

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
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F000000	<p>This visit was for the Investigation of Complaint IN00161190.</p> <p>Complaint IN00161190- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F309.</p> <p>Survey dates: December 17 and 18, 2014</p> <p>Facility number: 010597 Provider number: 155657 AIM number: 200204440</p> <p>Survey team: Trudy Lytle, RN-TC Jennifer Sartell, RN Gloria Reisert, MSW</p> <p>Census bed type: SNF/NF: 86 Total: 86</p> <p>Census payor type: Medicare: 25 Medicaid: 41 Private: 16 Other: 4 Total: 86</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Attached you will find the completed Plan of Correction and attachments for complaint survey dated December 18, 2014. We respectfully request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 738-0550.</p> <p>Sincerely, Aaron Clarke, Executive Director</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000157 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on December 16, 2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the 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</p>						

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	<p>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 notify the physician when a resident experienced frequent elevated heart rate levels (Resident #D); a resident's chest tube site was observed to be swollen and reddened (Resident #E); and a resident continually refused daily dressing changes to a new surgical site (Resident #C). This deficient practice affected 3 of 5 residents reviewed for change in condition.</p> <p>Findings include:</p> <p>1. The Clinical Record for Resident D was reviewed on 12/17/14 at 10:50 a.m. Diagnoses included, but were not limited to cardiac dysrhythmia, cardiomyopathy, atrial fibrillation, dementia and hypertension.</p> <p>The Minimum Data Set Change in Condition assessment for Resident D, dated 10/20/14, indicated extensive assist of 1 with bed mobility, dressing and personal hygiene. It also indicated extensive assist of 2 with transfers and toileting.</p>	F000157	<p>F157</p> <p>I. Resident C is no longer a resident of this facility. Resident D is no longer a resident of this facility. Resident E is no longer a resident of this facility.</p> <p>II. All residents have potential to be affected. A chart audit for physician notification of change in condition for past 30 days was completed, any discrepancy has been corrected immediately with physician and family/responsible party notification.</p> <p>III. SDC/designee will in-service licensed nurses on timely physician notification of change in condition by January 17, 2014.</p> <p>IV. Director of Nursing/Designee will audit dashboard report for resident change of condition with timely physician notification of change of condition 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then during IDT meeting weekly as an ongoing process of this facility. The DNS/designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting for at least 3 months or until the PI committee determines 100% compliance.</p> <p>V. The DNS is responsible for</p>	01/17/2015			

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	<p>Review of the document titled, Weights and Vitals Summary, indicated between 8/2/14 and 10/14/14, Resident D's heart rate ranged between 56 and 82. It also indicated between 10/15/14 and 11/22/14, Resident D's heart rate ranged between 92 and 117.</p> <p>During an interview on 12/17/14 at 1:20 p.m., LPN #2 indicated if a residents' heart rate was in the 100's, she would notify the physician. She also indicated she would consider a continuous elevated heart rate a significant change.</p> <p>During an interview on 12/17/14 at 1:22 p.m., LPN #3 indicated an elevated heart rate is a significant change in condition and she would notify the physician immediately.</p> <p>During an interview on 12/17/14 at 1:24 p.m., LPN #1 indicated she would consider an elevated heart rate a significant change in condition and notify the physician.</p> <p>During an interview on 12/17/14 at 1:27 p.m., LPN #4 indicated a heart rate in the 100's is tachycardia and would be a significant change. She also indicated she would definitely notify the physician.</p>		compliance.	

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	<p>Review of the nurses note's between 10/15/14 and 11/22/14, lacked documentation of physician and family notification of Resident D's elevated heart rate.</p> <p>On 12/17/14 at 10:45 a.m., the Director of Nursing provided a current copy of the Policy and Procedure titled Condition Change of a Resident. It included but was not limited to the following: "Rationale Resident change of condition...Definitions...IMMEDIATE NOTIFICATION...NON-IMMEDIATE NOTIFICATION-the physician should be informed of the problem or event during office hours and generally no later than the next regular office day...The nurse should not hesitate to contact the physician at any time for a problem that in their judgement requires immediate medical attention...Significant Change A decline or improvement in a resident's status that: Will not normally resolve itself without intervention...Impacts more than one area of the resident's health status...Procedure 1. Assess Resident...5. Notify the physician of the clinical problems...8. Notify family member/responsible party of resident's condition...11. Monitor and reassess resident's condition...Documentation Guidelines 1. Document in the resident's medical record...b. Assessment of</p>			

