

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER ALEXANDRIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 S PARK AVE ALEXANDRIA, IN 46001
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F000000	<p>This visit was for the Investigation of Complaint IN00131305.</p> <p>Complaint IN00131305 - Substantiated - Federal deficiencies related to allegation are cited at F157, F315, F328 and F514.</p> <p>Survey dates: June 26 and June 27, 2013</p> <p>Facility number: 000518 Provider number: 155521 AIM number: 100266670</p> <p>Survey team: Shelley Reed, RN TC Betty Retherford, RN Karen Koeberlein, RN (June 27, 2013)</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 4 Medicaid: 44 Other: 9 Total: 57</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p>	F000000		
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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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F000157 SS=E	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was contacted when there was a change in resident condition and/or a decline in health noted for 3 of 6 residents reviewed</p>	F000157	<p>1. The physicians of Resident's #C,D and E have been notified of the residents' current condition.2. All residents have the potential to be affected. All nurses' notes for all residents for the last 30 days</p>	07/12/2013			

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	<p>for physician notification of condition changes in a sample of 6. (Resident #'s C, D, and E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #E was reviewed on 6/26/13 at 10 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, Dementia, history of urinary tract infection, weakness, and hypertension.</p> <p>A quarterly minimum data set (MDS) assessment, dated 6/7/13, indicated Resident #E was severely cognitively impaired and required the assistance of the staff for transfers and toileting.</p> <p>A health care plan problem, dated 6/4/13, indicated Resident #E had a problem with incontinence and was at risk for infection and other health problems. Two of the approaches for this problem were for the staff to monitor for signs and symptoms of infection which included, but were not limited to, pain, foul smelling urine and elevated temperature and notify the charge nurse of any problems for further evaluation and possible doctor and responsible party notification.</p> <p>A nursing note, dated 6/5/13 at 4:45 a.m.,</p>		<p>have been reviewed to ensure physicians have been notified of significant change in condition, as warranted.3. The facility policy and procedure for Notification of Changes has been reviewed and no revisions have been made. (See Attachments #1A and 1B) The nurses have been re-educated on the policy and procedure. (See Attachment #2)4. The DON or her designee will monitor nurses notes and 24 hour reports daily on scheduled days of work to ensure that physicians have been notified, if warranted, daily for 2 weeks, then two times a week until compliance is maintained for 6 consecutive months. (See Attachment #3) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility' quarterly QA meetings and the plan adjusted accordingly, if warranted.</p>				

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	<p>indicated the resident had been medicated twice during that shift for complaints of pain. The note indicated the resident complained of "severe burning with urination" and was awake most of the night. The urine was noted to be "dark yellow" in the toilet. The note indicated "will alert 6-2 [6 a.m. to 2 p.m. shift] to contact doctor for further instructions."</p> <p>The next nursing note was dated 6/5/13 at 11:25 p.m. and indicated the resident complained of pain and "burning" and "hurting" during urination. The note indicated the urine was light yellow and cloudy with sediment. The note indicated the resident's temperature was 99 axillary and pain medication had been given. The note indicated a new order was received at 11:25 p.m. for the resident to have a urinalysis and culture and sensitivity lab test done.</p> <p>This indicated a time period of 18 hours and 30 minutes from the time the resident complained of severe burning upon urination until the doctor was made aware of the resident's discomfort and possible urinary tract infection symptoms.</p> <p>During an interview with the Administrator and Director of Nursing on 6/27/13 at 12:10 p.m., additional information was requested related to the</p>						

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	<p>lack of timely physician notification of the resident's complaints of pain and severe burning during urination on 6/5/13 at 4:45 a.m.</p> <p>During an interview on 6/27/13 at 2:45 p.m., the Consultant RN indicated the facility had no information to provide related to physician notification of the resident's urinary complaints prior to 6/5/13 at 11:25 p.m. as noted previously.</p> <p>2. The clinical record for Resident (C) was reviewed on 6/26/13 at 1:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, anxiety, diabetes mellitus type 2, hyperlipidemia, depression and chronic obstructive pulmonary disease.</p> <p>During record review, a "late entry" nursing note, dated 6/18/13 at 11:45 p.m., indicated a CNA reported to LPN #4 that Resident (C) complained of shortness of breath. On assessment, LPN #4 indicated Resident (C) had audible wheezes on inspiration and expiration. Respirations were 36 breaths per minutes and oxygen saturation was 79% on room air. LPN #4 applied 2 LPM (liters per minute) and gave a DuoNeb (a medication used to open the airway) treatment at 11:07 p.m. LPN #4 reported to 3rd shift nurse RN #8</p>			

