

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN46385
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: October 3, 4, 5, 6, and 7, 2011</p> <p>Facility number: 000224 Provider number: 155331 AIM number: 100267700</p> <p>Survey team: Sheila Sizemore, RN-TC Kelly Sizemore, RN Marcia Mital, RN Regina Sanders, RN (October 3, 4, and 5, 2011)</p> <p>Census bed type: SNF: 21 SNF/NF: 80 Total: 101</p> <p>Census payor type: Medicare: 34 Medicaid: 54 Other: 13 Total: 101</p> <p>Sample: 21 Supplemental sample: 6</p> <p>These deficiencies reflect state findings</p>	F0000		

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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	cited in accordance with 410 IAC 16.2.  Quality review completed 10/17/11 by Jennie Bartelt, RN.				

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F0157 SS=D	<p>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 observation, record review, and interview, the facility failed to ensure residents' physicians were notified of changes related to a significant weight loss and a change in a pressure ulcer for 2 of 21 reviewed for physician notification in a total sample of 21. (Residents #42 and #54)</p>	F0157	F 1571. The physicians for residents # 42 and # 54 were contacted and appraised of the identified concerns by 10/7/11.2. The DON and/or designees will review resident weights with the Registered Dietitian and/or Dietary Manager weekly to identify residents who have had a significant weight loss. The DON	11/02/2011

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	<p>Findings include:</p> <p>1. Resident #54's record was reviewed on 10/4/11 at 2:00 p.m. Resident #54's diagnoses included, but were not limited to, dementia, Clostridium difficile (C dif - bacteria which causes diarrhea), and diabetes mellitus.</p> <p>Resident #54's weights indicated: 7/28/11 149.6 pounds and 9/21/11 135.6 pounds. This is a 10% weight loss in less than 2 months.</p> <p>The resident's nurses' notes, dated 9/21/11 through 10/5/11, lacked documentation to indicate the resident's physician had been notified of the 10% weight loss.</p> <p>During an interview on 10/4/11 at 3:30 p.m., the 300 hall unit manager indicated she was unable to find where the physician had been notified of the resident's weight loss. .</p>		<p>and/or designees will audit Daily Change of Condition logs 5 times per week for data reflecting post admission pressure ulcers or deep tissue injuries as well as any other change in condition meeting criteria to notify the physician.3. Staff responsible for informing the physician about the weight loss and pressure ulcer were re-educated by the Staff Development Coordinator by 10/17/2011. Licensed nursing staff were educated on the policy for physician notification via the facility newsletter dated 10/14/2011 (attached). An inservice on these topics is scheduled for licensed nurses by 10/25/2011. 4. As of 10/10/2011, the DON or designee will audit Change of Condition logs 5x per week for 6 months to ensure notification of physician and responsible parties has been charted. Resident weight histories will be run weekly for six months and reviewed by the DON and/or designee, the Dietary Manager or designee and the Registered Dietitian during her facility visits. Data from this review is used to identify residents with weight loss and ensure the physician and responsible party are notified with documentation in the clinical record reflecting that notification. Any noncompliance will be remedied and disciplinary action initiated as appropriate. Audit data and analysis results will be presented by the DON or</p>		

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	<p>2. Resident #42's record was reviewed on 10/5/11 at 10:40 a.m. Resident #42's diagnoses included, but were not limited to, diabetes, hypertension, and depressive disorder.</p> <p>Nurses' notes on the following dates and times indicated:</p> <p>10/1/11 at 2 p.m., a late entry for 9/30/11 11 a.m., indicated, "Deep tissue injury noted to the ball of res's (resident's) L (circled) (left) foot. This area measures 1.3 cm (centimeters) x (by) 1.0 cm..."</p> <p>9/30/11 at 8:30 p.m., "Area remains to L (circled) plantar aspect of foot. Skin surrounding pink in color. Area tender to touch."</p> <p>10/1/11 at 6 a.m., "L (circled) foot remains c/ (with) area to ball by the great toe, tender to touch, surrounding area pink."</p>		<p>designee for review at the monthly Quality Improvement meetings and audits will then be adapted to accommodate the need to increase/decrease the number of audits and/or frequency of audits. Any negative trends will be addressed with an action plan. DATE CERTAIN 11/2/2011 THIS IS MY CREDIBLE ALLEGATION</p>		

