

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/22/2014
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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaints IN00156224 and IN00156234.</p> <p>Complaint IN00156224 - Substantiated. Federal/State deficiency related to the allegations is cited at F328.</p> <p>Complaint IN00156234 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 18, 19 & 22, 2014</p> <p>Facility number: 001149 Provider number: 155618 AIM number: 200145500</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 36 SNF/NF: 29 Residential: 78 Total: 143</p> <p>Census Payor Type: Medicare: 12 Medicaid: 29 Other: 30</p>	F000000	<p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</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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F000328 SS=D	<p>Total: 65</p> <p>Sample: 4 Residential sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on September 28, 2014.</p> <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>A. Based on record review and interview the facility failed to provide and ensure the necessary care regard to a breathing treatment, in that when a resident who had physician orders for scheduled breathing treatments the licensed nurse failed to attend to the resident while the treatment was in progress, and left the resident's bedside for 1 of 1 closed record reviewed for respiratory care. (Resident</p>	F000328	<p>F 328 SS=D Right to Exercise Rights- Free of Reprisal</p> <p>It is the practice of this center to comply with F-328 SS=D Treatment/Care For Special Needs</p>	10/21/2014			

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	<p>"A").</p> <p>B. Based on observation, record review and interview the facility failed to ensure competency skills of the nursing staff, in that when residents had tracheostomy's, the nursing staff failed to provide the necessary treatment, and perform required skills, procedures and infection control measures in the care of tracheostomy's for 2 of 3 current residents reviewed. (Residents "B" and "D").</p> <p>Findings include:</p> <p>A 1. The record for Resident "A" was reviewed on 09-19-14 at 1:00 p.m. Diagnoses included, but were not limited to, Congestive heart failure, sleep apnea, paraplegia, depressive disorder, anxiety, and hypertension. The record indicated the resident had a tracheostomy and received oxygen at 8 liters per the tracheostomy collar. These diagnoses remained current at the time of the record review.</p> <p>The Resident had physician orders at the time of admission for DuoNeb (a bronchodilator) Solution 0.5 - 2.5 (3) mg/ml (milligrams/milliliters) (Ipratropium-Albuterol) 1 vial via tracheostomy every four hours for</p>		<p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>-</p> <p>Resident A no longer resides at the center.</p> <p>Resident B physician orders and medical record were reviewed. The patient did not suffer any negative outcomes as a result of the deficient practice.</p> <p>Resident D physician orders and medical record were reviewed. The patient did not suffer any negative outcomes as a result of the deficient practice.</p> <p>Licensed Nurse #3 received 1:1 education on the facility guidelines for Tracheostomy care and suctioning.</p> <p>Licensed Nurse #5 received 1:1 education on the facility guidelines for Medication Pass related to Nebulizer administration, tracheostomy</p>				

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	<p>shortness of breath. The breathing treatments were scheduled at midnight, 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.</p> <p>The record indicated the resident had an incident of decrease oxygen saturation levels on 04-03-14 and was subsequently sent to the local area hospital for evaluation and treatment. A review of the EMT [Emergency Medical Technician] report indicated the resident's oxygen saturation level was at 84%. In addition the report indicated the nursing home staff oxygen saturation level for the resident "showed 64%. Crew noted that when they first entered room O2 [oxygen] may have not been turned on."</p> <p>A review of the hospital record on 09-18-14 at 1:30 p.m., indicated the resident had the decrease in her oxygen saturation level due to a "small mucous plug red streaked," in the cannula of the tracheostomy. The resident returned later that day to the facility.</p> <p>Further review of the clinical record indicated on 04-05-14, Licensed Nurse #5 administered the physician ordered breathing treatment to the resident at approximately "8:45 a.m.," and exited the resident's room. While unattended the resident had a change in condition.</p>		<p>care and suctioning.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>-</p> <p>Residents residing in the center with a tracheostomy have the potential to be affected by this deficient practice.</p> <p>Residents receiving nebulizer therapy have the potential to be affected.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>-</p> <p>Licensed Nursing Staff will be re-educated on:</p> <p>1.) Medication Administration: Medication Pass (Nebulizer Treatments)</p>				

