

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2014
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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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F000000	<p>This visit was for the Investigation of Complaints IN00143843, IN00143908, IN00144001 and IN00144354.</p> <p>Complaints: IN00143843 Substantiated. Federal/State deficiency related to the allegation is are cited at F441.</p> <p>IN00143908 Substantiated. No deficiencies related to the allegations are cited.</p> <p>IN00144001 Substantiated. No deficiencies related to the allegations are cited.</p> <p>IN00144354 Federal/State deficiencies related to the allegations are cited at F201, F202, F204 and F328.</p> <p>Survey dates: February 12, 13, 14, and 19, 2014</p> <p>Facility Number: 000191 Provider Number: 155294 AIM Number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p>	F000000	<p>F000000 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Census Bed Type: SNF: 58 Residential: 27 Total: 85</p> <p>Census Payor Type: Medicare: 34 Private: 51 Total: 85</p> <p>Sample: 7 Supplemental sample: 1 Residential sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on February 25, 2014.</p>				

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F000201 SS=D	<p>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>Based on record review and interview the facility failed to ensure a resident was allowed to remain in the facility, in that the nursing staff failed to verify a resident's equipment and the needs associated with the operation of the machine prior to the resident being</p>	F000201	<p>F201</p> <p><i>In response to the cited findings R/T to F201, the following actions will be taken:</i></p> <p>A) Resident D was discharged from the facility after determination by the administrative/clinical team that his needs could not be met in the facility.</p>	03/19/2014			

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	<p>admitted to the facility. After the resident resided in the facility for over 48 hours, and was allowed to use the respiratory equipment, the facility indicated a determination was made to discharge the resident. This deficient practice affected 1 of 3 resident's reviewed for inappropriate discharge in a sample of 7. (Resident "D").</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 02-12-14 at 2:00 p.m. Diagnoses included, but were not limited to, anoxic brain injury, cardiac arrest, aphasia, coronary artery disease and atrial fibrillation. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 02-04-14.</p> <p>A review of the facility pre-admission assessment, dated 02-03-14, indicated the resident's primary diagnosis included anoxic encephalopathy with dysphasia. The record included "miscellaneous information," which included the following: "Pt [patient] presented on ED [emergency department] on 11-26-[2013] after falling face down in</p>		<p>Resident was on a VPAP machine that family indicted was malfunctioning, and facility was unable to obtain replacement equipment from two respiratory vendors. Due to resident history of anoxic brain injury from previous prolonged apneic event, facility determined the risk to the resident to be greater than the benefit of continued stay at the facility with questionable respiratory equipment. A joint decision (with the facility Executive Director and Director of Nursing, and resident's POA and 2 other family members) was made to send resident D back to hospital for evaluation by respiratory professionals to see if resident could be safely maintained on CPAP or BiPAP. Resident was transferred by ambulance to local hospital ER as noted. Family members elected hospital destination and removed personal effects from room. They were present at the time of discharge.</p> <p>B) No other residents residing in this facility have been affected by this alleged deficient practice.</p> <p>C) Interdisciplinary meeting held on February 25, 2014 with Admissions Liaison, Admissions Director, Executive Director (ED), Health Facility Administrator (HFA), Director of Nursing Services (DON), and Regional Director of Health Services to review facility admission/discharge policy. All</p>				

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	<p>driveway. Few days later pt. went into pulseless electrical activity. CPR [cardiopulmonary resuscitation] performed times 15 minutes...pt is NPO [nothing by mouth] A & O [alert and oriented] times 2. O2 [oxygen] per NC [nasal cannula]. VPAP [variable mode of a positive airway pressure] at noc [night]. Expected date of discharge - 02-04-14." At the top of this assessment was the following handwritten notation with asterisks adjacent to the notation: *VPAP.*</p> <p>A review of the Hospital Discharge Summary, dated 02-01-14 indicated "handwritten notes" which also instructed the resident used "VPAP for central sleep apnea." The physician notation indicated "The patient remained on the VPAP machine at night for his central sleep apnea. He also remained on supplementary oxygen through nasal cannula during the day. He, at time of discharge was medically stable with no new issues." The "Problem List" noted on this discharge summary indicated: "1. Anoxic encephalopathy secondary to cardiac arrest, 2. Central sleep apnea using VPAP machine at night."</p>		<p>future admissions involving any unfamiliar/non-routine orders/equipment will be reviewed by HFA and DON for appropriateness, and ability of the facility to meet the resident's needs. Any questionable diagnosis/medications/equipment will be reviewed with the Medical Director as needed prior to accepting resident for admission to facility.</p> <p>D) The facility's full Management/Administrative Team will be instructed of admission and discharge policies/procedures with respect to comprehensive assessments of unfamiliar equipment and/or non-routine orders/equipment. Personnel involved will be Nursing Supervisors, Medical Records Clerk, and MDS Nurses. Any physicians who admitted patients to the facility in the last six months will be advised of updated policies and procedures.</p> <p>E) Monitoring will include review of new admissions at bi-weekly Continuous Quality Improvement (CQI) meetings to ensure compliance and identify any need for continued education with Clinical Liaison/Admissions Director.</p> <p>F) Any Management Team or personnel involved with admissions found with failure to adhere to established polices will be re-educated and/or reprimanded as indicated. The HFA will be responsible to ascertain</p>		

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	<p>A review of the hospital "Discharge Report," dated 02-04-14, indicated "oxygen therapy - oxygen, CPAP [continuous positive airway pressure], home machine."</p> <p>The facility "New Patient Admission Report," undated, indicated the resident had a "cardiac arrest at home - anoxic brain injury. Sleep apnea with special CPAP machine."</p> <p>The facility "admission orders and plan of care," dated 02-04-14 and verified by the facility nurse with the physician, indicated "treatments - VPAP O2 via N/C [nasal cannula] to maintain sats [saturation] > [greater than] 90 % O2 equip. [equipment] care to protocol."</p> <p>The resident was assessed by the Nurse Practitioner on 02-05-14. The assessment lacked documentation or a concern related to the resident's use of the VPAP machine at night.</p> <p>A review of the nurses notes, indicated the following:</p> <p>"02-05-14 at 0400 [4:00 a.m.] CPAP in place with O2 at 2 L [liters] per M [minute]. Personal caregiver at bedside."</p>		<p>full staff cooperation. He will monitor complete adherence to Admission/Discharge policies and procedures.</p> <p>The Executive Director will review 50% of Admissions/Discharges weekly for the next 30 days, then 25 % for the following 60 days to ensure compliance.</p> <p>Date of compliance with proposed actions: March 19, 2014</p>		

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	<p>"02-06-14 at 0330 [3:30 a.m.] Res. [resident] is alert. Restless this noc. [night]. Takes CPAP off - O2 at 2L per NC [nasal cannula], Sat 97 % - no SOB [shortness of breath]. Personal caregiver at bedside."</p> <p>"02-06-14 3:00 p.m. - VPAP setting ordered to continues per home setting. Family set it up in the room."</p> <p>During an interview on 02-14-14 at 11:30 a.m., the Director of Nurses indicated she made the initial contact with the spouse and asked if the resident had a CPAP machine and the resident's spouse indicated the resident had his own. The Director of Nurses indicated the nursing staff realized it wasn't a CPAP machine as thought, but the resident's family member said a family member would set it up. The Director of Nurses instructed the family member that he would need to have someone here to come in and monitor. The Director of Nurses indicated that when she spoke with the resident's family member on Wednesday (02-05-14) he told her the machine malfunctioned during then night and requested a "back up" machine. Although the facility didn't have an order for that machine, the Director of Nurses</p>			