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	<p>10/1/11 at 8:55 a.m., "Area remains to plantar side of foot. Skin intact surrounding skin pink. No c/o (complaints of) pain voiced."</p> <p>10/1/11 at 8 p.m., "Deep tissue injury remains to plantar side of foot. Skin intact surrounding skin pink..."</p> <p>10/2/11 at 3:35 a.m., "Deep tissue injury remains to foot, surrounding skin pink..."</p> <p>10/2/11 at 9 a.m., "Area remains to plantar side of L (circled) foot. Area intact. Surrounding tissue pink..."</p> <p>10/2/11 at 11 p.m., "Area remains to plantar side of L circled foot. Area intact surrounding tissue pink..."</p> <p>10/3/11 at 3:40 a.m., "Area remains to plantar side of L circled foot. Skin intact...open to air..."</p> <p>10/3/11 at 10:30 a.m., "Examined Lt (left) foot area, is on plantar side of foot near great toe. Skin discolored deep purple-black, skin intact, no (indicated by a zero) surrounding redness..."</p> <p>The nurses' notes lacked documentation the physician was notified the pressure area got worse.</p>			

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	<p>During an observation of Resident #42's left foot with LPN #4, on 10/5/11 at 2:05 p.m., the area on the ball of the foot was observed to be a reddish fluid filled blister with dried skin surrounding. LPN #4 measured the blister, 1 cm x 1 cm, and the whole area including the dried skin, 1.5 cm x 1.2 cm. During an interview at the time of the observation, LPN #4 indicated the resident's physician was coming in today and she was going to have him look at the area.</p> <p>During an interview with LPN #4, on 10/5/11 at 2:25 p.m., she indicated the physician should have been notified on 10/3 when the area got worse.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F0250 SS=D	<p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure social services was notified for assistance with planning care related to behavior management for 2 of 8 residents exhibiting behaviors in a sample of 21. (Residents #24 and #93)</p> <p>Findings include:</p> <p>1. Resident #24's record was reviewed on 10/3/11 at 1:15 a.m. Resident #24's diagnoses included, but were not limited to, dementia, failure to thrive, and depression.</p> <p>Resident #24's admission MDS (Minimum Data Set) assessment, dated 9/15/11, indicated the resident had severe cognitive impairment and had displayed no behaviors in the last 7 days.</p> <p>The resident's care plans, dated 9/8/11 and updated 9/21/11, lacked documentation of a care plan for behaviors.</p> <p>The resident's nurses' notes indicated: 9/13/11 at 6 a.m., "Nurse alerted to Res (Resident) room @ (at) this time by CNA to witness res had finger down throat self-inducing vomiting. Nurse</p>	F0250	<p>F 2501. Residents #24 and #93 have a Behavior Plan in place that has been effectively communicated to nursing staff via care guides and the care plan.2. The DON or designee will obtain a list of residents with behaviors from Social Services, audit the past one month of Change of Condition Audit logs to identify any residents with behaviors and ensure a Behavior Plan is in place and communicated to caregivers for any resident with behaviors by 10/14/2011. The DON provided education to all department heads by 10/31/2011 to describe the methods of communication of information in the facility and measures to ensure they are appraised of any areas requiring attention.3. An inservice will be developed and presented by the Staff Development Coordinator/designee to nursing staff addressing the need to communicate resident behaviors and/or psychoactive medication orders via the 24 hour report. Also, direct caregivers will be educated on use of Behavior Monitoring forms and documenting behaviors in RITA by the Staff Development Coordinator by 10/31/2011. 4. Using the Change of Condition logs, physician orders and the list</p>	11/02/2011			

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	<p>intervened..."</p> <p>9/13/11 at 9:45 a.m., "...Res was down in therapy gym c (with) fingers down throat. Attempting to self-induce vomit (sic)...Spouse here- aware of behaviors...Res very hesitant c staff et (and) care becoming very aggitated (sic) c nurse. Upon administering compazine (medication for nausea)...Spouse stated, 'she always had problems c stomach. Self -inducing vomiting is the only thing that makes her feel better.'..."</p> <p>9/16/11 at 11 a.m., "...Res up (indicated by an arrow) in w/c (wheelchair). Aggitation (sic) noted res aggressive c (with) staff...Nos (new orders) rec'd (received)..."</p> <p>A physician's order, dated 9/16/11, indicated "Dx (diagnosis): dementia w(with)/aggitation (sic) Risperdal (antipsychotic medication) 0.25 mg (milligrams) a.m. &amp; hs (bedtime)."</p> <p>The resident's social service notes indicated: 9/15/11, "...staff have not reported any behavioral concerns -but do say that her family reports that she'll make herself vomit-sticking her fingers sown her throat if c/o (complaints of) nausea..."</p> <p>9/19/11, indicated the resident had not exhibited any behaviors and the only psychotropic medication the resident was</p>		<p>provided by Social Services, the DON or designee will audit charting for residents with behaviors 5x per week for six months to ensure that there is a Behavior Plan in place and it is followed. RITA documentation will also be audited 5x per week for six months for the presence of charting indicating resident behaviors. Any non-compliance will be addressed with re-education and/or disciplinary action as needed. Audit data and analysis results will be presented by the DON or designee for review at the monthly Quality Improvement meetings and audits will then be adapted to accommodate the need to increase/decrease the number of audits and/or frequency of audits. Any negative trends will be addressed with an action plan.DATE CERTAIN 11/2/2011THIS IS MY CREDIBLE ALLEGATION</p>		

