the premises. The Director of Nursing also indicated Resident E was discharged to a home based hospice provider, which did not offer a place for the resident to reside. The hospice provider had found a place for the resident at a shelter. She indicated she had been involved in the decision to immediately discharge Resident E from the facility due to a violation of the facility's smoking policy. She indicated she believed the facility had the right to discharge a resident immediately if they violated smoking policy. She indicated she was aware the resident did not have a place to live at the time of discharge, but knew hospice would work with him to find a place to live.</p> <p>This Federal tag related to complaint number IN00103116.</p> <p>3.1-12(a)(3) 3.1-12(a)(4)(A) 3.1-12(a)(4)(C) 3.1-12(a)(4)(D) 3.1-12(a)(7) 3.1-12(a)(8)(A) 3.1-12(a)(8)(B)</p>				

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F0282 SS=J	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician's order regarding monitoring a resident following a non-responsive episode and providing IV fluid therapy after a non-responsive episode for 1 of 7 residents reviewed for following physician's orders in a sample of 9. (Resident F) This deficient practice resulted in immediate jeopardy.</p> <p>The immediate Jeopardy began on 11/25/11 when the facility failed to follow physician orders to assess and monitor vital signs of for Resident F after the resident became non-responsive and failed to ensure intravenous fluids were provided timely. The resident's condition deteriorated resulting in the need for CPR and transfer to the hospital. The Administrator and Director of Nursing were notified on 2/2/12 at 11:15 a.m. The immediate jeopardy was removed on 2/3/12, but non compliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p>	F0282	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.F282A)Resident no longer resides within the facility so no further corrective actions can be takenB)Facility maintains on a daily basis a log of those residents identified to be at risk. This log is reviewed every morning with the IDT and communicated to direct care staff via the 24 hour report for shift to shift assessments and documentation review. Please note that the SBAR documentation presented to the surveyors, at the time of survey, is part of the medical record. The same was communicated to surveyors by the DNS.C) Through the admission process and the 24 hour report process the facility will identify those residents that show new signs and symptoms and or change of condition. Residents will be reviewed during regularily scheduled department manager meetings per the ED,</p>	02/29/2012			

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	<p>1.) Resident F's closed clinical record was reviewed 2/1/12 at 2:45 p.m.</p> <p>Resident F's diagnoses included, but were not limited to, Alzheimer's disease, status post hip fracture and anxiety.</p> <p>Resident F had an order for full code status (initiate life sustaining measures including CPR) upon admission on 11/11/11 which continued to be in place until his discharge to the hospital on 11/25/11.</p> <p>Resident F had an 11/25/11, 2:00 p.m., "Resident Progress Note" late entry for 12:00 p.m. (noon) which indicated the Resident had been up in his wheelchair and had become unresponsive to voice and touch. His pupils were dilated and sluggish. His vital signs were: temperature 98.6, blood pressure 97/73, heart rate 90, irregular pulse-weak, respirations 24-30, lungs course rattle noted when laid flat. Nonbreather (facial mask means to administer oxygen) on at 10 liters for 10 minutes to increase oxygen saturation. Oxygen saturation at 91%.</p> <p>Resident F had an 11/25/11, 12:45 p.m., "SBAR-(a tool used by nursing to notify physicians of resident condition change)</p>		<p>DNS, and Unit Managers. Re-education of licensed nursing staff occurred on 2-1-2012 and 2-2-2012 on nursing standards, timely accurate documentation, and physician notification, following physician's orders, as well as timely and appropriate transfers to the hospital. Audits will be conducted by DNS/designee three times weekly on clinical documentation, change of condition and physician notification, to include all three shifts. Audits will continue for 6 months then decrease to weekly reviews per DNS/designeeD) Monitoring of this plan of correction will be the responsibility of the Director of Nursing and Unit Managers with ED oversight. Auditing will continue for 12 months and or until the Performance Improvement committee recommends discontinuation of the monitoring. Any deviation from the above plan will be immediately reported to the Regional Director of Operations.E) DOC- 2-29-2012</p>				