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	<p>Resident (C)'s assessment. Resident (C) remained anxious, crying and sweat was noted to her upper body and face. At 11:12 p.m., following the DuoNeb treatment, audible wheezes were still present and oxygen saturation was 97% on 2 LPM (liters per minute). LPN #4 reported post assessment to RN#8.</p> <p>A nursing note, dated 6/18/13 at 11:30 p.m., indicated Xanax (a medication to treat anxiety) was given to assist Resident (C) by RN #8.</p> <p>At 3:30 a.m. on 6/19/13, Resident (C) complained of respiratory distress. Audible expiratory wheezes were heard. A second nebulizer treatment was given to assist with breathing and a cold wash cloth was applied to the resident's forehead by RN #8.</p> <p>At 6:00 a.m., Resident (C) complained of respiratory distress. Report was given to LPN #6 who had just arrived. LPN #6 did an assessment and called an ambulance to transport Resident (C) to the emergency room.</p> <p>A second nursing note, at 6:00 a.m. on 6/19/13, indicated Resident (C) was yelling for "help" and was complaining of shortness of breath. Respiratory therapy provided a nebulizer treatment and</p>			

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	<p>increased her oxygen to 4 LPM (liters per minute). Resident (C)'s respiratory rate was 48 breaths per minutes and oxygen saturation was 96%.</p> <p>A phone call was then placed to the Power of Attorney (POA) and a message was left for the ADoN. Resident (C) was a full code status and she was transported to the local emergency room at 6:45 a.m.</p> <p>During an interview on 6/26/13 at 2:40 p.m., LPN #4 indicated she had already given report and turned in her keys and was finishing charting when she was called to Resident (C)'s room by the CNA. She indicated she provided an assessment, applied oxygen and started the nebulizer treatment. She indicated she reported to RN#8 the pre and post status of the resident. She indicated she had to go get keys to open the medication cart to start the nebulizer treatment because she was not still on duty. She indicated she did not notify the physician.</p> <p>During an interview on 6/26/13 at 2:40 p.m., LPN #6 indicated she was the day nurse who came on duty 6/19/13. She indicated Resident (C) was pale in color, short of breath and had increased respirations. She indicated she initially started the paperwork to send the resident to the hospital. She indicated she did not</p>			

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	<p>notify the physician.</p> <p>Resident (C) was admitted to the local hospital on 6/19/13 with hypoxemic respiratory failure and myocardial infarction. Resident (C) was readmitted to the facility on 6/24/13 on hospice care.</p> <p>During an interview on 6/27/13 at 8:30 a.m., RN #8 indicated the resident was fine when she arrived and received report. She indicated she was also covering the Memory Care Center and was receiving report in the back when she was notified of Resident (C)'s change of condition. She indicated she did not notify the physician of the change of condition. She indicated she gave the resident Xanax to help calm her down and continued to monitor her.</p> <p>3. The clinical record for Resident (D) was reviewed on 6/26/13 at 10:15 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, debility, hypertension, hyperlipidemia, dementia and Alzheimer's disease.</p> <p>The Minimum Data Set (MDS) assessment, dated 4/26/13, indicated Resident (D) was unable to complete the Brief Interview Mental Status (BIMS). Resident (D) received the following</p>				