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	<p>indicated she would request the Nurse Practitioner to write an order for the use of the VPAP machine, which she did.</p> <p>The Director of Nurses indicated that is when she started "working on it" and spoke with the facility respiratory company. She indicated the staff person she spoke to, told her the VPAP was a "home vent [ventilator] machine," and she reported this information to [name of the Executive Director]. Furthermore the Director of Nurses indicated the facility respiratory company instructed her that, this type of machine couldn't be used in "our setting."</p> <p>The Director of Nurse further indicated she called (name of a Home Health Agency the resident's family utilized), who told her they had been looking for that machine, and advised her they would check to see if they needed to come and pick up the machine that night. She further indicated the Home Health Agency instructed her that this type of machine was to be used at "home." The Director of Nurses indicated she tried to get someone to come to the facility but a respiratory therapist was unable to</p>			

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	<p>come. At that point the Director of Nurses indicated she felt the facility was "culpable" in this situation.</p> <p>When the family arrived at the facility, the Director of Nursing told them the Agency would probably be picking up the equipment and (name of resident) could not stay here in the facility, and spoke with them about taking the resident home. "They said 'no' to that and then I asked them what hospital they wanted to send him to, because if he couldn't use a CPAP [continuous positive airway pressure] machine then he couldn't stay here." She indicated the nursing staff called for the ambulance to come and pick up the resident and transport him to (name of local area hospital). The record indicated the resident left the facility at approximately 10:45 p.m. - 11:00 p.m., but verified the resident was allowed to use this equipment on 02-04-14 and again on 02-05-14 without knowledge of the operational modes of the equipment or staff education.</p> <p>A review of the facility physician documentation, dated 02-06-14, indicated "Subjective: [name of resident] is [age documented]. Anoxic encephalopathy, pt. [patient]"</p>				

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	<p>admitted to Forum after a stay at [name of Rehabilitation Center], pt. is still quite confused and is on a vpap and tube feedings. Extensive talk with [family member]. Family very involved." "Assessment: anoxic encephalopathy- ensure safe environment, debility ptot <sic> [physical therapy - occupational therapy], pcp [primary care physician] records reviewed, NP admission note reviewed." The physician documentation lacked concern of the use of the VPAP machine in the facility or the need to transfer/discharge the resident.</p> <p>A review of the "Patient Transfer Form," dated 02-06-14, indicated the name of the resident (misspelled), and where the resident was being transferred. The "Notice of Transfer or Discharge," dated 02-06-14, indicated the resident was being transferred/discharge to "another health facility - [name of hospital]." The "reason for Transfer or Discharge," indicated "The health of the individuals in the facility would otherwise be endangered." Handwritten adjacent to this statement indicated "Need for eval. [evaluation]."</p> <p>During an interview on 02-14-14 at</p>						

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	<p>9:15 a.m., the hospital RN [Registered Nurse] Case Manager indicated, "I came to work on the 7th [02-07-14]. The doctor said there was no reason for [name of resident] to be brought back to the hospital to the emergency room. The facility really didn't have a discharge plan for him so they sent him back to us. The family is confused and said they weren't told anything about any of this until the evening of 02-06-14 around 9:00 p.m., when they were told by the Director of Nurses they couldn't take care of him with the machine he had [in regard to the VPAP machine] and they were asked to take him home. The family member spoke with the pulmonologist who said he would give the orders needed for him to stay at the facility and the Director of Nurses refused to speak with him."</p> <p>When interviewed on 02-14-14 at 11:30 a.m., the Director of Nurses indicated she was at home by the time the doctor called the facility. "I told my nurse she had the chart in front of her and she needed to talk with the doctor."</p> <p>The record lacked documentation of a conversation between the night shift nurse and the physician.</p>			

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	<p>A review of the hospital ER (emergency room) Nursing flowsheet, dated 02-06-14 at 11:35 p.m., indicated the following:</p> <p>"ECF [extended care facility] called [name of ambulance service] to transport patient to hospital At ECF, they attempted to call Dr. [doctor] from hospital to get an appropriate order for his home equipment. Per [family member], the ECF is only able to manage CPAP and Bipap machines that are through a rental company. [Name of Home Health Agency] was called and explained that this patient's own equipment had 'vent like settings and are not accepted at Forum at the Crossing.' Family frustrated that patient needed to be transported in the middle of the night and after a 2 day stay at ECF and the information about patients respiratory equipment was just now not being accepted."</p> <p>Further review of the hospital ER Nursing Documentation, dated 02-06-14 at 11:51 p.m., indicated "[age of resident] transferred to ED [emergency department] via ambulance from ECF after ECF states 'We cannot take care of him and he is unable to return.'</p>			
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	<p>Speaking with [family member], pt. [patient] has had his own home CPAP machine since March 2013. After one month long stay in ICU [Intensive Care Unit] and [rehabilitation unit], pt continued to wear CPAP at night. Tonight at ECF after 2 days of staying there, DON [Director of Nurses] stated that his own piece of machinery is not acceptable and 'a liability' if he has an apnea period at the ECF with this piece of equipment."</p> <p>During hospital chart review on 02-14-14 at 9:00 a.m., the Pulmonologist indicated the following: " ... he is being sent back because of issues with the BiPAP machine or not knowing much about it. The family is frustrated. He is unable to put the mask and fix it (?) sometimes and needs some help with that. The patient has central/complex sleep apnea. He is on auto Bipap machine which is just like any other positive airway pressure machines including CPAP or Bipap but it has auto adjustment and a backup rate. This is not a ventilator, but this is called noninvasive ventilation, just like that CPAP and Bipap. All we need to do is to turn on the machine and adjust</p>						

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	<p>the mask if there is a leak. No need for a respiratory therapist to do that and in fact 99 % of patients on this machine live at home without respiratory therapist. No need to adjust the machine or the pressure. All we need to do is to adjust the mask if leaking. No need for continuous pulse oximetry or respiratory therapist at the bedside. The machine should not be a reason for him to be discharged or sent back to the hospital after he goes to rehabilitation. The goal is to get him through rehab. [rehabilitation] and then hopefully be able to go home."</p> <p>During an interview on 02-13-14 at 2:11 p.m., a concerned family member indicated, "I took off work on 02-05-14 and no one said anything to me about the breathing machine. On 02-06-14, I was there and was at three therapy sessions, left and went home. At 8:30 p.m., I'm getting ready to leave to go to the Forum and be with [resident] and [parent] called me and said there was a problem. She said the Executive Director called her and told her that they can't have the home machine in the building. He told her they called [name of Home Health Agency] and they are 'going to confiscate' the machine. I was</p>			

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	<p>there for those first two days and I saw [names of Executive Director and Director of Nurses] off and on all day and they didn't say anything. When I got there that night I told them what [parent] said, and I wanted to know what was going on. [Name of Executive Director] asked my [sibling] if he could take [resident] home. It was 7 degrees outside that night. [Name of the Director of Nurses] said 'your [resident] could not have this machine outside of the home.' I told her we've had it outside the home throughout [resident's] hospitalization. [Director of Nurses] said we didn't have to bring our own machine and that we could rent one from them, from our 'institutional provider.' I told her to go ahead and rent it. [Director of Nurses] had a clip board in front of her and said the discharge papers did not indicate the machine you brought here, and therefore we don't have matching orders. I told her I could call over to the Rehab. [Rehabilitation] and she could talk with them because I felt it was a misunderstanding that could be corrected. We thought it was a typo. She said 'No' and I asked 'what do you mean 'no ?' She said she spoke with her corporate office and the machine does not match the</p>			