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	<p>on was an antidepressant.</p> <p>During an interview on 10/4/11 at 4:22 p.m., the 300 hall unit manager indicated social services should have been aware of the resident's behaviors. She indicated she was not sure why the resident was started on the Risperdal or what the resident's behavior was other than agitated.</p> <p>During an interview on 10/4/11 at 4:30 p.m., the Social Service Director indicated she was not aware the resident had any behaviors or was on Risperdal. She indicated she did not consider the resident sticking her finger down her throat a behavior because the resident's husband had said the resident had done this in the past when she was nauseous to get it up. She indicated the resident should be on behavior management. She indicated the resident should have a care plan for behaviors. She indicated they would monitor the resident's behaviors and put things into place then if nothing worked they would look at medication.</p> <p>2. Resident #93's record was reviewed on 10/4/11 at 4:55 p.m. Resident #93's diagnoses included, but were not limited to, gout, pneumonia, and depression.</p> <p>A quarterly MDS assessment, dated</p>				

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	<p>9/15/11, indicated the resident had no cognitive deficits and had not exhibited any behaviors.</p> <p>A nurses' note, dated 10/1/11 at 7 a.m., indicated, "Resident attempted inappropriate touching of nurse...behavior corrected by nurse and resident reminded of proper public behaviors."</p> <p>The social service notes lacked documentation of the resident's behavior on 10/1/11.</p> <p>During an interview on 10/5/11 at 9:36 a.m., the Social Service Director indicated she was not aware of Resident #93 having any behaviors recently. She indicated she should have found out from the 24 hour report sheet and the staff should send a referral to her.</p> <p>A facility policy, dated 6/17/08, titled "Behavior Management" received from the administrator as current on 10/6/11, indicated, "...Behavior management includes assessing behavior patterns that interfere with the resident's functional capacity and ensuring that these patterns are reduced or eliminated...Through observation, interview, record review, and inquiry, Social Service staff assess the resident's behavior(s) that are potentially harmful to the resident or others...Social</p>			

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	<p>Service staff coordinate a system of monitoring the frequency and circumstances surrounding the behavior to assist in determining the following: *Symptoms *Cause *Patterns *Severity of behavior...The Social Service staff...formulate a specific, individualized behavior management plan to reduce or eliminate the cause(s) of behavior(s)...At the minimum, the monitoring system documents the following *The specific behavioral problem *The specific intervention/action taken to eliminate or reduce the occurrence of the behavioral problem * The resident's response to the intervention...."</p> <p>3.1-34(a)</p>				
F0282 SS=D	<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. Based on observation, record review, and interview, the facility failed to ensure a nebulizer treatment (breathing treatment)</p>	F0282	F 2821. Nursing assessment for resident #14 was performed by licensed staff immediately upon notification of the identified	11/02/2011	

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	<p>was administered by a licensed professional for 1 of 2 residents observed for nebulizer treatments in a supplemental sample of 6. (Resident #14)</p> <p>Findings include:</p> <p>During an observation of an evening medication pass with QMA #1 on 10/03/11 at 4:10 p.m., QMA #1 prepared the Resident #14's 5 p.m. medications, which included a single dose vial of Duoneb.</p> <p>During an interview on 10/03/11 at 4:20 p.m., QMA #1 indicated she could administer the Duoneb nebulizer treatment since she no longer needs to listen to the resident's lung sounds.</p> <p>QMA #1 then entered the resident's room and placed the Duoneb solution into the resident's nebulizer reservoir and then placed the nebulizer mask attached to the reservoir over the resident's mouth and nose. QMA #1 then turned on the nebulizer and walked out of the resident's room and moved the medication cart to the next room in the hallway, leaving Resident #14 alone during the nebulizer treatment.</p> <p>QMA #1 was observed in the hall and another resident's room from 4:20 p.m.</p>		<p>concern. 2. A listing of residents with HHN orders was generated. This listing was used by the DON and designees to audit the HHN treatments for the identified residents. The staff identified as not following the policy and procedure for HHN administration during the survey were re-educated by 10/17/2011 on the specific concerns. All QMAs were re-educated on the QMA scope of practice by 10/17/2011.3. The facility newsletter dated 10/14/2011 (attached) addressed concerns specific to HHN administration. An inservice for all licensed staff will be provided by the Staff Development Coordinator on the HHN policy and procedure by 10/17/2011 . 4. The DON or designee will audit one medication pass per shift per week for six months to ensure that proper medication pass procedures for HHN administration are followed. Any noncompliance will be addressed immediately and disciplinary action initiated as appropriate. Audit data will be evaluated by the DON or designee and audits adapted to address the need to increase or decrease the frequency of audits as indicated by the trending data. Audit data and analysis results will be presented by the DON at the monthly Quality Improvement meetings and an action plan developed for any negative trends identified. DATE CERTAIN</p>		