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	<p>resident condition...d. All attempts to notify of Physician and any new orders. e. Physician's response...g. all attempts to notify resident's family member/responsible party h. Resident Assessment...."</p> <p>2. Review of the clinical record for Resident #E on 12/17/14 at 12:50 p.m. indicated the resident was admitted to the facility from another nursing facility on 9/26/14. Diagnoses included, but were not limited to: malignant neoplasm bronchus/lung; pleural effusion and hypertension.</p> <p>Nursing notes between 9/26/14 and 10/6/14, indicated the following entries:</p> <p>- "9/26/14 at 19:40 [7:40 p.m.] - Admission 4 Hour Patient Nursing Evaluation completed:...Chest tube site to left back noted with redness around dressing site...."</p> <p>- "9/26/14 at 20:40 [8:40 p.m.] - Evaluation Summary: 72 hour Patient Nursing Evaluation completed:...Dressing intact with redness noted around dressing site...."</p> <p>- "9/27/14 at 13:44 [1:44 p.m.] - Health Status Note:...300ML [milliliters] drained for chest tube site (sic). Site around tube was red swollen and warm marked with</p>			

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	<p>marker to watch for expansion...."</p> <p>- "10/2/14 at 18:34 [6:34 p.m.] - Health Status Change: Situation: Site around chest tube red and hot to the touch. Slight swelling noted...Assessment:...Resident with c/o [complaint] of discomfort r/t [related to] chest tube site. Request: please advise." On 10/3/14, the physician responded with a new order for obtaining a wound culture of chest tube.</p> <p>Nursing Assessments between 9/26/14 and 10/4/14 indicated the following:</p> <p>- "9/26/14 Patient Nursing Evaluation Part 1 - B. Pain: 1. Pain B3. How much of the time have you experienced pain or hurting over the last 5 days? - with chest tube dressing changes...F Skin Inspection Anatomy Diagram: Site : Left back chest tube dressing with erythema around tube. JJ summary: ...Chest tube to left back noted with redness around dressing site."</p> <p>- "9/27/14 Weekly Non-Pressure Skin Condition Report - A. Skin Condition Information: Site: 1b - L [left] back drainage tube site; 1e: if Other skin condition checked - describe: Redness....D. Assessment/Care plan Summary: Continue to monitor tube site reddened area."</p> <p>- "9/27/14 Skin Inspection Anatomy</p>			

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	<p>Diagram - B. Skin Inspection Anatomy Diagram: L back. 2a. Drainage tube site redness. C. Conclusion/Comments: ...4. Comments: Reddened area to L back at drainage tube site. Continue to monitor for s/s [signs/symptoms] of infection."</p> <p>- "10/4/14 Weekly Non-Pressure Skin Condition Report - A Skin Condition Information: 1a. Date of First Observance: 9/27/14. 1b. Site: L side of back drain tube site..B Assessment of Wound: 1c. Pale red/pink - sub-optimal healing...D. Assessment/Care Plan Summary: Continue to monitor area surrounding drain tube site for redness."</p> <p>Documentation was lacking of the physician having been notified that the resident's chest tube site was observed to be reddened and warm to hot-to-the-touch until 10/2/14. This was 7 days after the resident had been admitted.</p> <p>During interviews on 12/17/14 between 1:20 p.m. and 1:40 p.m., LPN #2, #3 and #4 indicated that if they noticed a resident's chest tube site to be reddened and/or swollen, they would immediately notify the physician as it could signify a sign of infection. They also indicated that if nothing else, they would send it as an FYI [For Your Information] to the</p>			