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	orders. Now it's around 9:30 p.m., and she told me we would have to leave the facility because they could have a liability. She said we were not allowed to stay and that we needed to take [resident] home - put him in the car and take him home, when it's 7 degrees outside, he has a GT [gastrostomy] feeding tube and incontinent. I said to her 'let us call the doctor to get this straightened out,' and she said 'no' again. I said to her that [resident] was admitted on Tuesday and today is Thursday and you're now telling me about the machine. My question to her was that if we couldn't use our machine, where was the machine she should have ordered for [resident] before he was admitted. The machine from their institutional provider should have been there the first day per their protocol. She told me 'we can accept a CPAP but your [resident] is on a Ventilator. We can't have a ventilator here.' When we got to the ER the doctor said 'this is ridiculous - why are you here ? You can't take up ER for this.' He called [name of pulmonologist] and he said he would give the Forum anything needed. He then called the Forum. Then he came back and told us that [name of Director of Nurses] had left the Forum and the night nurse said she			

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	<p>[the Director of Nurses] was not calling the doctor and the family and resident are not allowed to come back. I talked to the Case Manager the next day and she called the Forum and was told the same thing, they were not going to take him back because he had a ventilator. She told us she was going to call the Ombudsman and that the facility can't 'dump' a resident. I was told the Ombudsman also called the Forum and was told the same thing, that they would not take him back. We were humiliated and embarrassed."</p> <p>During an interview on 02-17-14 at 12:30 p.m., the representative from the Home Health Agency who indicated the reason they wanted to pick up the VPAP, was a "payment issue, as Medicare would not pay for the use of the equipment in a skilled nursing setting and therefore they wouldn't get paid." The representative further indicated the VPAP is not a ventilator and it is "specifically pre-set for each patient."</p> <p>A review of the facility policy on 02-14-14 at 11:15 a.m., titled "Facility Initiated Transfer and Discharge," and dated as 12-08-08</p>				

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	<p>indicated the following:</p> <p>"Purpose: To ensure all residents, legal representatives, responsible parties and family members know and understand their transfer and discharge right under state and federal statutes."</p> <p>"Program Guidelines: Federal regulations require the facility permit each resident to remain in the facility, and not transfer or discharge the resident unless certain specific criteria are met. The attending physician must sign and authorize the transfer or discharge for a clinical reason."</p> <p>"Definitions: A Discharge is defined as a facility initiated movement of a resident outside of the facility to any other setting including, for example, an acute care hospital."</p> <p>"Fundamental Information: Facility initiated transfers and discharges are handled appropriately to assure proper notification and assistance to residents and family in accordance with federal and state specific regulations."</p> <p>"Documentation: The content of the notice for transfer or discharge must</p>						

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	<p>contain the following information - the reason for transfer or discharge."</p> <p>"Documentation of Orientation for the Transfer or Discharge: Except in cases of an emergency discharge, the Social Worker must document appropriate referrals have been made for the discharge and the resident/family/legal representative have been oriented to the new residence, including but not limited to: information on date, time and method of transportation to the new facility, addressing adjustment issues related to moving to new health care center."</p> <p>"Procedure: The resident's physician must provide documentation to demonstrate the reason for the discharge."</p> <p>This Federal tag relates to Complaint IN00144354.</p> <p>3.1-12(a)(3) 3.1-12(a)(4)(A) 3.1-12(a)(4)(C)</p>				

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F000202 SS=D	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>Based on record review and interview the facility failed to ensure appropriate documentation by the resident's physician, in that when it was determined a resident was not allowed to remain in the facility, and a facility transfer/discharge was initiated, the resident's record lacked physician documentation for the need of transfer for 1 of 3 resident's reviewed for transfer/discharge in a sample of 7. (Resident "D").</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 02-12-14 at 2:00 p.m. Diagnoses included, but were not limited to, anoxic brain injury, cardiac arrest, aphasia, coronary artery disease and atrial fibrillation. These diagnoses remained current at the time of the record review. The</p>	F000202	<p>F202</p> <p><i>In response to the cited findings R/T to F202, the following actions will be taken:</i></p> <p>A) Resident physician/Medical Director saw resident on 2/5/14, with progress note indicating resident needed to be in safe environment. MD was aware of equipment concerns, and facility efforts to resolve them. Call was placed to physician during evening hours on 2/6/14 indicating that efforts to get replacement equipment had failed after multiple attempts. Order rec'd from MD to transfer resident to hospital for respiratory monitoring.</p> <p>B) No other residents residing in this facility have been affected by this alleged deficient practice.</p> <p>C) Meeting held with Medical Director/NP on 3/12/14 to review regulations for resident discharge documentation as outlined in IC 483.12 (a)(2)(i).</p> <p>Medical Records Coordinator will be</p>	03/19/2014			

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	<p>resident was admitted to the facility on 02-04-14.</p> <p>A review of the facility pre-admission assessment, dated 02-03-14 indicated the resident's primary diagnosis included anoxic encephalopathy with dysphasia, the assessment included secondary diagnoses. The record included "miscellaneous information," which included the following:</p> <p>"Pt [patient] presented on ED [emergency department] on 11-26-[2013] after falling face down in driveway. Few days later pt. went into pulseless electrical activity. CPR [cardiopulmonary resuscitation] performed times 15 minutes...pt is NPO [nothing by mouth] A & O [alert and oriented] times 2. O2 [oxygen] per NC [nasal cannula]. VPAP [various mode of a positive airway pressure] at noc [night]. Expected date of discharge - 02-04-14." At the top of this assessment was the following handwritten notation: *VPAP.*</p> <p>A review of the Hospital Discharge Summary, dated 02-01-14 indicated "handwritten notes" which also instructed the resident used "VPAP for central sleep apnea." The</p>		<p>responsible to audit/review all resident discharges and specific MD/NP documentation</p> <p>D) Monitoring will include review of all discharges related to IC 483.12 (a)(2) (i). at bi-weekly Continuous Quality Improvement (CQI) meetings to ensure compliance and identify any need for continued education with MD/NP.</p> <p>E) The facility's full Management/Administrative Team will be instructed of admission and discharge policies/procedures with respect to comprehensive assessments of unfamiliar equipment and/or non-routine orders/equipment. Personnel involved will be Nursing Supervisors, Medical Records Clerk, and MDS Nurses. Any physicians who admitted patients to the facility in the last six months will be advised of updated policies and procedures.</p> <p>E) Monitoring will include review of new admissions at bi-weekly Continuous Quality Improvement (CQI) meetings to ensure compliance and identify any need for continued education with Clinical Liaison/Admissions Director.</p> <p>F) Any Management Team or personnel involved with admissions found with failure to adhere to established polices will be re-educated and/or reprimanded as indicated. The HFA will be responsible to ascertain full staff cooperation. He will monitor complete adherence to Admission/Discharge policies and procedures.</p> <p>The Executive Director will review 50% of Admissions/Discharges weekly for the</p>	