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	<p>through 4:35 p.m. QMA #1 did not return to Resident #14's room until 4:35 p.m. when she was informed the resident had removed the nebulizer mask and the resident turned off the nebulizer machine.</p> <p>During an interview on 10/03/11 at 4:35 p.m., QMA #1 indicated she was supposed to take off the nebulizer mask. QMA #1 stated, "She (resident) even put it in the bag (nebulizer mask)".</p> <p>During an interview on 10/04/11 at 8:25 a.m., the Director of Nursing (DoN) indicated QMA's in the facility do nebulizer treatments. She indicated administering nebulizer treatments were not a part of the QMA scope of practice. She indicated the nurses are supposed to assess the resident's lung sounds and heart rate with the nebulizer treatments.</p> <p>An undated facility policy, titled, "AEROSOLIZED MEDICATION THERAPY HAND HELD NEBULIZER", received from RN #3 on 10/03/11 at 2:25 p.m., indicated, "...assess patient, establish baseline respiratory rate, heart rate and breath sounds and lung sounds...Monitor heart rate, level of consciousness before, during and immediately after the treatment...After treatment assess effectiveness of treatment. Listen to lung sounds, take</p>		11/2/2011 THIS IS MY CREDIBLE ALLEGATION	

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN46385		
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F0328 SS=E	<p>pulse and resp (respiratory) rate, sputum production..."</p> <p>A profession resource, website, "www.in.gov/isdh/20507.htm", titled, "412 IAC 2-1-9 Scope of Practice", indicated, "... b) The following tasks shall not be included in the QMA scope of practice:...(2) Administer medication used for intermittent positive pressure breathing (IPPD) treatments or any form of medication inhalation treatments, other than metered dose inhaler...."</p> <p>3.1-35(g)(2)</p> <p>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 observation, record review, and interview, the facility failed to assess</p>	F0328	F 3281.Residents #14, #98 were assessed by licensed staff for heart rate, lung and breath	11/02/2011	

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	<p>residents' lung sounds and heart rate before, during, and after a nebulizer treatment (breathing treatment) for 2 of 2 residents observed during a nebulizer treatment in a supplemental sample of 6 (Residents #14 and #98, QMA #1 and LPN #2 ). The facility also failed to ensure a licensed professional administered the nebulizer treatment and failed to ensure a licensed professional stayed with a resident during the nebulizer treatment for 1 of 2 residents observed during a nebulizer treatment in a supplemental sample of 6. (Resident #98 and QMA #1)</p> <p>B. Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered by the physician for 3 of 8 residents with oxygen in a sample of 21 residents. (Residents #1, #9, and #44)</p> <p>Findings include:</p> <p>A1. During an afternoon medication pass with LPN #2 on 10/03/11 at 1:45 p.m., LPN #2 was observed to prepare a nebulizer treatment for Resident #98.</p> <p>LPN #2 obtained a dose of impratropium and albuterol (breathing medications) 0.5-3 (2.5 milligram per 3 milliliters) (Duoneb) and placed the single dose of</p>		<p>sounds on 10/3/2011. Residents #1, #9 and #44 had the oxygen flow rate adjusted as per physician orders on 10/3/2011. 2. A listing of all residents with oxygen orders was obtained from Care Pharmacy Medical Records staff on 10/3/2011 and used to check the oxygen flow rates for all identified residents. A listing of residents with HHN orders was also obtained from Care Pharmacy Medical Records on 10/3/11 to audit HHN treatments provided per policy.3. Education from the Staff Development Coordinator was provided to licensed staff regarding communicating and responsibility for ensuring the oxygen liter flow is correct for all residents receiving oxygen therapy and the policy and procedure for HHN treatments by 10/17/2011. 4. As of 10/17/2011, audits of care guide data and visual observation of oxygen flow rates by the DON and/or designees are scheduled for 3x per week for six months to validate oxygen flow rates per physician orders. The DON or designee is auditing one medication pass per week per shift for six months to ensure the policy and procedure for HHN treatments is followed. Audits are adapted to address the need to increase or decrease the frequency of audits as indicated by the trending data. Results of these audits will be presented at the monthly Quality Improvement</p>		