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	<p>When the licensed nurse noticed the resident had a change in condition she returned to the resident's bedside.</p> <p>A review of the nurses notes, documented by Registered Nurse #5 and dated 04-05-14 at 10:58 a.m., indicated the following events:</p> <p>"RN [Registered Nurse] started pts. [patients] breathing treatment around 8:45 [a.m.]. RN took pts. vital signs pre breathing treatment and recorded them. RN was speaking with patient at this time about opening the window, and drawing her blood from her PICC [peripherally inserted central catheter]. RN finished labs, started the treatment and stepped outside. Pt. moans when alone and <sic> room and RN was preparing her medications, and heard her stop moaning. RN entered the room at about 8:48 a.m. to check on her and she was slumped over not breathing. RN check <sic> a pulse and could no <sic> detect one. RN hollered for help from other RN. 911 was called and we began bagging her leaving her O2 [oxygen] on thru trach [tracheostomy] and completeing <sic> chest compressions. EMT's arrived around 8:55 a.m. and took over. The <sic> worked on patient until about 9:20 a.m. At that point a heart rate was detected so they moved her to [name of</p>		<p>2.) Respiratory: Tracheostomy Care Policy</p> <p>3.) Respiratory: Suctioning – Nasal, Oropharyngeal and Tracheostomy</p> <p>4.) Infection Control (Glove Use Policy)</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>-</p> <p>Director of Nursing or designee will conduct 5 direct observations of Tracheostomy Care and hand hygiene per week x 4 weeks, then bi-weekly x 2 months on all shifts to validate the facility guidelines & policy. Observations will be recorded in the QAA monitoring tool and results of the audit will be submitted to the QA&A Committee for further review and recommendations.</p> <p>Director of Nursing or designee will conduct 5 direct observations of a Nebulizer Treatment Administration per week x 4 weeks, then bi-weekly x 2 months on all shifts to validate the facility guidelines & policy. Observations will be recorded in the QAA monitoring tool and</p>		

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	<p>local area hospital]."</p> <p>The EMT report indicated the following: "Dispatched to Summer Trace rehab. [rehabilitation] side for a cardiac arrest. Found pt. supine in hospital type bed...unconscious, unresponsive to stimuli...pulseless and apneic. Summer Trace staff prevorning <sic> CPR and ventilations...had staff stop compressions to assess. No pulse carotid, respirations zero. Resumed CPR. Attached monitor via pads and 4 lead. Initial rhythm - asystole. CPR continued throughout incident with rhythm checks every 2 minutes. Suction vomit from mouth and mucous from tracheostomy times 1. Nurse from Summer Trace explained she had left pt's room to get supplies and pt was ok. Nurse explained she returned approx. [approximately] 10 minutes later and found pt. in cardiac arrest and activated code. Estimated time of arrest > [greater than] 20 minutes."</p> <p>A review of the hospital "Discharge Summary" dated 04-05-14 at 9:18 p.m. indicated the following: "In brief, [age documented] who has a history of VATS [video-assisted thorascopic surgery], pneumonia, paraplegia, who has a tracheostomy who presented from ECF [extended care facility] for cardiac arrest. It seems the</p>		<p>results of the audit will be submitted to the QA&A Committee for further review and recommendations.</p> <p>Director of Nursing or designee will conduct 5 direct observations of Suctioning per week x 4 weeks, then bi-weekly x 2 months to validate the system facility guidelines & policy. Observations will be recorded in the QAA monitoring tool and results of the audit will be submitted to the QA&A Committee for further review and recommendations.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>10/21/2014</p>				