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	<p>physician notation indicated "The patient remained on the VPAP machine at night for his central sleep apnea. He also remained on supplementary oxygen through nasal cannula during the day. He at time of discharge was medically stable with no new issues." The "Problem List" noted on this discharge summary indicated: "1. Anoxic encephalopathy secondary to cardiac arrest, 2. Central sleep apnea using VPAP machine at night."</p> <p>A review of the hospital "Discharge Report," dated 02-04-14, indicated "oxygen therapy - oxygen, CPAP [continuous positive airway pressure], home machine."</p> <p>The facility "New Patient Admission Report," undated, indicated the resident had a "cardiac arrest at home - anoxic brain injury. Sleep apnea with special CPAP machine."</p> <p>The facility "admission orders and plan of care," dated 02-04-14 and verified by the facility nurse with the physician, indicated "treatments - VPAP O2 via N/C to maintain sats [saturation] > [greater than] 90 % O2 equip. [equipment] care to protocol."</p>		<p>next 30 days, then 25 % for the following 60 days to ensure compliance</p> <p>Date of compliance with proposed actions: March 19, 2014.</p>	

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	<p>The resident was assessed by the Nurse Practitioner on 02-05-14. The assessment lacked documentation or a concern related to the resident's use of the VPAP machine at night.</p> <p>During an interview on 02-14-14 at 11:30 a.m., the Director of Nurses indicated she made the initial contact with the spouse and asked if the resident had a CPAP machine and the resident's spouse indicated the resident had his own. The Director of Nurses indicated the nursing staff realized it wasn't a CPAP machine as thought, but the resident's family member said a family member would set it up. The Director of Nurses instructed the family member that he would need to have someone here to come in and monitor. The Director of Nurses indicated that when she spoke with the resident's family member on Wednesday (02-05-14) he told her the machine malfunctioned during then night and requested a "back up" machine. Although the facility didn't have an order for that machine, the Director of Nurses indicated she would request the Nurse Practitioner to write an order for the use of the VPAP machine, which she did.</p>				

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	<p>The Director of Nurses indicated that is when she started "working on it" and spoke with the facility respiratory company. She indicated the staff person she spoke to, told her the VPAP was a "home vent [ventilator] machine," and she reported this information to (name of the Executive Director). Furthermore the Director of Nurses indicated the facility respiratory company instructed her that, this type of machine couldn't be used in "our setting."</p> <p>The Director of Nurse further indicated she called (name of a Home Health Agency the family utilized), who told her they had been looking for that machine, and advised her they would check to see if they needed to come and pick up the machine that night. She further indicated the Home Health Agency instructed her that this type of machine was to be used at "home." The Director of Nurses indicated she tried to get someone to come to the facility but a respiratory therapist was unable to come. At that point the Director of Nurses indicated she felt the facility was "culpable" in this situation.</p> <p>When the family arrived at the</p>			

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	<p>facility, the Director of Nursing told them the Agency would probably be picking up the equipment and (name of resident) could not stay here in the facility, and spoke with them about taking the resident home. "They said 'no' to that and then I asked them what hospital they wanted to send him to, because if he couldn't use a CPAP [continuous positive airway pressure] machine then he couldn't stay here." She indicated the nursing staff called for the ambulance to come and pick up the resident and transport him to (name of local area hospital). The record indicated the resident left the facility at approximately 10:45 p.m. - 11:00 p.m., but verified the resident was allowed to use this equipment on 02-04-14 and again on 02-05-14 without knowledge of the operational modes of the equipment or staff education.</p> <p>A review of the physician documentation, dated 02-06-14, indicated "Subjective: [name of resident] is a [age documented]. Anoxic encephalopathy, pt. [patient] admitted to Forum after a stay at [name of Rehabilitation Center], pt. is still quite confused and is on a vpap and tube feedings. Extensive talk with [family member]. Family</p>			

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	<p>very involved." "Assessment: anoxic encephalopathy- ensure safe environment, debility ptot [physical therapy - occupational therapy], pcp [primary care physician] records reviewed, NP admission note reviewed." The physician documentation lacked concern of the use of the VPAP machine in the facility or the need to transfer/discharge the resident.</p> <p>A review of the nurses notes, dated 02-06-14 at 10:35 p.m. indicated "Res. [resident] is being transferred to [name of local hospital via ambulance/stretchers per Admin. [administrator] for respiratory monitoring/eval. [evaluation]."</p> <p>A review of the "Patient Transfer Form," dated 02-06-14, indicated the name of the resident (misspelled), and where the resident was being transferred. The "Notice of Transfer or Discharge," dated 02-06-14 indicated the resident was being transferred/discharge to "another health facility - [name of hospital]." The "reason for Transfer or Discharge," indicated "The health of the individuals in the facility would otherwise be endangered." Handwritten adjacent to this statement indicated "Need for eval.</p>				

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	<p>[evaluation]."</p> <p>The Director of Nurses verified the resident was allowed to use this equipment on 02-04-14 and again on 02-05-14 without knowledge of the operational modes of the equipment.</p> <p>During hospital chart review on 02-14-14 at 9:00 a.m., the Pulmonologist indicated the following: "... he is being sent back because of issues with the BiPAP machine or not knowing much about it. The family is frustrated. He is unable to put the mask and fix it (?) sometimes and needs some help with that. The patient has central/complex sleep apnea. He is on auto Bipap machine which is just like any other positive airway pressure machines including CPAP or Bipap but it has auto adjustment and a backup rate. This is not a ventilator, but this is called noninvasive ventilation, just like that CPAP and Bipap. All we need to do is to turn on the machine an adjust the mask if there is a leak. No need for a respiratory therapist to do that and in fact 99 % of patients on this machine live at home without respiratory therapist. No need to</p>						

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	<p>adjust the machine or the pressure. All we need to do is to adjust the mask if leaking. No need for continuous pulse oximetry or respiratory therapist at the bedside. The machine should not be a reason for him to be discharged or sent back to the hospital after he goes to rehabilitation. The goal is to get him through rehab. [rehabilitation] and then hopefully be able to go home."</p> <p>A review of the facility policy on 02-14-14 at 11:15 a.m., titled "Facility Initiated Transfer and Discharge," and dated as 12-08-08 indicated the following:</p> <p>"Purpose: To ensure all residents, legal representatives, responsible parties and family members know and understand their transfer and discharge right under state and federal statutes."</p> <p>"Procedure: The resident's physician must provide documentation to demonstrate the reason for the discharge."</p> <p>This Federal tag relates to Complaint IN00144354.</p> <p>3.1-12(a)(5)(A)</p>						

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F000204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>Based on record review and interview the facility failed to ensure a safe and orderly transfer/discharge of a resident, in that when the facility determined the need to transfer/discharge a resident, the facility did not allow adequate preparation or an orderly transfer/discharge for the resident and family members.</p> <p>This deficient practice affected 1 of 3 resident's reviewed in regard to transfer/discharge preparation in a sample of 7. (Resident "D").</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 02-12-14 at 2:00 p.m. Diagnoses included, but were not</p>	F000204	<p>F204 In response to the cited findings R/T to F204, the following actions will be taken: A) Facility Administrative/Nursing staff made the decision to transfer resident D to hospital at approximately 6 p.m. on 2/6/14 after consultation with Regional clinical staff and MD. Spouse advised via telephone of concerns with equipment/resident transfer. She ended conversation without resolution. And indicated family members would contact the facility. Telephone calls were attempted to Son/POA. Messages were left without responses. Executive Director noted another family member (non-POA son) was sitting in the lobby area with resident D at approximately 8:00 p.m. When approached by the ED, he stated family members were en route to</p>	03/19/2014