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	<p>the medication into the nebulizer reservoir. LPN #2 then placed the nebulizer mask with the reservoir attached over the resident's mouth and nose and turned on the nebulizer machine at 1:55 p.m.</p> <p>LPN #2 then stood with the resident while the nebulizer treatment was administered at 1:55 p.m. through 2:10 p.m. . LPN #2 did not listen to the resident's lungs or heart rate prior to starting the nebulizer treatment. LPN #2 did not monitor the resident's breathing, lung sounds, or heart rate during or after the nebulizer treatment.</p> <p>During an interview on 10/03/11 at 2:15 p.m., LPN #2 indicated it was no longer a facility policy to check the resident's lungs and heart rate. She indicated, "Typically the resident can tell you if the medication works." She indicated she did not know Resident #98 that well, but the resident was starting to clear her throat and sneeze so that indicated the medication was working.</p> <p>A2. During an observation of an evening medication pass with QMA #1 on 10/03/11 at 4:10 p.m., QMA #1 prepared the Resident #14's 5 p.m. medications, with included a single dose vial of Duoneb.</p>		meeting by the DON or designee and action plans developed for any negative trends. DATE CERTAIN 11/2/2011THIS IS MY CREDIBLE ALLEGATION		

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	<p>During an interview on 10/03/11 at 4:20 p.m., QMA #1 indicated she could administer the Duoneb nebulizer treatment since she no longer needs to listen to the resident's lung sounds.</p> <p>QMA #1 then entered the resident's room and placed the Duoneb solution into the resident's nebulizer reservoir and then placed the nebulizer mask attached to the reservoir over the resident's mouth and nose. QMA #1 then turned on the nebulizer and walked out of the resident's room and moved the medication cart to the next room in the hallway, leaving Resident #14 alone during the nebulizer treatment.</p> <p>QMA #1 was observed in the hall and another resident's room from 4:20 p.m. through 4:35 p.m. QMA #1 did not return to Resident #14's room until 4:35 p.m. when she was informed the resident had removed the nebulizer mask and the resident turned off the nebulizer machine.</p> <p>During an interview on 10/03/11 at 4:35 p.m., QMA #1 indicated she was suppose to take off the nebulizer mask. QMA #1 stated, "she (resident) even put it in the bag (nebulizer mask)".</p> <p>During an interview on 10/04/11 at 8:25</p>				

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	<p>a.m., the Director of Nursing (DoN) indicated QMA's in the facility do nebulizer treatments. She indicated administering nebulizer treatments were not a part of the QMA scope of practice. She indicated the nurses are suppose to assess the resident's lung sounds and heart rate with the nebulizer treatments.</p> <p>An undated facility policy, titled, "AEROSOLIZED MEDICATION THERAPY HAND HELD NEBULIZER", received from RN #3 on 10/03/11 at 2:25 p.m., indicated, "...assess patient, establish baseline respiratory rate, heart rate and breath sounds and lung sounds...Monitor heart rate, level of consciousness before, during and immediately after the treatment...After treatment assess effectiveness of treatment. Listen to lung sounds, take pulse and resp (respiratory) rate, sputum production..."</p> <p>A profession resource, website, "www.in.gov/isdh/20507.htm", titled, "412 IAC 2-1-9 Scope of Practice", indicated, "... b) The following tasks shall not be included in the QMA scope of practice:...(2) Administer medication used for intermittent positive pressure breathing (IPPD) treatments or any form of medication inhalation treatments, other than</p>				

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	<p><b>metered dose inhaler..."</b></p> <p>B1. During the initial tour on 10/3/11 at 11:10 a.m. with LPN #5, Resident #44 was in his room and his oxygen was observed to be on 2 liters. During an interview at the time of the observation, LPN #5 indicated the resident should be on 3 liters and then changed the oxygen to 3 liters.</p> <p>During an observation on 10/3/11 at 1:10 p.m., Resident #44 was in bed and his oxygen was on at 2 liters. During an interview at the time of the observation, CNA #6 indicated the resident is suppose to be on 2 liters.</p> <p>Resident #44's record was reviewed on 10/3/11 at 1:15 p.m. Resident #44's diagnoses included, but were not limited to, Alzheimer's disease, renal insufficiency, and hypertension.</p> <p>Physician's recapitulation orders for September 2011, indicated an order for oxygen at 3 liters/minute per nasal canula continuously, originally ordered 4/19/11.</p> <p>A Daily Care Guide, used by the CNA's to provide care for resident's, indicated Resident #44 was to have oxygen at 2 liters per nasal canula.</p> <p>During an interview with LPN #5, on</p>						