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	<p>physician.</p> <p>3. Review of the clinical record for Resident #C on 12/17/14 at 10:20 a.m., indicated the resident was re-admitted to the facility on 11/11/14 after undergoing amputation of Left (L) Great Toe.</p> <p>Nursing notes between 11/11/14 and 11/17/14, indicated the following entries: - "11/11/14 at 21:45 [9:45 p.m.] - Admission Summary:...Unable to assess left foot due to pt [patient] refusing to let this nurse assess left foot due to pt stating [name of physician] said not to touch once wrapped...."</p> <p>- "11/12/14 at 00:32 [12:32 a.m.] - Evaluation Summary: Readmission 4 Hour Patient Nursing Evaluation completed:...Comments/Summary: Pt told this nurse that [name of physician] said not to touch left foot wrap until seen again by [name of physician], This nurse questioned pt about assessing incision area from surgery but pt refused saying quote '[name of physician] said not to touch left foot after being dressed and wrapped...."</p> <p>- "11/12/14 at 04:55 [4:55 a.m.] - pt expressed a lot of concern over foot wrap getting wet. pt was anxious about voiding with fears of getting foot wrap wet and pt</p>			

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	<p>stated 'I'll go septic and it'll kill me.' after being assisted to the bathroom pt was unwilling to approach sink to wash hands because of water spotted on the floor and requested a wet paper towel to wipe hands with instead. bedpan was offered and pt refused with concerns of getting foot wrap wet."</p> <p>- "11/15/14 at 17:22 [5:22 p.m.] - Health Status Note:...Complaints of pain r/t [related to] foot amputation...refused to let this nurse change dressing stated that the MD [physician] told her not to change it until Wednesday 11/19/14...."</p> <p>- "11/16/14 at 20:03 [8:03 p.m.] - Health Status Note:...refused to let this nurse change dressing stated that the MD told her not to change it until Wednesday 11/19/14...."</p> <p>- "11/17/14 at 01:36 [1:36 a.m.] - Skin/Wound Note: Resident has not allowed dayshift Nurses x [times] 5 days to treat L Great Toe amputation site, or even to unwrap and check surgical area...."</p> <p>Documentation was lacking of the physician having been notified of the resident's continued refusal to allow nursing to complete daily wound dressings and assessment of the wound.</p>			

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F000282 SS=D	<p>During interviews on 12/17/14 between 1:20 p.m. and 1:40 p.m., LPN #3 and #4 indicated that if a resident was refusing a dressing change of a wound, especially a new surgical site, they would notify the physician the first time a resident refused. LPN #2 indicated she would notify the resident's physician after the third refusal.</p> <p>On 12/18/14 at 9:16 a.m., the Director of Nursing presented a copy of the facility's current policy titled "Resident Refusal of Treatment." Review of this policy at this time included, but was not limited to: Compliance Guidelines:...7. Notify the Physician and consult for any alternative treatment and document in the resident's medical record..."</p> <p>This Federal tag relates to Complaint IN00161190.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>			

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	<p>Based on record review and interview, the facility failed to follow physician's orders for 1 of 5 residents reviewed for physician's orders. Resident D</p> <p>Finding includes:</p> <p>The Clinical Record for Resident D was reviewed on 12/17/14 at 10:50 a.m. Diagnoses included, but were not limited to cardiac dysrhythmia, cardiomyopathy, atrial fibrillation, dementia and hypertension.</p> <p>The Minimum Data Set Change in Condition assessment for Resident D, dated 10/20/14, indicated extensive assist of 1 with bed mobility, dressing and personal hygiene. It also indicated extensive assist of 2 with transfers and toileting..</p> <p>The faxed copy of a document titled [facility name] Progress Notes included, but was not limited to the following: "Date: Sep 28, 2014...Patient Name...Note Text: Situation: Resident has a small knot aproximatly [sic] 1 cm [centimeter] in length in R [right] thigh vein. It is not red, or painful...10/1/14 would observe...call for problem...."</p> <p>During an interview on 12/18/14 at 10:15 a.m., the Director of Nursing indicated</p>	F000282	<p>F282I. Resident D is no longer a resident of this facility.II. All residents have potential to be affected. An audit of all faxed physician communication for the past 30 days has been completed for accurate transcription to physicians order sheets and compared to related monitoring sheet to validate physicians orders are completed as ordered any discrepancy has been corrected with immediate physician and family/responsible party notification. III. SDC/designee will in-service licensed nurses on PRO 62000-14 Readmission, Hand Written Orders, Written Transfer Orders or Faxed Orders by January 17, 2014. IV. Director of Nursing/Designee will audit transcription of all new faxed physician communications 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then weekly as an ongoing process of this facility. The DNS/designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting for at least 3 months or until the PI committee determines 100% compliance. V. The DNS is responsible for compliance.</p>	01/17/2015			

