

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2015
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F000000	<p>This visit was for the Investigation of Complaint IN00165440.</p> <p>Complaint IN00165440- Substantiated. Federal/State deficiencies related to the allegation are cited at F 157, F 314, and F 514.</p> <p>Survey dates: February 17 & 18, 2015</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payer type: Medicare: 23 Medicaid: 36 Other: 11 Total: 70</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F000000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the February 18, 2015 Complaint Survey that was conducted at Hammond Whiting Care Center.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community.</p> <p>The Plan of Correction submitted on March 6, 2015 serves as our allegation of</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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F000157 SS=D	<p>16.2-3.1.</p> <p>Quality review completed on February 22, 2015, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the</p>		<p>compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.</p> <p>Respectfully,</p> <p>Kimberly M. Ready, HFA Executive Director</p>		

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	<p>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 record review and interview, the facility failed to ensure the resident's Physician and Responsible Party were notified of the development of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers in the sample of 7. (Resident #F)</p> <p>Finding includes:</p> <p>The closed record for Resident #F was reviewed on 2/17/15 at 9:10 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, major depression, gout, cardiac pacemaker, chronic obstructive pulmonary disease, and dementia with delusions.</p> <p>Review of the 2/2015 Physician Order Statement (POS) indicated there were orders to apply Vasolex ointment to both heels three times a day, apply Ammonium Lactate 12% lotion topically to the feet twice daily, and to off load the</p>	F000157	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #F no longer resides at the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>A full facility skin sweep was completed on 2/10/2015. Physician and family notification provided for any issues identified along with ensuring proper documentation and follow up per facility policy.</p> <p>Involved nurses were provided individual education regarding timely assessment, physician/family notification, and necessary documentation in accordance with facility policy</p>	03/09/2015			

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	<p>resident's heels when in bed. There were no further orders for any other treatments to any open areas, pressure ulcers, or blisters to the heels obtained between 2/1/15 and 2/8/15.</p> <p>The 2/2015 Nursing Progress Notes were reviewed. The 2/7/15 entries were reviewed. There was no documentation of the development of any blisters or pressure ulcers to the resident's left heel. There were two entries made on 2/8/15. The first entry was made at 7:44 a.m. This entry indicated the resident slept well without any complaints. There was no documentation of the development of any blisters or pressure ulcers to the resident's left heel.</p> <p>The next entry was made at 10:16 p.m. This entry indicated the resident was sent out to the hospital. There was no documentation of the development of any blisters or pressure ulcers to the resident's left heel. There were no SBAR (Change in Condition) Notes related to the presence of blisters or pressure ulcers to the resident's heels. There was no documentation of the resident's family or Responsible Party being notified of any pressure ulcer or blisters.</p> <p>The 2/2015 Hospital records were reviewed. An entry was made by the</p>		<p>related to wound care documentation.</p> <p>Social Service performed an abuse audit with alert and oriented residents on the unit with no issues identified with care and/or staff members. In addition, resident observations were completed with non-interviewable residents on the unit with any issues identified addressed as needed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed nursing staff will be educated by DON and/or designee by March 8, 2015 on timely and proper notification to family and physician along with conveying pertinent information relating to resident care via the 24-hour report and nursing documentation, so oncoming licensed nursing staff are aware of any significant change in condition. In addition, nursing staff will be educated by DON and/or designee by March 8, 2015 on completing shower/skin check sheets as per facility policy. Lastly, nursing staff was educated by DON and/or designee by March 8, 2015 of Medical Record Documentation and Falsification Prevention.</p>				