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	<p>Activities of Daily Living (ADL) assistance; transfer-extensive assistance with one person physical help from staff, ambulation-independent with no assistance, dressing-limited assistance with one person physical assist, hygiene and bathing-extensive assistance with one person physical assist, bowel-always continent and bladder-occasionally incontinent.</p> <p>During record review, a nursing note dated 6/17/13 at 7:50 p.m., indicated Resident (D) fell in the hall and hit his head on the side rail. A fall report was completed and neurological assessments were initiated.</p> <p>A nursing note, dated 6/17/13 at 9:45 p.m., indicated the family, DoN and physician were notified of the fall and a laceration to Resident (D)'s forehead, requiring Steri Strips and dressing to be applied.</p> <p>A nursing note, dated 6/18/13 at 1:15 a.m., indicated Resident (D) was unstable, required assistance with walking with one person assist.</p> <p>A nursing note, dated 6/18/13 at 3:30 p.m., indicated Resident (D) was assisted to the dining room, gait unsteady. The 4:00 p.m. Seroquel (a medication used to</p>				

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	<p>treat depression) and Tramadol (a medication used to treat moderate to severe pain) were held due to lethargy.</p> <p>A neurological assessment flowsheet with a dated entry on 6/18/13 at 2:30 a.m. and 11:30 a.m. indicated Resident (D)'s pupil response was [s] for sluggish.</p> <p>A nursing note, dated 6/18/13 at 5:30 p.m., indicated Resident (D)'s gait remained unsteady and he was softly mumbling to himself when asked about pain or discomfort.</p> <p>A nursing note, dated 6/18/13 at 7:30 p.m., indicated Resident (D) was having difficulty standing and ambulating with staff assistance. Resident remained confused and resistant to care and easily agitated.</p> <p>A "late entry," dated 6/18/13 at 7:30 p.m., indicated the physician was notified of the assessment related to lethargy, fixed and pinpoint size pupils and unable to follow commands. Physician gave an order for Resident (D) to be sent to the local hospital for evaluation and treatment. Resident (D) returned to the facility on 6/19/13 at 1:00 a.m.</p> <p>During an interview on 6/27/13 at 8:34 a.m., the ADoN indicated if a resident has</p>			

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	<p>a change of condition, staff are to call the physician on call and notify them of their concern. The staff are also to notify the nurse manager on duty and the family.</p> <p>Review of the current facility policy, dated 1/06, provided by the Administrator on 6/27/13 at 8:00 a.m., titled "Physician & family notification procedure", included, but was not limited to, the following:</p> <p>"Telephone:</p> <ol style="list-style-type: none"> 1. Telephone notification is required for all emergencies or all condition changes that require an immediate response. 2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan. 3. Notify the primary physician during regular office hours and the on-call or alternate physician during closed office hours or when the physician is not available. 4. Document the information reported to the physician in the nurses notes including the time and date of notification. Be thorough and explicit. 5. Document the response from the 						

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	<p>physician in the nurses notes."</p> <p>This federal tag relates to complaint number IN00131305.</p> <p>3.1-5(a)(2)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure the nursing staff monitored and assessed a resident with signs and symptoms of a urinary tract infection in order to treat the resident in a timely manner for 1 of 1 resident reviewed for burning and pain upon urination in a sample of 6. (Resident #E)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #E was reviewed on 6/26/13 at 10 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, Dementia, history of urinary tract infection, weakness, and hypertension.</p> <p>A quarterly minimum data set (MDS) assessment, dated 6/7/13, indicated Resident #E was severely cognitively impaired and required the assistance of</p>	F000315	<p>1. Residnet #E incurred no negative outcome. Residnet #E's physician has been notified of the resident's current condition.2. All residnets have the potential to be affected. All nurses' notes for the last 30 days have been reviewed to ensure appropriate charting and assessment has been completed, as warranted.3. The facility policy and procedure for Nursing Department Charting has been reviewed and no revisions have been made. (See Attachment #4A and 4B) The nurses have been re-educated on the policy and procedure. (See Attachment 2)4. The DON or her designee will monitor all resident nurses notes to ensure that appropriate charting and assessment has been completed on scheduled days of work daily for 2 weeks then two times a week until compliance is maintained for a minimum of 6 consecutive months.(See Attachment #3) Should concerns</p>	07/12/2013			