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	<p>when the physician has written on a returned fax, it is considered a physicians' order.</p> <p>During an interview on 12/18/14 at 10:17 p.m., LPN #4 indicated when a fax comes back from the physician, what is written on it is considered an order and we transpose that to a physician's order.</p> <p>During an interview on 12/18/14 at 10:20 a.m., LPN #5 indicated if she faxes a lab or a note to the physician and the physician sends it back with a response, she writes it out as a physician's order.</p> <p>The Clinical Record for Resident D lacked a physician's order on 10/1/14, to observe and call for problem.</p> <p>Review of the September and October Medication Administration Record and Treatment Administration Record lacked documentation for observation of the knot to Resident D's right thigh.</p> <p>This Federal tag relates to Complaint IN00161190.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident was educated on the risks associated with refusal of dressing changes, clarify a physician's order for daily dressing changes and assess the reasons for a resident's refusal for daily dressing changes; and accurately assess a resident with an elevated heart rate . This deficient practice affected 2 of 5 residents reviewed significant changes. (Resident #C and D)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #C on 12/17/14 at 10:20 a.m., indicated the resident was re-admitted to the facility on 11/11/14 after undergoing amputation of Left (L) Great Toe.</p> <p>Nursing notes between 11/11/14 and 11/17/14 indicated the following entries:</p>	F000309	F309I. Resident C is no longer a resident of this facility. Resident D is no longer a resident of this facility.II. All residents refusing dressing changes and residents with consistent change in heart rate have potential to be affected. An audit of all dressing changes for the past 30 days have been completed to validate treatments are completed as ordered and if dressing change was refused for 2 or more consecutive treatments resident and responsible party have been educated on risks associated with refusal of dressing changes and notification to physician and responsible parties have been made, any discrepancy has been corrected immediately with resident and responsible party risk of refusal education and notification to physician and family/responsible party completed. An audit of all heart rates for the past 30 days have been completed to validate any consistent change in heart	01/17/2015			

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	<p>- "11/11/14 at 21:45 [9:45 p.m.] - Admission Summary:...Unable to assess left foot due to pt [patient] refusing to let this nurse assess left foot due to pt stating [name of physician] said not to touch once wrapped...."</p> <p>- "11/12/14 at 00:32 [12:32 a.m.] - Evaluation Summary: Readmission 4 Hour Patient Nursing Evaluation completed:...Comments/Summary: Pt told this nurse that [name of physician] said not to touch left foot wrap until seen again by [name of physician], This nurse questioned pt about assessing incision area from surgery but pt refused saying quote '[name of physician] said not to touch left foot after being dressed and wrapped'...."</p> <p>- "11/12/14 at 04:55 [4:55 a.m.] - pt expressed a lot of concern over foot wrap getting wet. pt was anxious about voiding with fears of getting foot wrap wet and pt stated 'I'll go septic and it'll kill me.' after being assisted to the bathroom pt was unwilling to approach sink to wash hands because of water spotted on the floor and requested a wet paper towel to wipe hands with instead. bedpan was offered and pt refused with concerns of getting foot wrap wet."</p> <p>- "11/15/14 at 17:22 [5:22 p.m.] - Health</p>		<p>rate, as identified for this audit as an increase of 30 bpm from baseline or greater than 100 bpm on repeat assessment in at least 2 consecutive readings, and notifications of physician and family/responsible party completed, any discrepancy has been corrected immediately with physician and family/responsible party notification. III. SDC/designee will in-service licensed nurses on PRO 61003-01 Condition Change of a Resident and PRO 65000 Resident Refusal of Care by January 17, 2014. IV. Director of Nursing/Designee will audit all Treatment Administration Records to validate treatments are completed as ordered, if dressing change are refused for 2 or more consecutive treatments resident and responsible party have been educated on risks associated with refusal of dressing changes and notification to physician and responsible parties have been made, for 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then weekly as an ongoing process of this facility. Director of Nursing/Designee will audit vital sign records to validate change in pulse as identified per TL 6103-09 (Resting pulse greater than 130 bpm, less than 55 bpm, or greater than 110 bpm and patient has dyspnea or palpitations or resting pulse greater than 120 bpm on repeat</p>				