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	<p>Emergency Room RN on 2/8/15 at 8:30 p.m. This entry indicated the resident arrived to the hospital Emergency Room on 2/8/15 from a nursing home. The resident's temperature was 102.4 and his skin was hot to touch. An unstageable (a wound with full thickness tissue loss in which the base of the ulcer was covered by slough and/or eschar in the ulcer bed) wound to the left heel was noted with eschar (thick leathery necrotic or devitalized tissue, frequently black or brown in color) present. Gauze removed from the left foot had a date of 2/7/15 and a "smiley face" written on it. The dressing was adhered to the skin with minimal bleeding noted. The foot was soaked to remove the bandage. The wound to the left heel measured about 4 cm (centimeters) in length and was unstageable. The 2/11/15 Infectious Disease Physician Progress Note indicated the resident was admitted with an infected eschar area and cellulitis (redness to the skin) to the left heel.</p> <p>When interviewed on 2/17/15 at 12:55 p.m., the Wound Nurse indicated she first observed an area to Resident #F's left heel on 2/7/15 during the Evening shift. The Wound Nurse indicated she was working as a floor Nurse on another unit and Resident #F's Nurse called her over to look at the new area to this left heel</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The process change for conveying significant change of condition relating to resident care via the 24-hour report along with updating the care directive and plan of care as necessary will be ongoing with revisions made as required. In addition, nursing administration will perform a weekly audit for the next 6 months on a minimum of 5 residents to ensure weekly skin checks are completed, along with proper documentation and follow up as per facility policy. Lastly, nursing administration will continue to monitor for physician/family notification during the Change of Condition meeting. This meeting occurs Monday through Friday with oversight on Saturday and Sunday. Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>The Wound Nurse indicated the Nurse informed her a CNA had found the area. The Wound Nurse indicated the area appeared as an opened dark purple blister staged as "Unstageable." The Wound Nurse indicated she wrapped the area with Kerlix and signed the date of 2/7/15 on the Kerlix bandage and informed the Nurse to measure and assess the wound and notify the Physician and Family.</p> <p>When interviewed on 2/17/15 at 1:25 p.m., the facility Administrator indicated she was first made aware the resident had an ulcer to the left heel on 2/9/15 when the family voiced concerns about the heel pressure ulcer to her. The Administrator indicated the resident had been sent out to the hospital on 2/8/15 in the evening. The Administrator indicated the Nurse who provided care for the resident on 2/7/15 was interviewed and indicated she had been aware of the area on 2/7/15 and paged the Physician. There was no return call from the Physician. The Administrator indicated the Nurse did not pass the information of the new pressure ulcer and no return call from the Physician onto the next shift. The Nurse also indicated she had not notified the resident's family either.</p> <p>The facility policy titled "Changes in Resident's Condition or Status" was</p>				

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F000314 SS=G	<p>reviewed on 2/17/15 at 9:06 a.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated Nursing staff were responsible for notifying the Physician when there were significant changes in the resident's physical condition or a need to alter the resident's treatment or medications.</p> <p>This Federal tag relates to Complaint IN00165440.</p> <p>3.1-5(a)(3)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 provide the necessary treatment and services for a pressure ulcer related to the failure to complete weekly skin assessments, failure to assessment a pressure ulcer at the time it was first observed, failure to notify the</p>	F000314	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #F no longer resides at</p>	03/09/2015			

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	<p>Physician of the ulcer, and failure to provide on going treatment to the unstageable pressure ulcer for 1 of 3 residents reviewed for pressure ulcers in the sample of 7. (Resident #F)</p> <p>Finding includes:</p> <p>The closed record for Resident #F was reviewed on 2/17/15 at 9:10 a.m. The residents diagnoses included, but were not limited to, high blood pressure, major depression, gout, cardiac pacemaker chronic obstructive pulmonary disease, and dementia with delusions. The resident was sent to the hospital Emergency Room on 2/8/15 and was then admitted to the hospital</p> <p>A Braden Scale for predicting the risk of pressure ulcer development was completed on 11/28/14. The resident's score was (16). A score of (16) indicated the resident was at risk for the development of pressure ulcers.</p> <p>The 12/23/14 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief interview for Mental Status) score was (5). A score of (5) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of two staff</p>		<p>the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>A full facility skin sweep was completed on 2/10/2015. Physician and family notification provided for any issues identified along with ensuring proper documentation and follow up per facility policy.</p> <p>Involved nurses were provided individual education regarding timely assessment, physician/family notification, and necessary documentation in accordance with facility policy related to wound care documentation.</p> <p>Social Service performed an abuse audit with alert and oriented residents on the unit with no issues identified with care and/or staff members. In addition, resident observations were completed with non-interviewable residents on the unit with any issues identified addressed as needed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>				