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	<p>limited to, anoxic brain injury, cardiac arrest, aphasia, coronary artery disease and atrial fibrillation. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 02-04-14.</p> <p>A review of the facility pre-admission assessment, dated 02-03-14 indicated the resident's primary diagnosis included anoxic encephalopathy with dysphasia. The record included "miscellaneous information," which included the following: "Pt [patient] presented on ED [emergency department] on 11-26-[2013] after falling face down in driveway. Few days later pt. went into pulseless electrical activity. CPR [cardiopulmonary resuscitation] performed times 15 minutes...pt is NPO [nothing by mouth] A & O [alert and oriented] times 2. O2 [oxygen] per NC [nasal cannula]. VPAP [various mode of a positive airway pressure] at noc [night]. Expected date of discharge - 02-04-14." At the top of this assessment was the following handwritten notation with asterisks adjacent to the word: *VPAP.*</p> <p>During an interview on 02-14-14 at</p>		<p>the facility. Approximately 8:30 pm, POA-son and daughter arrived. Children of resident D met in his room. They discussed resident condition, equipment concerns with VPAP, and need for transfer secondary to possible faulty VPAP machine and risk of repeat anoxic event. Family members expressed concerns about resident's sleep study results and ambiguity of orders for equipment. Discussion continued among siblings as to which hospital they wished to utilize. By 9:30 p.m. a decision was made by family members to send resident D to St. Vincent Hospital ER. Facility Staff called for ambulance transport, transfer and discharge documents were completed for family members to sign. Family members declined signing documents and removed personal effects from facility.</p> <p>Ambulance transport occurred at approximately 10:30 p. m. Note: <i>The transfer process started approximately 4 hours prior to actual event. Risks associated with keeping resident D in the facility at night with potential risk of apneic/anoxic event outweighed late discharge/transfer to safe environment.</i> B) No other residents residing in this facility have been affected by this alleged deficient practice. C) The facility will comply with policies related to transfer/discharge of residents as noted on all future</p>		

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	<p>11:30 a.m., the Director of Nurses indicated she made the initial contact with the spouse and asked if the resident had a CPAP machine and the resident's spouse indicated the resident had his own. The Director of Nurses indicated the nursing staff realized it wasn't a CPAP machine as thought, but the resident's family member said a family member would set it up. The Director of Nurses instructed the family member that he would need to have someone here to come in and monitor. The Director of Nurses indicated that when she spoke with the resident's family member on Wednesday (02-05-14) he told her the machine malfunctioned during then night and requested a "back up" machine. Although the facility didn't have an order for that machine, the Director of Nurses indicated she would request the Nurse Practitioner to write an order for the use of the VPAP machine, which she did.</p> <p>The Director of Nurses indicated that is when she started "working on it" and spoke with the facility respiratory company. She indicated the staff person she spoke to, told her the VPAP was a "home vent [ventilator] machine," and she reported this information to (name of</p>		<p>discharges to acute care hospitals. Social Services documentation is not applicable since resident D was not being transferred to another healthcare facility. D) Monitoring will include review of all discharges/transfers related to IC 483.12 (a)(2)(i). at bi-weekly Continuous Quality Improvement (CQI) meetings to ensure compliance. E) The facility's full Management/Administrative Team will be instructed of admission and discharge policies/procedures with respect to comprehensive assessments of unfamiliar equipment and/or non-routine orders/equipment. Personnel involved will be Nursing Supervisors, Medical Records Clerk, and MDS Nurses. Any physicians who admitted patients to the facility in the last six months will be advised of updated policies and procedures. F) Any Management Team or personnel involved with admissions found with failure to adhere to established polices will be re-educated and/or reprimanded as indicated. The HFA will be responsible to ascertain full staff cooperation. He will monitor complete adherence to Admission/Discharge policies and procedures. The Executive Director will review 50% of Admissions/Discharges weekly for the next 30 days, then 25 % for the following 60 days to</p>		

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	<p>the Executive Director). Furthermore the Director of Nurses indicated the facility respiratory company instructed her that, this type of machine couldn't be used in "our setting."</p> <p>The Director of Nurse further indicated she called (name of a Home Health Agency the family utilized), who told her they had been looking for that machine, and advised her they would check to see if they needed to come and pick up the machine that night. She further indicated the Home Health Agency instructed her that this type of machine was to be used at "home." The Director of Nurses indicated she tried to get someone to come to the facility but a respiratory therapist was unable to come. At that point the Director of Nurses indicated she felt the facility was "culpable" in this situation.</p> <p>When the family arrived at the facility, she told them the Agency would probably be picking up the equipment and (name of resident) could not stay here in the facility, and spoke with them about taking the resident home. "They said 'no' to that and then I asked them what hospital they wanted to send him to,</p>		ensure compliance Date of compliance with proposed actions: March 19, 2014.		

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	<p>because if he couldn't use a CPAP [continuous positive airway pressure] machine then he couldn't stay here." She indicated the nursing staff called for the ambulance to come and pick up the resident and transport him to (name of local area hospital). The record indicated the resident left the facility at approximately 10:45 p.m. - 11:00 p.m., but verified the resident was allowed to use this equipment on 02-04-14 and again on 02-05-14 without knowledge of the operational modes of the equipment or staff education.</p> <p>A review of the physician documentation, dated 02-06-14, indicated "Subjective: [name of resident] is a [age documented]. Anoxic encephalopathy, pt. [patient] admitted to Forum after a stay at [name of Rehabilitation Center], pt. is still quite confused and is on a vpap and tube feedings. Extensive talk with [family member]. Family very involved." "Assessment: anoxic encephalopathy- ensure safe environment, debility ptot [physical therapy - occupational therapy], pcp [primary care physician] records reviewed, NP admission note reviewed." The physician documentation lacked concern of</p>			

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	<p>the use of the VPAP machine in the facility or the need to transfer/discharge the resident.</p> <p>A review of the "Patient Transfer Form," dated 02-06-14, indicated the name of the resident (misspelled), and where the resident was being transferred. The "Notice of Transfer or Discharge," dated 02-06-14 indicated the resident was being transferred/discharge to "another health facility - [name of hospital]." The "reason for Transfer or Discharge," indicated "The health of the individuals in the facility would otherwise be endangered." Handwritten adjacent to this statement indicated "Need for eval. [evaluation]."</p> <p>During an interview on 02-14-14 at 9:15 a.m., the hospital RN (Registered Nurse) Case Manager indicated, she came to work on the 7th (02-07-14), and further indicated the doctor said there was no reason for the resident to be brought back to the hospital to the emergency room. The RN indicated the facility didn't have a discharge plan for the resident so they sent him back to the hospital. During further interview the RN indicated the family was confused and in addition weren't told</p>						

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	<p>anything about "any of this" until the evening of 02-06-14 around 9:00 p.m. She indicated the family members were told they couldn't take care of the resident with the type of machine (in regard to the VPAP machine) and they were asked to take the resident home. The RN indicated she was told the family member spoke with the resident's pulmonologist who said he would give the orders needed for the resident to stay at the facility and that the Director of Nurses refused to speak with him.</p> <p>A review of the hospital ER (emergency room) Nursing flowsheet, dated 02-06-14 at 11:35 p.m., indicated the following:</p> <p>"ECF [extended care facility] called [name of ambulance service] to transport patient to hospital At ECF, they attempted to call Dr. [doctor] from hospital to get an appropriate order for his home equipment. Per [family member], the ECF is only able to manage CPAP and Bipap machines that are through a rental company. [Name of Home Health Agency] was called and explained that this patient's own equipment had 'vent like settings and are not accepted at Forum at the Crossing.'</p>						