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	<p>patient had been doing well yesterday and was uneventful; however did get restless while she was getting breathing treatment, which she usually does when she gets her treatment. This morning when she was getting her breathing treatment, she suddenly stopped breathing and was found to be pulseless so resuscitation was initiated at the ECF. Patient was then transferred to the ER [emergency room] where she was coded for almost 45 minutes, however to no avail. Patient had fixed pupils that were dilated, most likely had anoxic brain injury. In the ER when her cannula was removed, there was an extensive mucous plug throughout the cannula, which may have added to her respiratory failure."</p> <p>During an interview on 09-22-14, Registered Nurse # 5 indicated, "I had moved my whole cart down there. She asked me to open the window. She didn't have her valve [passe muir] in. She was always hot, - large lady never wanted her gown on always hot. I started the treatment and then went to the med. [medication] cart to get the rest of her medications. I could still see her. She had been moaning more than normal. I work to the edge of the cart and I could still see her. She stopped moaning and went in to see what was the matter and she was kind of a gray color. I checked</p>			

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	<p>for a pulse and [name of another RN #] we hooked up an oximetry and there was no pulse. She never had thick secretions and I suctioned her and nothing came up. I didn't get it in report but when I was looking through the chart I saw that she had gone to the hospital. She went to the hospital for low Sat's - she was sating real low for them. [Name of RN #4] said they bagged her too on the day she went out for low Sat's." When interviewed if the resident had an oximeter on during the breathing treatment the nurse stated, "[Resident] didn't have the pulse oximetry on during the breathing treatment."</p> <p>A review of the facility policy on 09-19-14 at 8:30 a.m., titled "Medication Administration: Medication Pass," dated 03/2010, indicated the following:</p> <p>"Purpose: To safely and accurately prepare and administer medication according to physician order and patient needs."</p> <p>"Procedure: 1. Position medication cart in full view outside patient room or dining room. 7. Obtain vital signs, if applicable and record results on MAR [Medication Administration Record]. 9. Knock on door and request entrance, introduce self, explain medication</p>			

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	<p>administration need and provide privacy, administer medication in accordance with frequency prescribed by physician - within 60 minutes before or after prescribed dosing time, take the medication(s) and cup of liquid/food, if applicable, to patient, identify patient by calling name, checking identification band, referring to photo, describe name of medication and reason for use to patient and answer any questions if needed, administer medication according to specific procedure such as oral, topical, injection, etc, remain with patient until administration of medication complete."</p> <p>B1. The record for Resident "B" was reviewed on 09-19-14 at 12:30 p.m. Diagnoses included, but were not limited to, Vocal cord paralysis, attention deficit disorder, depression, and an aneurysm. The resident had a tracheostomy. These diagnoses remained current at the time of the record review.</p> <p>The resident had current physician orders for "O2 [oxygen] at 6 L [liters] with 28% humidity per trach [tracheostomy] mask, trach care Q [every] shift as needed."</p> <p>A review of the resident record indicated the resident recently went to the local area hospital due to decannulation. The</p>			

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	<p>record indicated the resident removed the tracheostomy "because it was clogged."</p> <p>A request was made on 09-22-14 at 9:00 a.m., to observe tracheostomy care including suctioning of the tracheostomy. The resident agreed and Licensed Nurse # 3 began preparations to complete the treatment.</p> <p>When interviewed the nurse indicated that to perform the requested treatment and that the facility currently did not have another disposable inner cannula or emergency cannula in the building. She further indicated the order had been placed "last Thursday but they haven't been delivered. The last one was used yesterday." The nurse indicated to perform the tracheostomy care she would need to use an "entire tracheostomy kit for the procedure."</p> <p>The nurse placed the tracheostomy kit on the bedside table and then indicated that suctioning was a sterile procedure.</p> <p>Without washing her hands the nurse donned non sterile gloves removed the oxygen collar and placed it on the resident's chest. She then removed the inner cannula and disposed it in the trash bag.</p>			