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	<p>members for bed mobility, transfers, and personal hygiene. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one staff member for dressing. The assessment indicated the resident was at risk for the development of pressure ulcers and had no current pressure ulcers.</p> <p>A Care Plan initiated on 11/7/14 indicated the resident was at risk for the development of pressure ulcers. Care Plan interventions included for staff to complete weekly skin assessments, off load the resident's heels when in bed, and notify the Nurse immediately of any new skin areas noted.</p> <p>Review of the 2/2015 Physician Order Statement (POS) indicated there were orders to apply Vasolex ointment to both heels three times a day, apply Ammonium Lactate 12% lotion topically to the the feet twice daily, and to off load the resident's heels when in bed. There were no further orders for any other treatments to any open areas, pressure ulcers, or blisters to the heels obtained between 2/1/15 and 2/8/15.</p> <p>The 2/2015 Nursing Progress Notes were reviewed. The 2/7/15 entries were reviewed. There was no documentation</p>		<p>Licensed nursing staff will be educated by DON and/or designee by March 8, 2015 on timely and proper notification to family and physician along with conveying pertinent information relating to resident care via the 24-hour report and nursing documentation, so oncoming licensed nursing staff are aware of any significant change in condition. In addition, nursing staff will be educated by DON and/or designee by March 8, 2015 on completing shower/skin check sheets as per facility policy. Lastly, nursing staff was educated by DON and/or designee by March 8, 2015 of Medical Record Documentation and Falsification Prevention.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The process change for conveying significant change of condition relating to resident care via the 24-hour report along with updating the care directive and plan of care as necessary will be ongoing with revisions made as required. In addition, nursing administration will perform a weekly audit for the next 6 months on a minimum of 5 residents to ensure weekly skin checks are completed, along with proper documentation and follow up as per facility policy. Lastly,</p>				

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	<p>of the development of any blisters or pressure ulcers to the resident's left heel. There were two entries made on 2/8/15. The first entry was made at 7:44 a.m. This entry indicated the resident slept well without any complaints. There was no documentation of the development of any blisters or pressure ulcers to the resident's left heel. The next entry was made at 10:16 p.m. This entry indicated the resident was sent out to the hospital. There was no documentation of the development of any blisters or pressure ulcers to the resident's left heel. There were no SBAR (Change in Condition) Notes related to the presence of blisters or pressure ulcers to the resident's heels.</p> <p>The Weekly Skin Integrity sheets were reviewed. The most recent sheet available was dated 1/30/15. The sheet indicated the resident's skin was intact. The sheet was signed by a CNA. There was a line for the Nurse's signature on the form. There was no Nursing signature on this sheet.</p> <p>The 2/2015 Hospital records were reviewed. An entry was made by the Emergency Room RN on 2/8/15 at 8:30 p.m. This entry indicated the resident arrived to the hospital Emergency Room on 2/8/15 from a nursing home. The resident's temperature was 102.4 and his</p>		nursing administration will continue to monitor for physician/family notification during the Change of Condition meeting. This meeting occurs Monday through Friday with oversight on Saturday and Sunday. Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.		