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	<p>Physician/NP/PA Communication and Progress Note For New Symptoms, Signs, and Other Changes in Condition" which indicated the following:</p> <p>"Recommended IV fluids Monitor vital signs and observe Change in current orders hold BP [blood pressure] medications</p> <p>Resident F had a 11/25/11, Physician's order for:</p> <ol style="list-style-type: none"> 1.) 1/2 normal saline at 50 ccs an hour for 12 hours of intravenous therapy. 2.) Hold blood pressure medication for 24 hours 3.) Nonrebreather oxygen administration, keep saturations greater than 90%. <p>These orders were consistent with the 12:45 p.m., SBAR-physician notification notes.</p> <p>Following the 11/25/11, 12:00 p.m. note, the clinical record lacked any documentation of monitoring vital signs up to and including his 6:25 p.m. discharge via 911.</p> <p>An 11/25/11, 6:10 p.m., Resident Progress Note indicated the CNA (certified nursing assistant) called the writer to the room concerning the inability to obtain blood pressure. The oxygen saturation level was 78-80%. The</p>			
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	<p>resident was cold to the touch. The nurse was unable to obtain a pulse. Pulse oxymeter had pulse of 32. Respirations were 6 per minute. Doctor's office notified and an order was given to send the resident out to the hospital. When the nurse returned to the room, the resident had no pulse and not respirations CPR (cardio- pulmonary resuscitation) was started and 911 called.</p> <p>An 11/25/11, 6:25 p.m., Resident Progress Note indicated EMTs arrived and took over CPR.</p> <p>During a 2/2/12, 8:15 a.m. interview, the Director of Nursing indicated Resident F died on 11/25/11.</p> <p>On 2/2/12 at 8:10 a.m., the Director of Nursing and Administrator provided one set of vital signs from the Nursing 24 hour report sheet, which was identified as not being a part of the clinical record. The vital signs lacked a time taken and indicated only 11/25/11 evening. The vital signs were as follows: Blood pressure 94/60, heart rate 84, respirations 22, temperature 98.4, oxygen saturation 90-92%. This information was not signed.</p> <p>During a 2/2/12 at 8:10 a.m. interview, The Director of Nursing indicated the</p>						

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902
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	<p>facility did not have any additional documentation regarding the monitoring of Resident F's 11/25/11 condition during the period of time from 12:00 p.m. to 6:25 p.m. She indicated the SBAR-physician notification tool was not a part of the resident's clinical record but could be added if chosen to be. She indicated she believed the resident had been assessed during this period, but had no means to identify if the resident remained the same or his condition deteriorated during the time.</p> <p>The immediate jeopardy that began on 11/25/11 was removed on 2/3/12 at 2:30 p.m., when the facility</p> <p>a.) evaluated all residents for the need for services following a significant change of condition.</p> <p>b.) educated all licensed nursing personal regarding the assessment of residents with a significant change of condition, the provision of monitoring of residents with changes in condition and following physician's orders</p> <p>c.) educated all Certified Nursing Aides regarding the notification of the charge nurse regarding the change of condition of any resident, but the noncompliance remained at the lower scope and severity level of isolated potential for more than minimal harm that is not immediate jeopardy because sufficient time had not</p>			
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	<p>elapsed to allow the facility to monitor their quality assurance for monitoring residents with a significant change of condition and following physician's orders following a significant change in condition.</p> <p>This Federal tag related to complaint number IN00103116.</p> <p>3.1-35(g)(2)</p>			
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F0309 SS=J	<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 ensure a resident who required IV fluids and ongoing monitoring of vital signs and condition received said services in order to determine the resident's need for altered care and services including emergency services in order to prevent further decline for 1 of 7 residents reviewed for quality of care in a sample of 7. (Resident F) This deficient practice resulted in immediate jeopardy. This deficient practice resulted in Resident F's death.</p> <p>The immediate Jeopardy began on 11/25/11 when the facility failed to thoroughly assess and monitor vital signs of Resident F after the resident became non-responsive and failed to ensure intravenous fluids were provided timely. The resident's condition deteriorated resulting in the need for CPR and transfer to the hospital. The Administrator and Director of Nursing were notified on 2/2/12 at 11:15 a.m. The immediate jeopardy was removed on 2/3/12, but non compliance remained at the lower scope and severity level of isolated, no actual</p>	F0309	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.F309A)Resident no longer resides within the facility so no further corrective actions can be takenB)Facility maintains on a daily basis a log of those residents identified to be at risk. This log is reviewed every morning with the IDT and communicated to direct care staff via the 24 hour report for shift to shift assessments and documentation review. Please note that the SBAR documentation presented to the surveyors, at the time of survey, is part of the medical record. The same was communicated to surveyors by the DNS.C) Through the admission process and the 24 hour report process the facility will identify those residents that show new signs and symptoms and or change of condition. Residents will be</p>	02/29/2012			