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	<p>Family frustrated that patient needed to be transported in the middle of the night and after a 2 day stay at ECF and the information about patients respiratory equipment was just now not being accepted."</p> <p>Further review of the hospital ER Nursing Documentation, dated 02-06-14 at 11:51 p.m., indicated "[age of resident] transferred to ED [emergency department] via ambulance from ECF after ECF states 'We cannot take care of him and he is unable to return. Speaking with [family member], pt. [patient] has had his own home CPAP machine since March 2013. After one month long stay in ICU [Intensive Care Unit] and [rehabilitation unit], pt continued to wear CPAP at night. Tonight at ECF after 2 days of staying there, DON [Director of Nurses] stated that his own piece of machinery is not acceptable and 'a liability" if he has an apnea period at the ECF with this piece of equipment."</p> <p>During hospital chart review on 02-14-14 at 9:00 a.m., the Pulmonologist indicated the following: "... he is being sent back because of issues with the BiPAP machine or</p>						

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	<p>not knowing much about it. The family is frustrated. He is unable to put the mask and fix it (?) sometimes and needs some help with that. The patient has central/complex sleep apnea. He is on auto Bipap machine which is just like any other positive airway pressure machines including CPAP or Bipap but it has auto adjustment and a backup rate. This is not a ventilator, but this is called noninvasive ventilation, just like that CPAP and Bipap. All we need to do is to turn on the machine an adjust the mask if there is a leak. No need for a respiratory therapist to do that and in fact 99 % of patients on this machine live at home without respiratory therapist. No need to adjust the machine or the pressure. All we need to do is to adjust the mask if leaking. No need for continuous pulse oximetry or respiratory therapist at the bedside. The machine should not be a reason for him to be discharged or sent back to the hospital after he goes to rehabilitation. The goal is to get him through rehab. [rehabilitation] and then hopefully be able to go home."</p> <p>During an interview on 02-13-14 at 2:11 p.m., a concerned family member indicated, "I took off work</p>			

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	<p>on 02-05-14 and no one said anything to me about the breathing machine. On 02-06-14 I was there and was at three therapy sessions, left and went home. At 8:30 p.m., I'm getting ready to leave to go to the Forum and be with [resident] and [parent] called me and said there was a problem. She said the Executive Director called her and told her that they can't have the home machine in the building. He told her they called [name of Home Health Agency] and they are 'going to confiscate' the machine. I was there for those first two days and I saw [names of Executive Director and Director of Nurses] off and on all day and they didn't say anything. When I got there that night I told them what [parent] said, and I wanted to know what was going on. [Name of Executive Director] asked my [sibling] if he could take [resident] home. It was 7 degrees outside that night. [Name of the Director of Nurses] said 'your [resident] could not have this machine outside of the home.' I told her we've had it outside the home throughout [resident's] hospitalization. [Director of Nurses] said we didn't have to bring our own machine and that we could rent one from their 'institutional provider.' I</p>			

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	told her to go ahead and rent it. [Director of Nurses] had a clip board in front of her and said the discharge papers 'did not indicate the machine you brought here, and therefore we don't have matching orders.' I told her I could call over to the Rehab. and she could talk with them because I felt it was a misunderstanding that could be corrected. We thought it was a typo. She said 'No' and I asked 'what do you mean 'no ?' She said she spoke with her corporate office and the machine does not match the orders.' Now it's around 9:30 p.m. and she told me we would have to leave the facility because they could have a liability. She said we were not allowed to stay and that we needed to take [resident] home - put him in the car and take him home, when it's 7 degrees outside, he has a GT [gastrostomy] feeding tube and incontinent. I said to her 'let us call the doctor to get this straightened out, and she said 'no' again. I said to her that [resident] was admitted on Tuesday and today is Thursday and you're now telling me about the machine. My question to her was that if we couldn't use our machine, where was the machine she should have ordered for [resident] before he was admitted. The machine from			
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	<p>their institutional provider should have been there the first day per their protocol. She told me 'we can accept a CPAP but your [resident] is on a Ventilator. We can't have a ventilator here. When we got to the ER the doctor said 'this is ridiculous - why are you here ? You can't take up ER for this.' He called [name of pulmonologist] and he said he would give the Forum anything needed. He then called the Forum. Then he came back and told us that [name of Director of Nurses] had left the Forum and the night nurse said she [the Director of Nurses] was not calling the doctor and the family and resident are not allowed to come back. I talked to the Case Manager the next day and she called the Forum and was told the same thing, they were not going to take him back because he had a ventilator. She told us she was going to call the Ombudsman and that the facility can't 'dump' a resident. I was told the Ombudsman also called the Forum and was told the same thing, that they would not take him back. We were humiliated and embarrassed."</p> <p>A review of the facility policy on 02-14-14 at 11:15 a.m., titled "Facility Initiated Transfer and</p>						

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	<p>Discharge," and dated as 12-08-08 indicated the following:</p> <p>"Definitions: A Discharge is defined as a facility initiated movement of a resident outside of the facility to any other setting including, for example, an acute care hospital."</p> <p>"Documentation: The content of the notice for transfer or discharge must contain the following information - the reason for transfer or discharge."</p> <p>"Documentation of Orientation for the Transfer or Discharge: Except in cases of an emergency discharge, the Social Worker must document appropriate referrals have been made for the discharge and the resident/family/legal representative have been oriented to the new residence, including but not limited to: information on date, time and method of transportation to the new facility, addressing adjustment issues related to moving to new health care center."</p> <p>"Procedure: The resident's physician must provide documentation to demonstrate the reason for the discharge."</p> <p>This Federal tag relates to</p>			

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F000328 SS=D	<p>Complaint IN00144354.</p> <p>3.1-12(a)(21)</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>Based on record review and interview the facility failed to ensure the respiratory needs of a resident were met, in that when a resident was admitted to the facility with specific respiratory equipment, the facility failed to verify the physician orders related to the machine, the operation of the equipment or educational needs for the nursing staff and if acute monitoring was needed prior to admission for 1 of 1 resident reviewed with respiratory/breathing equipment in a sample of 7. (Resident "D").</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 02-12-14 at 2:00 p.m.</p>	F000328	<p>F328 In response to the cited findings R/T to F328, the following actions will be taken: A) Resident D was evaluated at a hospital by the facility's Clinical Liaison prior to admission. Pre-admission screening documentation noted resident to be on VPAP, CPAP and BiPAP used interchangeably throughout hospital records. Clinical Liaison confirmed ambiguous orders with hospital discharge planner and was told the VPAP was simply a CPAP, which is considered a routine order for this facility. After admission, plans to get a CPAP machine ordered for resident was interrupted by resident D's spouse, who stated the resident had his own special machine with custom fitted face mask which had been used at the hospital. She indicated her son would</p>	03/19/2014
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	<p>Diagnoses included, but were not limited to, anoxic brain injury, cardiac arrest, aphasia, coronary artery disease and atrial fibrillation. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 02-04-14.</p> <p>A review of the facility pre-admission assessment, dated 02-03-14, indicated the resident's primary diagnosis included anoxic encephalopathy. The record included "miscellaneous information," which included the following: "...2. O2 [oxygen] per NC [nasal cannula]. VPAP [variable mode of a positive airway pressure] at noc [night]. Expected date of discharge - 02-04-14." At the top of this assessment was the following handwritten notation with asterisks adjacent to the notation: *VPAP.*</p> <p>A review of the Hospital Discharge Summary, dated 02-01-14 indicated "handwritten notes" which also instructed the resident used "VPAP for central sleep apnea." The physician notation indicated, "The patient remained on the VPAP machine at night for his central sleep apnea. He also remained on</p>		<p>show the staff how to apply it properly. Approximately 24 hours later (next day), resident D's son reported to Clinical Liaison that the VPAP possibly malfunctioned during night and he wanted the facility to obtain a replacement/back-up machine. The DON was made aware of this situation and contacted the POA-Son to investigate R/T equipment concerns. She offered to order a CPAP machine for the resident. Resident D's Family declined, insisting on using VPAP. At 48 hours, the facility was unable to obtain a replacement machine from two respiratory vendors, and a decision made to transfer resident out to hospital due to risk of recurrent apnea/anoxic event. B) No other residents residing in this facility have been affected by this alleged deficient practice. C) Interdisciplinary meeting held on February 25, 2014 with Admissions Liaison, Admissions Director, Executive Director (ED), Health Facility Administrator (HFA), Director of Nursing Services (DON), and Regional Director of Health Services to review facility admission/discharge policy. All future admissions involving any unfamiliar/non- routine orders/equipment will be reviewed by HFA and DON for appropriateness, and ability of the facility to meet the resident's needs. Any questionable</p>				