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	<p>10/3/11 at 1:20 p.m., she indicated the order was for 3 liters and the CNA care guide was wrong. She indicated, "We will fix it."</p> <p>B2. During the initial tour on 10/3/11 at 10:25 a.m. with LPN #5, Resident #1 was observed in her room and her oxygen was on 3 liters. During an interview at the time of the observation, LPN #5 indicated the resident should be on 2 liters.</p> <p>Resident #1's record was reviewed on 10/4/11 at 2:10 p.m. Resident #1's diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and hypertension.</p> <p>Physician recapitulation orders for September 2011, indicated an order for oxygen at 2 liters /minute per nasal canula continuously, originally ordered 4/1/11.</p> <p>B3. During the initial tour on 10/3/11 at 10:10 a.m., with LPN #4, Resident #9 was observed sleeping in bed on her back. The resident's oxygen was observed at 3 liters. LPN #4 indicated the resident's oxygen should be set at 2 liters.</p> <p>Resident #5's record was reviewed on 10/4/11 at 2:15 p.m. Resident #9's diagnoses included, but were not limited</p>			

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	<p>to, chronic obstructive pulmonary disease and congestive heart failure.</p> <p>A physician's order, dated 8/27/10, indicated, "Oxygen at 2 liters/min (minute) per NC (nasal canula)...."</p> <p>Review of the nurses' notes, indicated Resident #9's oxygen was set on 3 liters at 3:30 a.m. and 9:30 a.m. on 9/7/11 and 6:00 a.m., on 9/8/11.</p> <p>During an interview on 10/4/11 at 3:25 p.m., RN #3 indicated the resident should have been on 2 liters of oxygen.</p> <p>A facility policy, provided by the Administrator as current on 10/6/11 at 8:35 p.m., and titled "Respiratory Care Services Policy," indicated, "...1. Check physician order to determine...liter rate..."</p> <p>3.1-47(a)(6)</p>				

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F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from significant medication errors related to administering a medication to a resident with a known allergy and administering a medication after a meal instead of on an empty stomach for 1 of 21 residents reviewed for significant medication errors in a total sample of 21. (Resident #44)</p> <p>Findings include:</p> <p>A. Resident #44's record was reviewed on 10/3/11 at 1:15 p.m. Resident #44's diagnoses included, but were not limited to, Alzheimer's disease, renal insufficiency, and hypertension.</p> <p>A physician's order, dated 9/16/11 at 5:30 p.m., indicated, "...Rocephin (antibiotic) 1 gm(gram) IM (intramuscular) x (times) 10 days daily..."</p> <p>Physician's recapitulation orders for</p>	F0333	<p><b>F 3331.</b>The time of administration for the synthroid was changed to 6:00 am for Resident #44. Resident #44 had been assessed for "adverse reactions" on 9/17/2011 after the administration of the Rocephin as documented in the nursing notes.2. A listing was obtained of all residents with synthroid orders and the time of administration validated as 6:00 am. Appropriate nursing response for "risk for cross sensitivity reactions" were reviewed with the Care Pharmacy Director on 10/21/2011.3. Care Pharmacy Medical Records staff, the entity printing resident Medication Administration Records, was advised of the need to select 6:00 am for all synthroid administration unless specifically ordered at another time on 10/5/2011. As of that date, the computer database was updated to select 6:00 am for all synthroid dosing unless specific orders for another time are received. Charge nurses were also re-educated on the importance of correcting any inaccuracies</p>	11/02/2011

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	<p>September 2011, indicated the resident has an allergy to penicillins.</p> <p>A Medication Administration Record (MAR) for September 2011, indicated Rocephin 1 gram IM was given on 9/16/11 at 9 p.m.</p> <p>A physician's order, dated 9/17/11 at 1:45 p.m., indicated, "Penicillin Allergy DC (discontinue) Rocephin."</p> <p>During an interview with LPN #8, on 10/4/11 at 9:47 a.m., she indicated, "The pharmacy faxed over a letter stating "attention resident has a penicillin allergy." She indicated the resident had received one dose of the Rocephin so she had called the physician and he said to discontinue the Rocephin."</p> <p>A 2010 Nursing Spectrum Drug Handbook, page 219, indicated, "...Rocephin...Pharmacologic class: Third-generation cephalosporin...Precautions Use cautiously in: hypersensitivity to cephalosporins or penicillins, allergies..."</p> <p>B. Physician's recapitulation orders for September 2011, indicated an order for Levothyroxine (Synthroid) 25 micrograms give 1 tablet orally once a day for hypothyroidism, originally ordered</p>		<p>specific to medication administration times. Licensed nurses were re-educated on cross-sensitivity reactions and synthroid dosing by 10/19/2011.</p> <p>4. The DON or designee will use a listing of all residents with synthroid orders and "cross sensitivity" concerns to audit for compliance 3 times per week for six months. Audits are adapted to address the need to increase or decrease the frequency of audits as indicated by the trending data. Results of these audits will be presented at the monthly Quality Improvement meeting by the DON or designee and action plans developed for any negative trends. DATE CERTAIN 11/2/2011 THIS IS MY CREDIBLE ALLEGATION This F tag is being disputed with an Informal Dispute Resolution request for a face-to-face hearing due to evidence within the clinical record documentation that does in fact support the facility's contention that resident #44 had a valid signed physician order to administer the synthroid at 9:00 am and that this order did not indicate to administer the medication on an empty stomach. As per the reference to administering a medication to a resident with a known allergy, resident #44 did not have an allergy to Rocephin. His allergy was to penicillin. While his physician chose to discontinue the Rocephin, data received from</p>		

