

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00119226.</p> <p>Complaint IN00119226 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: November, 26, 27, 28, 29 and 30, 2012</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Survey team: Sharon Lasher, RN, TC Angel Tomlinson, RN Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 115 Total: 115</p> <p>Census payor type: Medicare: 6 Medicaid: 85 Other: 24 Total: 115</p> <p>These deficiencies reflect state</p>	F0000		
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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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	findings cited in accordance with 410 IAC 16.2. Quality review 12/10/12 by Suzanne Williams, RN			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of a change in respiratory status, for 1 of 25 residents reviewed for physician notification. (Resident</p>	F0157	To accomplish corrective actions for resident #73, the physician was made aware of the respiratory status. To ensure that no other residents are affected by the practice, all residents with	12/30/2012	

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	<p>#73)</p> <p>Findings include:</p> <p>The record of Resident #73 was reviewed on 11/28/12 at 9:00 a.m. Resident #73's diagnoses included, but were not limited to, acute and chronic respiratory failure, COPD (chronic obstructive pulmonary disease), pneumonia and asthma</p> <p>Resident #73's physician's orders, dated 11/27/12, indicated DuoNeb 0.5-2.5 (3) mg (milligrams/3 ml (milliliters) Ipratropium-Albuterol, (to prevent bronchospasm) 0.5 Solution inhalation two times a day.</p> <p>Resident #73's "Respiration Summary" indicated on 11/18/12, respirations were 44 (per minute), on 11/18/12, respirations 36, and on 11/18/12, respirations 36.</p> <p>Resident #73's schedule for November 2012, indicated DuoNeb 0.5-2.5 (3) mg/3ml Ipratropium-Albuterol inhalation dose: 0.5-2.5 (3) mg/ml two times a day. Take heart rate, respiration rate, oxygen saturation, and lung sounds prior to administering. The document indicated on 11/18/12 at 5:00 a.m., respirations were 44 and on 11/19/12</p>		<p>changes in condition have been reviewed daily by the nurse managers. Any identified changes not yet communicated to the physician were communicated promptly by the nurse. To ensure that the practice does not recur, the facility has created systemic changes. The medication administration orders were revised to require that nurses document respiratory assessments pre and post nebulizer treatments including respiratory rate, pulse, oxygen saturation, and minutes of treatment. Additionally the physician will give orders setting parameters on when they want to be called. Documentation of the notifications as appropriate will be located in the interdisciplinary notes. Retraining for the licensed nurses will be conducted by the DNS, ADNS, and DCE to be completed by December 22, 2012. Compliance will be monitored three times per week for four weeks, weekly for twelve weeks and ongoing for an additional 12 weeks to ensure that the practice does not recur, through daily review of the Change of Condition reports during daily clinical startup. Additionally audits of the record reports will be included in the monthly QAPI meeting agenda for 3 months and the next two quarterly QAPI meetings including the Medical Director.</p>				

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	<p>at 5:00 a.m., respirations 36.</p> <p>Review of Mosby's Clinical Nursing, 5th edition, indicated normal respirations 12-20 respirations/minute.</p> <p>Resident #73's record lacked any documentation the physician was notified of Resident #73's high respiration rate.</p> <p>During an interview on 11/30/12 at 12:10 p.m., the DON (Director of Nursing) indicated she did not know why there was not a nursing note of follow up assessment for the high respirations documented on 11/18/12 and 11/19/12, and the physician had not been notified.</p> <p>3.1-5(a)(2)</p>						

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to invite a resident's family to care plan meetings, for 1 of 1 resident who met the criteria for participation in care planning (Resident #133).</p> <p>Finding include:</p> <p>Interview with Resident #133's family member on 11-27-12 at 11:59 a.m. indicated they were not invited to care plan meetings for the resident. The family member indicated when the resident was first admitted to the facility they had a meeting with therapy. The family member indicated</p>	F0280	To accomplish corrective actions the family member for resident #133 was immediately handed a letter inviting him to the upcoming plan of care meeting. To ensure that no other residents are affected by the practice, the schedule for the care plan meeting was reviewed by the Activity Director. Letters were mailed to the family and notices were delivered to the resident for anyone with a scheduled care plan meeting. To ensure that the practice does not recur, the facility has created the following systemic changes. The Activity Director assumed the responsibility for mailing the Invitations to the Meetings and	12/30/2012	

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	<p>they visit frequently and no one had invited them verbally or by mail. The family member indicated they would like to attend care plan meetings for the resident.</p> <p>Interview with the Social Service Director (S.S.D.) on 11-29-12 at 2:10 p.m. indicated she was responsible to invite residents and their families to care plan conferences. The S.S.D. indicated Resident #133's family member came to her this morning and asked about care plan meetings for Resident #133, and she gave him a letter for the resident's next care plan meeting on 12-19-12. The S.S.D. indicated she did not know why Resident #133's family member had not been invited to the care plan meetings. The S.S.D. indicated she did not have any documentation where she had invited the resident's family member.</p> <p>Review of Resident #133's record on 11-30-12 at 10:30 a.m. indicated the resident's diagnoses included, but were not limited to, subdural hemorrhage, senile dementia, depression, convulsions, toxic encephalopathy, hypertension, hyperlipidemia, generalized pain and osteoarthritis.</p>		<p>delivering the notices to the resident effective 12/05/2012. Additionally, in the event that the family is not available to attend the meeting in person or by phone, the letter emphasizes their right to schedule a phone, personal, or written review of the meeting at their convenience. Compliance will be monitored three times per week for four weeks, weekly for twelve weeks and ongoing for an additional 12 weeks to ensure that the practice does not recur, through phone calls to the family members by the Guardian Angel to verify receipt of the invitation to the Care Plan Meeting. Additionally the IDT will record the number of families attending the Care Plan Meeting, number of residents attending the Care Plan Meeting, and number of alternate means of communicating the Care Plan Review in the monthly QAPI meeting minutes for three months and the next two Quarterly QAPI meeting.</p>		