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	<p>harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>1.) Resident F's closed clinical record was reviewed 2/1/12 at 2:45 p.m.</p> <p>Resident F's diagnoses included, but were not limited to, Alzheimer's disease, status post hip fracture and anxiety.</p> <p>Resident F had an order for full code status (initiate life sustaining measures including CPR) upon admission on 11/11/11 which continued to be in place until his discharge to the hospital on 11/25/11.</p> <p>Resident F had an 11/25/11, 2:00 p.m., "Resident Progress Note" late entry for 12:00 p.m. (noon) which indicated the Resident had been up in his wheelchair and had become unresponsive to voice and touch. His pupils were dilated and sluggish. His vital signs were: temperature 98.6, blood pressure 97/73, heart rate 90, irregular pulse-weak, respirations 24-30, lungs course rattle noted when laid flat. Nonbreather (facial mask means to administer oxygen) on at 10 liters for 10 minutes to increase</p>		<p>reviewed during regularily scheduled department manager meetings per the ED, DNS, and Unit Managers. Re-education of licensed nursing staff occurred on 2-1-2012 and 2-2-2012 on nursing standards, timely accurate documentation, and physician notification, following physician's orders, as well as timely and appropriate transfers to the hospital. Audits will be conducted by DNS/designee three times weekly on clinical documentation, change of condition and physician notification, to include all three shifts. Audits will continue for 6 months then decrease to weekly reviews per DNS/designeeD) Monitoring of this plan of correction will be the responsibility of the Director of Nursing and Unit Managers with ED oversight. Auditing will continue for 12 months and or until the Performance Improvement committee recommends discontinuation of the monitoring. Any deviation from the above plan will be immediately reported to the Regional Director of Operations.E) DOC- 2-29-2012</p>		

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	<p>oxygen saturation. Oxygen saturation at 91%.</p> <p>Resident F had an 11/25/11, 12:45 p.m., "SBAR-(a tool used by nursing to notify physicians of resident condition change) Physician/NP/PA Communication and Progress Note For New Symptoms, Signs, and Other Changes in Condition" which indicated the following: "The symptoms/sign/change I'm calling about is [change] of condition, [change] in mental status This started 12 noon This has gotten worse... lethargic... Recommended IV fluids Monitor vital signs and observe Change in current orders hold BP [blood pressure] medications Reported to [name] NP [nurse practitioner]. ... [no time listed] several attempts made @ IV access, [by facility staff] unsuccessful. Added to this same tool was a 3:00 p.m. note which indicated called [name] @ IV Access, [a interventions therapy service agency] arrival pending."</p> <p>Resident F had a 11/25/11, Physician's order for: 1.) 1/2 normal saline at 50 ccs an hour for</p>						

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	<p>12 hours of intravenous therapy.</p> <p>2.) Hold blood pressure medication for 24 hours</p> <p>3.) Nonrebreather oxygen administration, keep saturations greater than 90%. These orders were consistent with the 12:45 p.m., SBAR-physician notification notes.</p> <p>Resident F's clinical record contained a total of five entries regarding the resident condition following the 11/25/11, 2:00 p.m. entry. The record lacked documentation of any complete vital signs assessment from 12:00 p.m. through and including 6:25 p.m., when the resident coded and was sent to the hospital via EMT. Resident progress notes were as follows.</p> <p>a.) 11/25/11, 4:00 p.m. (4 hours following onset of condition change) indicated "Res [Resident] lethargic, check O2 [oxygen] sat 90%. Unresponsive to voice, responsive to touch..." The entry lacked a complete thorough assessment of the resident's condition and lacked a vital signs assessment of the resident. The entry did not address the inability to provide IV therapy nor was there an assessment of the lack of IV fluids on the resident's condition.</p> <p>b.) 11/25/11, 5:30 p.m. (1 and 1/2 hours</p>						