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	<p>4/20/11.</p> <p>The September 2011 MAR (Medication Administration Record), indicated Levothyroxine (Synthroid) 25 micrograms give 1 tablet orally once a day for hypothyroidism "medication has boxed warning; take on empty stomach take with plenty of water; take as single dose bef (before) brkfst (breakfast)." The MAR indicated the Synthroid was being given at 9 a.m.</p> <p>During an interview with LPN #5, on 10/4/11 at 10:05 a.m., she indicated the Synthroid was being given at 9 a.m. She indicated it needed to be given before breakfast and that she would fix it.</p> <p>A 2010 Nursing Spectrum Drug Handbook, pages 660-661, indicated, "Synthroid...Administration...Give tablets on an empty stomach 30 minutes to 1 hour before first meal of the day..."</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>		<p>Care pharmacy concerning the risk of "cross sensitivity" note that the potential risk "approaches 0%".Attachments:</p> <ul style="list-style-type: none"> <li>·A) Nurses notes 9/16/11-9/19/11</li> <li>·B) Physician order for Rocephin dated 9/16/2011</li> <li>·C) Acute care plan stating new medication ordered with goals and interventions that address assessment for adverse response to the medication</li> <li>·D) Items #D1 through #D2 Pharmacy information specific to risk of "cross sensitivity"</li> <li>·E) Physician order sheet signed 10/2/2011</li> <li>·F) Medication Administration Record indicating that the medication was given as per physician orders</li> <li>·G) Facility pharmacy notification specific to risk of "cross sensitivity"</li> </ul> <p>The resolution proposed is to remove the F tag from our 2567-facility survey report.</p>		

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F0360 SS=D	<p>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to provide residents' supplements to meet the special dietary needs of each resident for 2 of 4 residents reviewed with supplements served with their meals in a total sample of 21. (Residents #24 and #93)</p> <p>Findings include:</p> <p>1. Resident #24's record was reviewed on 10/3/11 at 1:15 a.m. Resident #24's diagnoses included, but were not limited to, dementia, failure to thrive, and depression.</p> <p>A physician's order, dated 9/22/11, indicated, "...weight loss...super foods c (with) each meal."</p> <p>A care plan, dated 9/22/11, indicated, "...Decline in oral food consumption and</p>	F0360	<p>F 3601. Residents #24 and #93 received the supplements as per physician orders.2. A listing of residents with dietary supplement orders was requested from Care Pharmacy Medical Records on 10/3/2011 to audit delivery of dietary supplements as per physician orders. 3. Care Pharmacy Medical Records staff will provide a listing of residents ordered dietary supplements to the Dietary Manager or designee weekly. This listing will be used starting 10/25/2011 to audit dietary supplement delivery to residents with dietary supplement orders 3 times per week for six months. Random audits of the provision of dietary supplements will be done by the Executive Director or designee 3 times per week for six months. The Dietary Manager educated Dietary staff by 10/7/2011 on the policy for providing dietary supplements ordered by the physician.4. Data from the Dietary Manager's or</p>	11/02/2011

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	<p>weight loss...Approaches...super foods each meal..."</p> <p>Resident #24 was observed on 10/3/11 at 12:35 p.m., during the noon meal. The resident had received her meal. The resident had turkey, green beans, and a baked potato. The resident had not received any super soup with her meal.</p> <p>Resident #24 was observed on 10/4/11 at 8:20 a.m., eating her breakfast with assistance from Occupational Therapist #7. The resident did not have any super cereal.</p> <p>During an interview on 10/4/11 at 9:34 a.m., Occupational Therapist #7 indicated the resident had not received super cereal for breakfast.</p> <p>During an interview on 10/6/11 at 9:30 a.m., the Dietary Manager indicated super foods were super soup with lunch and dinner and super cereal with breakfast.</p> <p>2. Resident #93's record was reviewed on 10/4/11 at 4:55 p.m. Resident #93's diagnoses included, but were not limited to, gout, pneumonia, and depression.</p> <p>A physician's order, dated 9/15/11, indicated, "weight loss Healthshakes i (one) carton TID (three times a day)..."</p>		<p>designee's audits will be presented by the Executive Director or designee at the Quality Assurance monthly meeting and any negative trends will be addressed with an action plan.DATE CERTAIN 11/2/2011THIS IS MY CREDIBLE ALLEGATION</p>		