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	<p>skin was hot to touch. An unstageable (a wound with full thickness tissue loss in which the base of the ulcer was covered by slough and/or eschar in the ulcer bed) wound to the left heel was noted with eschar (thick leathery necrotic or devitalized tissue, frequently black or brown in color) present. Gauze removed from the left foot had a date of 2/7/15 and a "smiley face" written on it. The dressing was adhered to the skin with minimal bleeding noted. The foot was soaked to remove the bandage. The wound to the left heel measured about 4 cm (centimeters) in length and was unstageable. The 2/11/15 Infectious Disease Physician Progress Note indicated the resident was admitted with an infected eschar area and cellulitis(redness to the skin) to the left heel.</p> <p>The 2/8/15 7:26 p.m. Emergency Room Physician notes indicated the resident was brought to the Emergency Room via EMS (Emergency Medical Services) from a Nursing Home with reported wheezing. The Physician's notes indicated Silvadene was applied to the left heel ulcer. The resident's diagnoses included left heel ulcer and bilateral pneumonia.</p> <p>When interviewed on 2/17/15 at 12:55</p>				

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	<p>p.m., the Wound Nurse indicated she first observed an area to Resident #F's left heel on 2/7/15 during the Evening shift. The Wound Nurse indicated she was working as a floor Nurse on another unit and Resident #F's Nurse called her over to look at the new area to his left heel. The Wound Nurse indicated the Nurse informed her a CNA had found the area. The Wound Nurse indicated the area appeared as an opened dark purple blister staged as "Unstageable." The Wound Nurse indicated she wrapped the area in Kerlix and signed the date of 2/7/15 on the Kerlix bandage and informed the Nurse to measure and assess the wound and notify the Physician and Family.</p> <p>When interviewed on 2/17/15 at 1:25 p.m., the facility Administrator indicated she was first made aware the resident had an ulcer to the left heel on 2/9/15 when the family voiced concerns about the heel pressure ulcer to her. The Administrator indicated the resident had been sent out to the hospital on 2/8/15 in the evening. The Administrator indicated the Nurse who provided care for the resident on 2/7/15 was interviewed and indicated she had been aware of the area on 2/7/15 and paged the Physician. There was no return call from the Physician. The Administrator indicated the Nurse did not pass the information of the new pressure</p>				

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	<p>ulcer and no return call from the Physician onto the next shift.</p> <p>When interviewed on 2/18/15 at 10:25 a.m., the facility Administrator indicated the above Nurse should have assessed the ulcer, notified the Physician and family, completed an ulcer assessment form, and documented all of the above in the resident's record. The Administrator indicated other staff providing care for the Resident indicated they had no knowledge of the resident having an ulcer to the area. The Administrator indicated there was no weekly skin check after 1/30/15 and the 1/30/15 skin check sheet should have been signed by the Nurse also.</p> <p>The facility titled "Skin Program Policy" was reviewed on 2/18/15 at 11:00 a.m. The policy had a revised date of 7/2008. The facility Administrator provided the policy and indicated the policy was current. The policy indicated all residents were to have a Weekly Skin Integrity checks performed by licensed staff. The policy also indicated documentation, reporting, and treatment of skin injuries were to be completed upon the occurrence.</p> <p>This Federal tag relates to Complaint IN00165440.</p>			

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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394			
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F000514 SS=D	<p>3.1-40(a)(2) 3.1-40(a)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to ensure Nebulizer Treatment Documentation Records were completed for 3 of 3 residents reviewed for Nebulizer treatments in the sample of 7. (Residents #F, #H, and #J)</p> <p>Findings include:</p> <p>1. The record for Resident #J was reviewed on 2/17/15 at 1:40 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, high blood pressure, and dementia.</p>	F000514	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #F no longer resides at the facility. Nebulizer Treatment Documentation Records were placed in the medical record for Resident #H and #J.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p>	03/09/2015			