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	<p>the staff for transfers and toileting.</p> <p>A health care plan problem, dated 6/4/13, indicated Resident #E had a problem with incontinence and was at risk for infection and other health problems. Two of the approaches for this problem were for the staff to monitor for signs and symptoms of infection which included, but were not limited to, pain, foul smelling urine and elevated temperature and notify the charge nurse of any problems for further evaluation and possible doctor and responsible party notification.</p> <p>A nursing note, dated 6/5/13 at 4:45 a.m., indicated the resident had been medicated twice during that shift for complaints of pain. The note indicated the resident complained of "severe burning with urination" and was awake most of the night. The urine was noted to be "dark yellow" in the toilet. The note indicated "will alert 6-2 [6 a.m. to 2 p.m. shift] to contact doctor for further instructions."</p> <p>The next nursing note was dated 6/5/13 at 11:25 p.m. and indicated the resident complained of pain and "burning" and "hurting" during urination. The note indicated the urine was light yellow and cloudy with sediment. The note indicated the resident's temperature was 99 degrees Fahrenheit (F) axillary and pain</p>		<p>be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p>		

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	<p>medication had been given. The note indicated a new order was received at 11:25 p.m. for the resident to have a urinalysis and culture and sensitivity lab test done.</p> <p>This indicated a time period of 18 hours and 30 minutes without any additional vital signs being monitored and/or resident assessment having been completed related to the resident's complaints of burning upon urination and symptoms of a possible urinary tract infection made on 6/5/13 at 4:45 a.m.</p> <p>During an interview with the Administrator and Director of Nursing on 6/27/13 at 12:10 p.m., additional information was requested related to the lack of assessment and monitoring by the nursing staff during the 18 hour and 30 minute time period.</p> <p>During an interview on 6/27/13 at 2:45 p.m., the Consultant RN indicated the facility had no information to provide related to additional nursing assessment and monitoring for the time period noted above.</p> <p>Review of the current facility policy, revised 1/08, provided by the Administrator on 6/27/13 at 8:10 a.m., titled "Nursing Department Charting</p>			

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	<p>Policy and Procedure", included, but was not limited to, the following:</p> <p>"Purpose: To accurately document in an organized manner all pertinent information related to the resident in the nurses' notes....</p> <p>Pertinent Charting:</p> <p>...Any physical or emotional symptom or complaint. Any condition change...</p> <p>Shift charting:</p> <p>Charting each shift will be completed on all residents experiencing a condition change until stable.</p> <p>Supplemental Assessments:</p> <p>Supplemental assessments will be completed on each resident...with significant changes in condition..."</p> <p>This federal tag relates to complaint number IN00131305.</p> <p>3.1-41(a)(2)</p>			

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F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure oxygen liter flow levels were monitored and oxygen saturation levels were obtained as ordered by the physician for 2 of 4 residents reviewed with orders for respiratory services in a sample of 6. (Resident #'s F and B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #F was reviewed on 6/26/13 at 1:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, weakness, dementia, hypertension and dyspnea.</p> <p>A quarterly minimum data set (MDS) assessment, dated 4/22/13, indicated Resident #F was severely cognitively impaired, had problems with shortness of breath, and received respiratory services</p>	F000328	<p>1. Residents # F and B incurred no negative outcomes. The oxygen flow for resident #F was checked and was observed at the prescribed liter of flow. Resident #B's oxygen saturation level was obtained and is within normal limits.2. All residents who receive oxygen therapy have the potential to be affected. All residents who receive oxygen therapy have been observed to ensure the oxygen flow is set at the prescribed amount and oxygen saturation levels have been obtained and documented as ordered.3. The facility policies and procedures for Medication Administration (See Attachments #5A and 5B) and Pulse Oximetry (See Attachment #6A and 6B) have been reviewed and no revisions have been made. The nurses have been re-educated on these policies and procedures. (See Attachment 2)4. The DON or her designee will monitor all residents who receive oxygen to ensure that the litre</p>	07/12/2013			