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	<p>A care plan, dated 9/15/11, indicated, "Weight loss...Approaches Give healthshake at breakfast, lunch, and supper..."</p> <p>Resident #93 was observed during the evening meal on 10/4/11 at 6:15 p.m. The resident had not received a healthshake with his meal.</p> <p>During an interview on 10/4/11 at 6:20 p.m., CNA #9 indicated the resident had not received a healthshake with his supper. CNA #9 indicated the resident should have received a healthshake and went to get the resident a healthshake.</p> <p>3.1-20(a)</p>				

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure food items were dated when opened. failed to store and prepare food under sanitary condition related to dirty cabinets and drawers, juice dispensers, bowls, and floor under the dried storage shelving and bottles of opened Prostat (protein supplement). These practices had the potential to affect 99 of 101 residents who received meals from 1 of 1 kitchen and 1 of 2 nutritional pantries.</p> <p>Findings include:</p> <p>1. During an observation of the facility's kitchen on 10/03/11 at 10 a.m. through 10:25 a.m. with the Dietary Manager (DM), the following was observed:</p> <p>A. There were crumbs in the drawer under the counter at the serving window, which stored clean and ready to use utensils.</p> <p>B. There was a dried brown stain in the drawer under the coffee pot. The DM indicated the stain was probably coffee.</p>	F0371	<p>F 3711. Immediate action taken to address the identified concerns: All supplements with staining were discarded on 10/5/11; the employee's purse was removed to the locker room, the undated lettuce in the kitchen was discarded and all cabinets, bowls and kitchen equipment identified as soiled were immediately cleaned and/or sanitized.2. All residents will benefit from the programs implemented by the facility to ensure that we store, prepare and serve food under sanitary conditions. 3. The DON and /or designee will audit products stored in the unit pantries 3 times per week for six months and discard any with staining. Nursing staff was educated on 10/20/2011 by the Staff Development Coordinator to clean bottles/containers of supplements if the liquid drips from the bottles during administration. The Dietary Manager or designee will audit refrigeration dates and the sanitation of cabinets, floors, bowls and kitchen equipment. The Ward Clerk was re-educated on the responsibility for checking supplements for staining. An ECO-LAB representative inserviced dietary staff on</p>	11/02/2011	

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	<p>C. There were crumbs and rust stains in the cabinet under the coffee maker of the preparation table. During interview at this time, the DM indicated the cabinets are cleaned as needed.</p> <p>D. There was an employee's purse stored in the cabinet under the serving window where dishes were stored.</p> <p>E. There was a build up of rust and dirt on the bottom of the cabinet under the sink.</p> <p>F. There was a build up of stickiness on the orange juice, apple juice, lemon-ade, and cranberry juice nozzles.</p> <p>G. There was dried food on 3 of 14 stored and ready to use bowls.</p> <p>H. There were crumbs in the drawer which stored clean and ready to use cooking utensils of the preparation table.</p> <p>I. The cabinet under the cooking utensil drawer had a light brown substance on the inside bottom shelf. The DM indicated it looked like hot chocolate.</p> <p>J. There was an opened and undated bag of lettuce in the walk-in refrigerator.</p> <p>K. There was a build up of dirt and debris</p>		<p>dishwashing procedures by 10/4/2011. The Dietary Manager inserviced all dietary staff on the policy for dating and storing food items, kitchen equipment sanitation and proper dishwashing procedures by 10/7/2011. The Dietary Manager or designee will audit food item dates and kitchen sanitation three times per week for six months. Any noncompliance will be addressed immediately with an action plan and disciplinary action. 4. The Dietary Manager or designee will audit for compliance with dating food items and sanitation policies three times per week for six months and address any concerns identified. The Ward Clerk or designee will check the supply of supplements 3 times weekly for six months and remove any found to be stained with dried fluid matter. Repeated noncompliance will require an action plan and disciplinary action as appropriate. The Executive Director or designee will make random audits to check food items dates, kitchen equipment, general sanitation, dishes and supplements weekly. The Ward Clerk will forward weekly supplement audits to the DON for follow-up. Trends from all audits will be forwarded to the DON or designee monthly to report at the monthly Quality Improvement meetings and any negative trends will be addressed with an action plan. DATE CERTAIN</p>		

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	<p>under the shelves in the dried food storage area. There was also an empty syrup container and trash located under the shelves. The DM indicated there was dirt and debris under the shelves.</p> <p>2. Central Wing Nutritional Pantry:</p> <p>During the environmental tour of the facility on 10/06/11 at 8:20 a.m. through 9:15 a.m. with the Maintenance Supervisor and the Housekeeping Supervisor, there were 8 opened bottles of Prostat on the shelf with dark brown liquid stained and dried running down the sides of the bottle.</p> <p>During an interview at the time of the observation, the Maintenance Supervisor indicated there was the dried liquid on the side of the bottles.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		11/2/2011 THIS IS MY CREDIBLE ALLEGATION		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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