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	<p>supplementary oxygen through nasal cannula during the day. He, at time of discharge was medically stable with no new issues." The "Problem List" noted on this discharge summary indicated: "1. Anoxic encephalopathy secondary to cardiac arrest, 2. Central sleep apnea using VPAP machine at night."</p> <p>The facility "admission orders and plan of care," dated 02-04-14 and verified by the facility nurse with the physician, indicated "treatments - VPAP O2 via N/C to maintain sats [saturation] > [greater than] 90 % O2 equip. [equipment] care to protocol."</p> <p>During an interview on 02-14-14 at 11:30 a.m., the Director of Nurses indicated she made the initial contact with the spouse and asked if the resident had a CPAP machine and the resident's spouse indicated the resident had his own. The Director of Nurses indicated the nursing staff realized it wasn't a CPAP machine as thought, but the resident's family member said a family member would set it up. The Director of Nurses instructed the family member that he would need to have someone here to come in</p>		<p>diagnosis/medications/equipment will be reviewed with the Medical Director as needed prior to accepting resident for admission to facility. D) Monitoring of admission/special needs will be done at bi-weekly Continuous Quality Improvement (CQI) meetings to ensure compliance. E) The facility's full Management/Administrative Team will be instructed of admission and discharge policies/procedures with respect to comprehensive assessments of unfamiliar equipment and/or non-routine orders/equipment. Personnel involved will be Nursing Supervisors, Medical Records Clerk, and MDS Nurses. Any physicians who admitted patients to the facility in the last six months will be advised of updated policies and procedures. E) Monitoring will include review of new admissions at bi-weekly Continuous Quality Improvement (CQI) meetings to ensure compliance and identify any need for continued education with Clinical Liaison/Admissions Director. F) Any Management Team or personnel involved with admissions found with failure to adhere to established polices will be re-educated and/or reprimanded as indicated. The HFA will be responsible to ascertain full staff cooperation. He will monitor complete adherence to Admission/Discharge policies and</p>				

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	<p>and monitor. The Director of Nurses indicated that when she spoke with the resident's family member on Wednesday (02-05-14) he told her the machine malfunctioned during then night and requested a "back up" machine. Although the facility didn't have an order for that machine, the Director of Nurses indicated she would request the Nurse Practitioner to write an order for the use of the VPAP machine, which she did.</p> <p>At that time, the Director of Nurses indicated that is when she started "working on it" and spoke with the facility respiratory company. She indicated the staff person she spoke to, told her the VPAP was a "home vent [ventilator] machine," and she reported this information to (name of the Executive Director). Furthermore the Director of Nurses indicated the facility respiratory company instructed her that, this type of machine couldn't be used in "our setting."</p> <p>The Director of Nurse further indicated she called (name of a Home Health Agency the family utilized), who told her they had been looking for that machine, and advised her they would check to see</p>		<p>procedures. The Executive Director will review 50% of Admissions/Discharges weekly for the next 30 days, then 25 % for the following 60 days to ensure compliance Date of compliance with proposed actions: March 19, 2014</p>		

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	<p>if they needed to come and pick up the machine that night, and further indicated the Home Health Agency instructed her that this type of machine was to be used at "home." The Director of Nurses indicated she tried to get someone to come to the facility but a respiratory therapist was unable to come. At that point the Director of Nurses indicated she felt the facility was "culpable" in this situation.</p> <p>The Director of Nurses verified the resident was allowed to use this equipment on 02-04-14 and again on 02-05-14 without knowledge of the operational modes of the equipment or staff education.</p> <p>The resident was discharged to the local area hospital on 02-06-14, at approximately 10:45 p.m. - 11:00 p.m.</p> <p>A review of the "Patient Transfer Form," dated 02-06-14, indicated the name of the resident (misspelled), and where the resident was being transferred. The "Notice of Transfer or Discharge," dated 02-06-14, indicated the resident was being transferred/discharge to "another health facility - [name of hospital]." The "reason for Transfer or</p>			

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	<p>Discharge," indicated "The health of the individuals in the facility would otherwise be endangered." Handwritten adjacent to this statement indicated "Need for eval. [evaluation]."</p> <p>A review of the hospital ER [emergency room] Nursing flowsheet, dated 02-06-14 at 23:35 (11:35 p.m.), indicated the following: "ECF [extended care facility] called [name of ambulance service] to transport patient to hospital At ECF, they attempted to call Dr. [doctor] from hospital to get an appropriate order for his home equipment. Per [family member], the ECF is only able to manage CPAP and Bipap machines that are through a rental company. [Name of Home Health Agency] was called and explained that this patient's own equipment had 'vent like settings and are not accepted at Forum at the Crossing. Family frustrated that patient needed to be transported in the middle of the night and after a 2 day stay at ECF and the information about patients respiratory equipment was just now not being accepted."</p> <p>Further review of the hospital ER Nursing Documentation, dated 02-06-14 at 11:51 p.m., indicated</p>				

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	<p>"[age of resident] transferred to ED [emergency department] via ambulance from ECF after ECF states 'We cannot take care of him and he is unable to return. Speaking with [family member], pt. [patient] has had his own home CPAP machine since March 2013. After one month long stay in ICU [Intensive Care Unit] and [rehabilitation unit], pt continued to wear CPAP at night. Tonight at ECF after 2 days of staying there, DON [Director of Nurses] stated that his own piece of machinery is not acceptable and 'a liability if he has an apnea period at the ECF with this piece of equipment.'"</p> <p>During hospital chart review on 02-14-14 at 9:00 a.m., the Pulmonologist indicated the following: "... he is being sent back because of issues with the BiPAP machine or not knowing much about it. The family is frustrated. He is unable to put the mask and fix it (?) sometimes and needs some help with that. The patient has central/complex sleep apnea. He is on auto Bipap machine which is just like any other positive airway pressure machines including CPAP or Bipap but it has auto adjustment</p>						