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	<p>including oxygen therapy.</p> <p>A physician's orders, dated 4/3/13, indicated the resident was to receive oxygen therapy at 2 LPM (liters per minute) per nasal cannula continuously for dyspnea.</p> <p>The June medication administration record (MAR), dated from 6/1/13 through 6/18/13, contained a section to record the monitoring of the resident's oxygen liter flow rate and oxygen saturation levels every shift. The MAR lacked any indication of the oxygen liter flow and/or oxygen saturation levels having been monitored on the night shift (10 p.m. to 6 a.m.) on the following dates:</p> <p>June 1, 2, 3, 7, 11, and 16, 2013.</p> <p>The nursing notes for the night shift on these dates lacked any information related to the resident's oxygen liter flow or saturation levels having been monitored.</p> <p>During an interview with Respiratory Therapist #10 on 6/27/13 at 10:30 a.m., she indicated the respiratory therapy staff did the respiratory treatments during the daytime hours, but did not do any treatments or monitoring on the night shift. She indicated this would be the responsibility of the nursing staff.</p>		<p>flow is set correctly and that the oxygen saturation has been obtained as ordered on the scheduled days of work daily for 2 weeks then two times a week until compliance is maintained for 6 consecutive months. (See Attachment #7) Should concerns be observed, re-education will be provided. The results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p>				

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	<p>During an interview with the Administrator and Director of Nursing on 6/27/13 at 12:10 p.m., additional information was requested related to the lack of monitoring of the resident's oxygen flow rates and saturation levels during the night shift on the dates noted previously.</p> <p>During an interview on 6/27/13 at 2:45 p.m., the Consultant RN indicated the facility had no information to provide related to the lack of monitoring.</p> <p>2. The clinical record for Resident (B) was reviewed on 6/26/13 at 11:20 a.m.</p> <p>Diagnoses for Resident (B) included, but were not limited to, prostate cancer, hypertension, hyperlipidemia, bladder cancer, urinary retention, Foley catheter and chronic obstructive pulmonary disease.</p> <p>Resident (B) had a current physician order for oxygen 1-3 LPM (liters per minute) to be given as needed with a maximum flow of 3 LPM (liters per minute) to keep saturations above 90%. Oxygen saturation was to be monitored once per shift.</p> <p>The clinical record lacked documentation</p>			

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	<p>for oxygen saturation on 6/24/13 for the day and evening shifts.</p> <p>During an interview on 6/26/13 at 2:30 p.m., RRT (Registered Respiratory Therapist) #9 indicated respiratory staff were in the facility from 6:00 a.m. to approximately 5:30 p.m. seven days per week. She indicated the respiratory staff were responsible for monitoring and managing oxygen therapy, oxygen saturations and respiratory treatments while they were in the facility. She indicated the nursing staff were responsible for all care after 5:30 p.m. She indicated she was not sure why the Medication Administration Record (MAR) did not have documentation related to oxygen saturation on the noted days. She indicated only the respiratory staff chart in the computer and nursing staff would chart in the MAR or respiratory book.</p> <p>Review of the current facility policy, revised 8/09, provided by the Administrator on 6/27/13 at 8:00 a.m., titled "Pulse oximetry", included, but was not limited to, the following:</p> <p>"Procedure:</p> <p>1. Check the medical record for a complete order...</p>						

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	<p>10. Document outcome of procedure in the resident's medical record including:</p> <ul style="list-style-type: none"> a. Date and time of procedure b. Results obtained c. FIO2 an type of oxygen delivery device d. Length of monitoring period (if other than single determination)." <p>This federal tag relates to complaint number IN00131305.</p> <p>3.1-47(a)(6)</p>						

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>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 record review and interview, the facility failed to ensure resident assessments were documented in the clinical record in regards to the administration of nebulizer treatments by the respiratory therapy department for 2 of 2 residents reviewed with orders for routine nebulizer treatments in a sample of 6. (Resident #'s F and C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #F was reviewed on 6/26/13 at 1:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, weakness, dementia, hypertension and dyspnea.</p> <p>A quarterly minimum data set (MDS)</p>	F000514	<p>1. Resident #F and C incurred no negative outcome. The clinical records for these residents have been reviewed to ensure proper assessment was completed when administering nebulizer treatments.2. All residents who receive nebulizer treatments have the potential to be affected. The clinical record of these residents has been reviewed to ensure proper assessment was completed with each nebulizer treatment.3. The facility policy and procedure for Hand Held Nebulizer Administration has been reviewed and no revisions were made. (See Attachments #8A, 8B and 8C)The nurses have been re-educated on the policy and procedure. (See Attachment #2). In the future, respiratory staff will make available to nursing staff results of assessments pre and post nebulizer treatment, and</p>	07/12/2013	