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	<p>The 2/2015 Physician orders were reviewed. An order was written on 2/11/15 for the resident to receive Nebulizer treatment of Proventil (a medication to treat asthma) 2.5 milligrams four times a day for two weeks.</p> <p>Review of the 2/2015 Medication Administration Record indicated the Nebulizer treatments were signed out as administrated as ordered on 2/11/15 through 2/17/15.</p> <p>A Nebulizer Treatment Documentation Record for Resident #J was reviewed. The Nebulizer Treatment Documentation Record indicated the resident's pulse rate, respiratory rate, documentation of the resident's lung sounds and sputum were to be documented pre and post the administration of each nebulizer treatment. The only entry on the sheet was made on 2/17/15 at 8:00 a.m.</p> <p>When interviewed on 2/17/15 at 12:40 p.m., LPN #3 indicated the resident was due to receive a nebulizer treatment. The LPN indicated there was no Nebulizer Treatment Documentation Record in the Medication Administration Book for the resident. The LPN indicated the sheet should have been present as an entry</p>		<p>A full facility audit to validate the Nebulizer Treatment Documentation Record was in place for all appropriate residents was completed on 2/17/2015. Any identified issues were immediately addressed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed nursing staff will be educated by the DON and/or designee by March 8, 2015 on appropriately filling out and completing the Nebulizer Treatment Documentation Record along with pre/post assessments prior to resident receiving a nebulizer treatment.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Nursing administration will perform a weekly audit for the next 6 months on a minimum of 5 residents to ensure the Nebulizer Treatment Documentation Record is appropriately filled out and completed pre/post assessment of nebulizer treatments. Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA</p>				

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	<p>needed to be made each time a Nebulizer treatment was given.</p> <p>2. The record for Resident #H was reviewed on 2/18/15 at 8:11 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, seizures, and hemiplegia.</p> <p>The 2/11/15 admission Physician orders were reviewed. There was an order for the resident to receive Albuterol-Iprotromide (medication to treat asthma) 2.5-0.5 milligrams/3 ml (millimeters) via a nebulizer every 4 hours.</p> <p>Review of the 2/2015 Medication Administration Record indicated the resident received the nebulizer treatments at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. 2/11/15 through 2/17/15. The 12:00 a.m. and 4:00 a.m. doses were circled as not given.</p> <p>Review of the Nebulizer Treatment Documentation Record indicated indicated the resident's pulse rate, respiratory rate, documentation of the resident's lung sounds and sputum was to be documented pre and post the administration of each nebulizer treatment. There was only one entry made on 2/17/15 at 12:30 p.m.</p>		Committee with subsequent plans of correction developed and implemented as deemed necessary.				

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	<p>3. The closed record for Resident #F was reviewed on 2/17/15 at 9:10 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, high blood pressure, atrial fibrillation (an irregular hear rate), and gout.</p> <p>The 2/2015 Physician orders were reviewed. An order was written on 2/7/15 for the resident to receive Albuterol (a medication to treat asthma) 0.83 % nebulizer treatments four times a day as needed. The 2/015 Medication Administration Record indicated the Albuterol nebulizer treatment was signed out as given only one time on 2/8/15 (no time listed). There were no Nebulizer Treatment Documentation Records available for February 2015.</p> <p>The 2/2015 Nursing Progress Notes were reviewed. The only entry made on 2/7/15 was completed at 11:13 p.m. This entry indicated there was a new order for nebulizer treatments to be given for wheezing, the resident was in no distress, and the family was made aware.</p> <p>When interviewed on 2/17/15 at 10:30 a.m. , RN #1 indicated she obtained the Physician's order on 2/7/15 and administered a treatment to the resident later in the evening at approximately</p>			
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	<p>10:30 p.m. or 11:00 p.m. The RN indicated she did not sign the treatment out on the resident's Medication Administration Record. The RN also indicated she did not complete any Nebulizer Treatment records related to the above nebulizer treatment.</p> <p>When interviewed on 2/18/15 at 10:25 a.m., the facility Administrator indicated there were no additional Nebulizer Treatment Documentation Records available for the above three residents. The Administrator indicated an entry was to be completed when each nebulizer was administered.</p> <p>The facility policy titled "Respiratory Care Services Policy & Procedure- Hand Held Nebulizer -Aerosolized Medication Administration" was reviewed on 2/17/15 at 1:55 p.m. There was no date on the policy. The Administrator provided the policy and indicated the policy was current. The policy indicated staff were to obtain a complete set of vitals, auscultation of the lungs, respiratory rate and quality and pulse oximetry and then administer the treatment. The policy also indicated a final set of vitals, auscultation of the lungs, cough effort, and any adverse effects were to be documented.</p>						

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