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	<p>With the contaminated gloves still on, the nurse opened the contents of the tracheostomy kit onto the bedside table surface touching the items with her contaminated gloves and then removed the gloves from both hands.</p> <p>The nurse donned sterile gloves to both hands, connected the end of the suction catheter to the suction machine and turned the switch to the "on" position. The licensed Nurse then requested Licensed Nurse # 5 to pour sterile normal saline into the small container.</p> <p>Licensed Nurse # 3 picked up the suction catheter with her right hand and advanced the catheter into the tracheostomy. As the nurse continued to advance the suction catheter she used her thumb to open and close the suction valve.</p> <p>The nurse removed the suction catheter in one motion and the resident began to cough. The mucous in the suction catheter was yellow in color and appeared to be thick in consistency.</p> <p>The nurse then indicated she completed the suctioning of the resident's tracheostomy then picked up the sterile cannula and inserted it into the resident's tracheostomy.</p>			

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	<p>The nurse removed the soiled dressing around the tracheostomy site and placed the soiled dressing into the trash bag and then placed new dressing around the tracheostomy site without changing her gloves.</p> <p>The licensed nurse placed the oxygen collar over the tracheostomy site and then removed her gloves.</p> <p>B2. The record for Resident "D" was reviewed on 09-22-14 at 1:00 p.m. Diagnoses included, but were not limited to, Cerebral vascular accident, pneumonia, anoxic brain syndrome and acute respiratory failure. The resident had a tracheostomy.</p> <p>The resident had physician orders for "Trach care every shift and PRN [as needed]. Remove inner cannula to clean and reinsert after cleaning."</p> <p>The Licensed Nurse indicated the resident had been suctioned earlier in the shift and indicated she didn't think he needed to be suctioned.</p> <p>As the Licensed Nurse donned non sterile gloves the resident began to cough and a thick amount of yellow mucous came from the tracheostomy. The nurse waited until the resident stopped coughing and</p>				

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	<p>removed the disposable inner cannula and the gloves and placed them into the trash bag.</p> <p>Without washing her hands the nurse re-donn'd a pair of non sterile gloves and opened the tracheostomy suctioning kit, emptied the contents of the kit onto the bedside table, picked up a bottle of sterile normal saline and poured the contents into a small container. The licensed nurse then connected the end of the suction catheter to the suction machine and turned the switch to the "on" position.</p> <p>The resident began to cough, and additional thick yellow mucous spewed from the tracheostomy and went down the front of the resident's chest to the top of his gown.</p> <p>The licensed nurse waited until the resident stopped coughing and then picked up the suction catheter with her right hand, placed the tip of the suction catheter into the normal saline. The Licensed Nurse then proceeded to insert the catheter into the tracheostomy. As the Licensed Nurse removed the suction catheter from the tracheostomy, she placed her finger on the suction valve. Thick and copious amounts of yellow mucous were suctioned from the</p>			

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	<p>resident's tracheostomy.</p> <p>The nurse indicated she completed the suctioning, but was prompted to suction the resident again by the corporate nurse who was in attendance. Again the licensed nurse placed the tip of the suction catheter into the sterile normal saline and suctioned the resident's tracheostomy. Again copious amounts of thick yellow mucous was suctioned from the tracheostomy.</p> <p>Without changing her gloves the nurse removed the soiled dressing situated around the tracheostomy site and placed a new gauze dressing.</p> <p>When interviewed if the resident had an emergency inner cannula at the bedside, the licensed nurse indicated, "I really don't know how to answer that." The corporate nurse prompted the nurse to check the supplies at the resident's bedside and the licensed nurse indicated she couldn't find an emergency inner cannula.</p> <p>B3 A review of the facility policy on 09-22-14 at 9:45 a.m., titled "Respiratory: Tracheostomy Care," and dated 01/2011 indicated the following:</p> <p>"Purpose: to describe a recommended</p>						