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	<p>assessment, dated 4/22/13, indicated Resident #F was severely cognitively impaired, had problems with shortness of breath, and received respiratory services including oxygen therapy.</p> <p>A recapitulation of physician's orders, dated 4/12/13, indicated the resident was to receive Albuterol (a medication given to improve respirations) 0.083% 1 vial of solution via nebulizer treatment twice daily.</p> <p>The June medication administration record (MAR), dated from 6/1/13 through 6/17/13, indicated this treatment was given twice daily during that time period at 7 a.m. and 1 p.m.</p> <p>During an interview with Respiratory Therapist #10 on 6/27/13 at 10:30 a.m., she indicated the respiratory therapy staff provided the respiratory treatments during the daytime hours. She indicated an assessment was done before and after the nebulizer treatment which included, but was not limited to, the resident's heart rate, oxygen saturation level, oxygen liter flow rate, and breath sounds. She indicated this information was recorded into the computer of the respiratory therapy service provider, but was not recorded anywhere in the resident's clinical record.</p>		<p>the same shall be recorded as part of the applicable resident's medical record.4. The DON or her designee will monitor all residents who receive nebulizer treatments to ensure proper assessment was completed with each administration of a nebulizer treatment on scheduled days of work daily for two weeks then two times a week thereafter until compliance is maintained for a minimum of 6 consecutive months. (See Attachment #7) Should concerns be observed, re-education will be provided. The results of the observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>		

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	<p>During an interview on 6/27/13 at 2:45 p.m., the Consultant RN indicated she was unaware that this information was not contained in the clinical record and she was working on a new form for this information.</p> <p>2. The clinical record for Resident (C) was reviewed on 6/26/13 at 1:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, anxiety, diabetes mellitus type 2, hyperlipidemia, depression and chronic obstructive pulmonary disease.</p> <p>Review of Resident (C)'s current Medication Administration Record (MAR), indicated Resident (C) had been receiving DuoNeb (a medication used to open the airway) twice daily since 4/11/13.</p> <p>During an interview with Respiratory Therapist #10 on 6/27/13 at 10:30 a.m., she indicated the respiratory therapy staff provided the respiratory treatments during the daytime hours. She indicated an assessment was done before and after the nebulizer treatment which included, but was not limited to, the resident's heart rate, oxygen saturation level, oxygen liter flow rate, and breath sounds. She</p>				

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	<p>indicated this information was recorded into the computer of the respiratory therapy service provider, but was not recorded anywhere in the resident's clinical record.</p> <p>During an interview on 6/27/13 at 12:15 p.m., the Administrator indicated she was unaware the computer charting by the respiratory department was not part of the resident's clinical record.</p> <p>Review of the current facility policy, revised 8/09, provided by the Administrator on 6/27/13 at 8:00 a.m., titled "Hand Held Nebulizer", included, but was not limited to, the following:</p> <p>"Procedure:</p> <ol style="list-style-type: none"> 1. Review physician's order on the chart for completeness, look for: <ol style="list-style-type: none"> a. Type of medication, diluents (as needed), and dosage... 13. Monitor resident's heart rate, respiratory rate and level of consciousness... 14. Assess the patient's response and effectiveness of therapy by assessing breath sounds... 17. Document therapy in the resident's 			

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	<p>medical record, including:</p> <ul style="list-style-type: none"> a. Date and time of treatment b. Type of therapy c. Type of medication, diluents (as needed) and dosage..." <p>This federal tag relates to complaint number IN00131305.</p> <p>3.1-50(a)(1)</p>				