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	<p>following the above entry) which indicated the resident continues to be lethargic and unresponsive to voice, the oxygen saturation was 88-90% with oxygen being administered at 10 liters. The nurse had spoken to IV Access and a nurse was in route to insert a midline intravenous port. The entry lacked a complete and thorough assessment of the resident's condition, lacked a vital sign assessment of the resident and did not assess the resident's condition with the delay of IV fluid therapy.</p> <p>c.) 11/25/11, 6:10 p.m., (40 minutes following the above entry) indicated the CNA (certified nursing assistant) called the writer to the room concerning the inability to obtain blood pressure. The oxygen saturation level was 78-80%. The resident was cold to the touch. The nurse was unable to obtain a pulse. Pulse oxymeter had pulse of 32. Respirations were 6 per minute. Doctor's office notified and an order was given to send the resident out to the hospital. When the nurse returned to the room, the resident had no pulse and not respirations CPR (cardio- pulmonary resuscitation) was started and 911 called.</p> <p>d.) 11/25/11, 6:20 p.m. (4 hours and 20 minutes after the 2:00 p.m. proceeding entry).-This entry was made by the nurse</p>			
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	<p>who came to place the IV midline for hydration therapy. "...Resident's condition deteriorated after being placed in bed. Nurse talked [with] dtr [daughter] resident to be sent out."</p> <p>e.) 11/25/11, 6:25 p.m., EMTs arrived and took over CPR.</p> <p>During a 2/2/12, 8:15 a.m., interview the Director of Nursing indicated Resident F died on 11/25/11.</p> <p>On 2/2/12 at 8:10 a.m., the Director of Nursing and Administrator provides one set of vital signs from the Nursing 24 hour report sheet, which was identified as not being a part of the clinical record. The vital signs lacked a time taken and indicated only 11/25/11 evening. The vital signs were as follows: Blood pressure 94/60, heart rate 84, respirations 22, temperature 98.4, oxygen saturation 90-92%. This information was not signed.</p> <p>During interview on 2/2/12 at 11:45 a.m., Unit Manager #2 indicated evening nursing shift was 2:30 p.m. to 11:00 p.m.</p> <p>During interview on 2/2/12 at 8:10 a.m., The Director of Nursing indicated the facility did not have any additional documentation regarding the monitoring</p>						

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	<p>of Resident F's 11/25/11 condition during the period of time from 12:00 p.m. to 6:25 p.m. She indicated the SBAR-physician notification tool was not a part of the resident's clinical record but could be added if chosen to be. She indicated she believed the resident had been assessed during this period, but had no means to identify if the resident remained the same or his condition deteriorated during the time.</p> <p>The immediate jeopardy that began on 11/25/11 was removed on 2/3/12 at 2:30 p.m., when the facility</p> <p>a.) evaluated all residents for the need for services following a significant change of condition.</p> <p>b.) educated all licensed nursing personal regarding the assessment of residents with a significant change of condition, the provision of monitoring of residents with changes in condition and following physician's orders</p> <p>c.) educated all Certified Nursing Aides regarding the notification of the charge nurse regarding the change of condition of any resident, but the noncompliance remained at the lower scope and severity level of isolated, potential for more than minimal harm that is not immediate jeopardy because sufficient time had not elapsed to allow the facility to monitor their quality assurance for monitoring</p>						

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	<p>residents with a significant change of condition and following physician's orders following a significant change in condition.</p> <p>This Federal tag related to complaint number IN00103116.</p> <p>3.1-37(a)</p>			
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