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	<p>method for: cleaning a tracheostomy site and tube, keeping site and tube free from mucous build-up, maintaining tube patency, reducing risk of infection and maintaining skin integrity at stoma site."</p> <p>"Procedure: 5. Perform hand hygiene, 6. Position plastic trash bag to receive contaminated disposable items, 7. Establish sterile field on over-bed table and maintain during procedure: Cover table with clean towel or paper towels, arrange supplies on table, open packages to reveal supplies, using inside of packages to form sterile field, add items to field by dropping items onto field, keeping packaging between items and hands, place sterile drape over chest area and surrounding site being treated, pour sterile normal saline on open packages of 4 by 4's, pour 1/2 sterile normal saline and 1/2 hydrogen peroxide into one sterile container and sterile normal saline - into the second sterile container. 9. Place in upright position, 9. Put on sterile latex free gloves and personal protective equipment e.g. gown, goggles - if indicated. Remember when performing tracheostomy care keep dominant hand sterile (usually right hand) and nondominant hand clean (usually left hand). 10. Discard dressing(s) in plastic trash bag."</p>			

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	<p>"Disposable Inner Cannula Tube Change: Replace at least once a day or as indicated per physician order. 1. While still wearing sterile gloves, remove inner cannula with sterile 4 by 4 and discard 4 by 4 and inner cannula. 2. Insert new inner cannula touching outer clamps and rim only, never reuse disposable inner cannula."</p> <p>"Cleaning Tracheostomy Site: 1. Squeeze out excess normal saline from 4 by 4 and cleanse under tracheostomy tube flanges and ties. Use on 4 by 4 per swipe. 2. Use cotton tipped applicator saturated with sterile normal saline to remove any encrusted material difficult to remove with sponge - use one cotton tipped applicator per swipe. 3. Continue cleaning until skin surrounding site clean. 4. Dry area with sterile 4 by 4 sponges."</p> <p>B4. A review of the facility policy on 09-22-14 at 10:15 a.m., titled "Respiratory: Suctioning - nasal, oropharyngeal and tracheostomy," and dated 01/2011 indicated the following:</p> <p>"Purpose: To describe a recommended method for: removing secretions from pharynx, trachea and bronchi, maintaining patent airway, decreasing potential for infection and stimulating cough reflex."</p>			

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	<p>"Procedure: 5. Perform hand hygiene. 7. When clinically indicated, assess lung fields and heart rate for a baseline comparison after suctioning completed. 8. When clinically indicated, connect pulse oximeter to patient and monitor before, during and after suctioning. Preparation of Suction Equipment: 1. Place suction equipment within reach, 2. Position trash bag to receive disposable items, 3. Attach tubing to suction unit. Tracheostomy insertion: 1. Using sterile technique, open sterile suction kit. Pour sterile normal saline into sterile solution container. 2. Put on sterile latex free gloves - designate non dominant hand, usually left hand as contaminated for disconnection and working suction control. Typically the dominant hand, usually right hand, is kept sterile and will be used to thread suction catheter. 3. Remove sterile catheter from package curling the catheter around gloved fingers and attach sterile suction catheter to tubing. 4. Dip catheter tip into sterile normal saline. 5. Place on finger over catheter's suction valve and suction a small amount of sterile normal saline through catheter. 6. With catheter suction valve uncovered and using a sterile gloved hand, gently insert catheter into tracheostomy tube until slight resistance is met and then withdraw</p>			

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R000000	<p>slightly. Suctioning: 1. Apply intermittent suction by covering catheter suction valve with thumb, 2. Limit suction time to no longer that 10 seconds, 3. Quickly rotate the catheter while it is being withdrawn, applying intermittent suctioning. 4. Rinse catheter between suction passes by inserting tip in cup of sterile normal saline and applying suction. 6. If airway remains congested, repeat procedure until breathing becomes quiet and relatively effortless if possible. 7. If oxygen is being administered, provide oxygen between suction passes and reconnect oxygen after procedure completed following physician orders. 11. Evaluate lung fields and heart rate and document any changes from baseline e.g. increase or decrease in crackles, wheezing and, or aeration of lung fields if clinically indicated."</p> <p>This Federal tag relates to Complaint IN00156224.</p> <p>3.1-47(a)(4) 3.1-47(a)(5)</p> <p>Manor Care Health Services - Summer Trace was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint Number</p>	R000000	The statements made in this Plan of Correction are not an admission to and do not				

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	IN00156234.		constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.		