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	<p>Status Note:...Complaints of pain r/t foot amputation...refused to let this nurse change dressing stated that the MD told her not to change it until Wednesday 11/19/14...."</p> <p>- "11/16/14 at 20:03 [8:03 p.m.] - Health Status Note:...refused to let this nurse change dressing stated that the MD [physician] told her not to change it until Wednesday 11/19/14...."</p> <p>- "11/17/14 at 01:36 [1:36 a.m.] - Skin/Wound Note: Resident has not allowed dayshift Nurses x [times] 5 days to treat L Great Toe amputation site, or even to unwrap and check surgical area...."</p> <p>Documentation was lacking of the resident having been educated on the risks associated with refusal to change the dressings on a new surgical wound and determine alternate treatments. Documentation was also lacking in which the nurses notified the physician to clarify the order for daily dressing changes due to the resident having indicated she had been told something different.</p> <p>During interviews on 12/17/14 between 1:20 p.m. and 1:40 p.m., LPN #2, #3 and #4 indicated that if a resident was refusing a dressing change of a wound,</p>		<p>exam) with notification to physician and responsible parties made, for 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then weekly as an ongoing process of this facility. The DNS/designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting for at least 3 months or until the PI committee determines 100% compliance. V. The DNS is responsible for compliance.</p>		

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	<p>especially a new surgical site, they would try to determine why she was refusing and notify the MD. They also would try to let the resident know the risks if she didn't let nursing look at the wound to be sure it was healing properly.</p> <p>On 12/18/14 at 9:16 a.m., the Director of Nursing presented a copy of the facility's current policy titled "Resident Refusal of Treatment." Review of this policy at this time included, but was not limited to: Compliance Guidelines:...2. If a resident is observed to refuse care/treatment,a representative of the Interdisciplinary Team (IDT) meets with the resident/family to determine the basis of the refusal, acceptable alternatives and assist the resident in implementing his/her choices...4. The IDT educates the resident and/or family to the risks of refusing care, treatment, and/or services...6. Center staff should: a. Assess the reasons for the resident's refusal, b. Clarify and educate the resident and/or legal representative as to the consequences of refusal, c. Offer alternative treatments,...7. Notify the Physician and consult for any alternative treatment and document in the resident's medical record...."</p> <p>2. The Clinical Record for Resident D was reviewed on 12/17/14 at 10:50 a.m.</p>			

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	<p>Diagnoses included, but were not limited to cardiac dysrhythmia, cardiomyopathy, atrial fibrillation, dementia and hypertension.</p> <p>The Minimum Data Set Change in Condition assessment for Resident D, dated 10/20/14, indicated extensive assist of 1 with bed mobility, dressing and personal hygiene. It also indicated extensive assist of 2 with transfers and toileting.</p> <p>Review of the document titled Weights and Vitals Summary indicated between 8/2/14 and 10/14/14, Resident D's heart rate ranged between 56 and 82. It also indicated between 10/15/14 and 11/22/14, Resident D's heart rate ranged between 92 and 117.</p> <p>During an interview on 12/17/14 at 1:20 p.m., LPN #2 indicated if a residents' heart rate was in the 100's, she would notify the physician. She also indicated she would consider a continuous elevated heart rate a significant change.</p> <p>During an interview on 12/17/14 at 1:22 p.m., LPN #3 indicated an elevated heart rate is a significant change in condition and she would notify the physician immediately.</p>			

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	<p>During an interview on 12/17/14 at 1:24 p.m., LPN #1 indicated she would consider an elevated heart rate a significant change in condition and notify the physician.</p> <p>During an interview on 12/17/14 at 1:27 p.m., LPN #4 indicated a heart rate in the 100's is tachycardia and would be a significant change. She also indicated she would definitely notify the physician.</p> <p>Review of the nurses note's between 10/15/14 and 11/22/14, lacked documentation of physician and/or nursing assessment regarding causative factors related to Resident D's elevated heart rate.</p> <p>On 12/17/14 at 10:45 a.m., the Director of Nursing provided a current copy of the Policy and Procedure titled Condition Change of a Resident. It included but was not limited to the following: "Rationale....Procedure 1. Assess Resident...12. Complete a full assessment if the residents condition does not return to baseline no later than 14 days...Documentation Guidelines 1. Document in the resident's medical record on appropriate designated form:...b. Assessment of resident condition....h. Resident Assessment...."</p>			

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	This Federal tag relates to Complaint IN00161190. 3.1-37(a)				