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	<p>and a backup rate. This is not a ventilator, but this is called noninvasive ventilation, just like that CPAP and Bipap. All we need to do is to turn on the machine and adjust the mask if there is a leak. No need for a respiratory therapist to do that and in fact 99 % of patients on this machine live at home without respiratory therapist. No need to adjust the machine or the pressure. All we need to do is to adjust the mask if leaking. No need for continuous pulse oximetry or respiratory therapist at the bedside. The machine should not be a reason for him to be discharged or sent back to the hospital after he goes to rehabilitation. The goal is to get him through rehab. [rehabilitation] and then hopefully be able to go home."</p> <p>During an interview on 02-13-14 at 2:11 p.m., a concerned family member indicated, the Director of Nurses said the discharge papers did not indicate the machine brought to the facility, and therefore the orders didn't match. "I told her I could call over to the Rehab. [Rehabilitation] and she could talk with them because I felt it was a misunderstanding that could be corrected. We thought it was a typo. She said 'No' and I asked 'what do</p>				

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	<p>you mean 'no ?' I said to her that [resident] was admitted on Tuesday and today is Thursday and you're now telling me about the machine. She told me 'we can accept a CPAP but your [resident] is on a Ventilator. We can't have a ventilator here.' When we got to the ER the doctor said 'this is ridiculous - why are you here ? You can't take up ER for this.' He called [name of pulmonologist] and he said he would give the Forum anything needed. He then called the Forum. Then he came back and told us that [name of Director of Nurses] had left the Forum and the night nurse said she [the Director of Nurses] was not calling the doctor and the family and resident are not allowed to come back. I talked to the Case Manager the next day and she called the Forum and was told the same thing, they were not going to take him back because he had a ventilator."</p> <p>When interviewed on 02-14-14 at 11:30 a.m., if she, the Director of Nurses, was involved in the admission process for this resident and the specific respiratory needs that involved the VPAP machine, the Director of Nurses indicated, "No that is a decision I'm not involved in. The Clinical Liaison makes that</p>				

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	<p>determination for admittance."</p> <p>This Federal tag relates to Complaint IN00144354.</p> <p>3.1-47(a)(6)</p>				

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview the facility failed to ensure</p>	F000441	F441 In response to the cited findings R/T to F328, the	03/19/2014	

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	<p>the accuracy of the surveillance data related to clostridium difficile infections, in that when residents were assessed and it was determined through laboratory testing, that an infection was present the surveillance data failed to include the residents and accuracy on specific data. This deficient practice affected 4 of 5 resident's reviewed for clostridium infections in a sample of 7. (Residents "A", "E" "G" and "K").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 02-12-14 at 3:10 p.m. Diagnoses included, but were not limited to, hypertension, dysphasia with a gastrostomy feeding tube, anxiety, dementia, and chronic kidney disease - stage three. These diagnoses remained current at the time of the record review.</p> <p>A review of the Nurses Notes indicated the following:</p> <p>"01-28-14 at 11:30 a.m. - Resident had two episodes of loose stools. Took all A.M. meds [medications] et [and] Imodium [a medication use to treat diarrhea stools] prn [as needed]. Later notified N.P. [Nurse</p>		<p><i>following actions will be taken:</i> A) All residents residing at facility who were on isolation procedures at time of tour by surveyor were noted to have proper signage on door frames indicating that all visitors/employees needed to see nurse before entering. The magnetic sign was approximately 2 inches x 9 inches, red in color and could have been mistaken for oxygen signage. B) No other residents residing in this facility have been affected by this alleged deficient practice. C) These magnetics strip signs have been discarded and replaced with full size (8 1/2 x 11 in) signage on the front door and outside wall of all residents in contact isolation to prevent any confusion as to status of residents in isolation. Nursing staff has been in-serviced on location of new signage and proper implementation. Ample supply provided to all nursing units and nursing management offices. D) On-going monitoring by DON/designee with all new isolation residents to ensure continued compliance with proper signage. Any lack of performance by nursing staff will be addressed and corrected. Continued performance issues will be processed through progressive discipline. E) Date of compliance with proposed actions: March 19, 2014.</p>		

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	<p>Practitioner] after another episode. Received N.O. [new order] for CBC [complete blood count] with differential, BMP [basic metabolic profile] STAT, collect stool specimen for c-diff [clostridium difficile] toxin et UA [urinalysis] C & S [culture and sensitivity]. Temp. [temperature] 98.9. Skin warm et dry to touch."</p> <p>"01-28-14 at 4:30 p.m. - Received lab values et reported to N.P. with [name of primary physician]. N.O. Flagyl [a medication use in the treatment of clostridium difficile] 500 mg [milligrams] PO [by mouth] Q [every] 8 hours times 14 days. Res. [resident] remains incontinent of B/B [bowel and bladder] - no stool, no urine specimen collected at this time."</p> <p>"01-29-14 at 7:30 a.m. - Loose stool foul smelling with mucous times two. Specimen obtained to check for c-diff. Awaiting pick up from lab."</p> <p>"01-30-14 at 3:00 a.m. - Resident cont. [continues] to have loose stool. Imodium times 1 given."</p> <p>"01-30-14 at 9:30 a.m. - Seen by [name of nurse practitioner] secondary to cont. [continues] loose stools, decreased appetite and</p>			

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	<p>lethargy. N.O. to send to E.D. [emergency department] for evaluation."</p> <p>"01-30-14 at 10:45 a.m. - Transferred to [name of local area hospital. [Family member] notified of transfer and + [positive result] for c-diff results."</p> <p>A review of the laboratory testing for Clostridium Difficile, dated 01-30-14, indicated the stool specimen tested positive for "C. Difficile Antigen and Toxin A & B."</p> <p>Review of the hospital record on 02-12-14 at 8:45 a.m., verified the resident was admitted to the hospital with "acute c-diff colitis, sepsis due to this."</p> <p>2. The record for Resident "E" was reviewed on 02-12-14 at 1:15 p.m. Diagnoses included, but were not limited to, septicemia, clostridium difficile infection, congestive heart failure and congestive heart failure. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 01-22-14.</p> <p>A review of the Hospital Discharge summary indicated the resident had</p>				

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	<p>a diagnosis of sepsis secondary to clostridium difficile. Started on Vancomycin [an antibiotic] empirically to C. diff as C. diff did comeback positive, so [resident] will complete this course on discharge for a 10 day course."</p> <p>During the Initial Tour of the facility on 02-12-14, the Assistant Director of Nurses indicated the resident had recently been treated for C. diff infection. "He was admitted with it."</p> <p>3. A review of the facility "Infection Control Surveillance" data on 02-13-14 at 9:00 a.m. lacked documentation of Resident "A" and "E."</p> <p>In addition, during an interview on 02-13-13 at 9:30 a.m., the Director of Nurses indicated if a resident had been determined with C. diff. infection, a posted notice, for employees and visitors, would be placed at the Resident's doorway to instruct to report to the nurses station.</p> <p>During the Initial Tour of the facility on 02-12-14, the Assistant Director of Nurses indicated Residents "G" and "K" currently had C. difficile infections. During observation on</p>			

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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>02-12-14 at 11:00 a.m., the doorway lacked the signage to alert employees and visitors of the infection and to report to the nurses station, as described by the Director of Nurses.</p> <p>This Federal tag relates to Complaint IN00143843.</p> <p>3.1-18(b)(1)(A) 3.1-18(b)(2)</p>			