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	<p>Resident #133 face sheet indicated the resident was admitted to the facility on 3-2-12.</p> <p>The care planning conference documentation for Resident #133 dated, 3-19-12, 4-16-12, 7-9-12 and 9-18-12 indicated in the space for "Responsible party invited- no call/no show," nothing was documented.</p> <p>The care plan policy, provided by the Director of Nursing on 11-30-12 at 2:15 p.m., indicated the purpose for the policy was "The interdisciplinary care plan is implemented to guide the Living Center in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well being of the resident and to promote the participation of the resident, family, or legal representative in planning care." "The resident/legal representative will be notified prior to each care plan meeting, encourage them to attend the meeting and solicit their input." "If unable to attend, the care plan will be reviewed with the resident, legal representative, and family if appropriate, and their response with be documented."</p> <p>3.1-35(d)(2)</p>						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the safety of 1 resident to be free of a potential hazardous risk by leaving a gait belt around the resident as an intervention for falls, for 1 of 3 residents reviewed for falls of 6 who met the criteria for falls. (Resident #55)</p> <p>Findings include:</p> <p>The record of Resident #55 was reviewed on 11/27/12 at 2:45 p.m. Resident #55's diagnoses included, but were not limited to, dementia with behavior disturbances, primary localized osteoarthritis lower leg, and Parkinson's disease.</p> <p>Resident #55's MDS (Minimum Data Set), assessment, dated 10/25/12, indicated the following:</p> <ul style="list-style-type: none"> - BIMS (Brief Interview for Mental Status), 7, with a score of 0-7 indicating severe impairment of cognition - transfer, limited assistance with one 	F0323	<p>To accomplish corrective actions the gait belt on resident #55 was tightened making it a safe intervention for fall prevention. To ensure that no other residents are affected by the practice, all residents who wear gait belts for ambulation have been assessed for proper placement and application of the gait belt. Any residents identified as not appropriate for use of the gait belt will have that intervention discontinued. To ensure that the practice does not recur, the facility has created the following systemic changes. All nursing staff will be retrained on proper application and use of gait belts. The training will be conducted by the Director of Nursing Services and the Director of Clinical Education and will be completed by 12/22/2012. Compliance will be monitored by the charge nurse and the unit coordination through an audit of any residents using gait belts ensuring proper utilization three times per week for four weeks and weekly for eight weeks and ongoing for twelve additional weeks. Additionally, the DNS, ADNS, and ED will observe for</p>	12/30/2012			

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	<p>person physical assist</p> <ul style="list-style-type: none"> - walk in room, limited assistance with one person physical assist - walk in hall, supervision - balance, moving from seated to standing position, not steady, only able to stabilize with staff assistance - balance, walking, not steady, only able to stabilize with staff assistance - falls, 0 <p>Resident #55's care plan, with an update of 10/1/12, indicated "Problem, at risk for falls related to, use of antidepressant medication. Has altered gait pattern, impaired cognition. Goal, no severe fall related injuries. Interventions, call light or personal items available and each in reach, encourage resident from unsafe tasks i.e. carrying dining room chairs, encourage appropriate footwear, encourage resident to keep environment well lit before ambulating and free of clutter, gait belt for transfer and ambulation, keep bed in low position, non-skid slipper socks at night and observe for side effects medications, drowsiness, dry mouth, blurred vision and urinary retention."</p> <p>Resident #55's "Risks for Falls," dated 10/24/12, indicated a score of 17. A score of 10 or above deems resident at risk.</p>		<p>non-compliance with use of the gait belt during routine unit rounds and make immediate corrections if noted. The non-compliance will be reviewed during the monthly QAPI meeting and the next two quarterly QAPI meetings including the Medical Director for any corrective recommendations. .</p>		

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	<p>Resident #55's "Change in Condition Report-Post Fall/Trauma," dated 11/16/12 at 11:59 p.m., indicated "summary, resident was found lying on floor next to bed during routine rounds stated 'he was trying to get up' Intervention, non-skid slipper socks at night."</p> <p>Resident #55's "Change in Condition Report-post Fall/Trauma" dated 11/22/12 at 8:00 p.m., indicated "summary, resident was on his way back to bed from the bathroom and lost his balance. Underlying illness, poor gait, leans forward and to the left and dementia. Witness, CNA indicated 'was changing resident in the bathroom and when he was walking back and I was picking up his clothing he lost his balance and fell.' Interventions, gait belt, Physical Therapy for screening and staff assist using gait belt for transfers and ambulation."</p> <p>On 11/28/12 at 9:45 a.m., CNA #2 was assisting Resident #55 from the bathroom to his chair. Resident #55 was observed taking short, stomping, unsteady steps, and leaning forward.</p> <p>On 11/28/12 at 1:10 p.m., Resident #55 was observed in his room, in his</p>			

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	<p>chair and the room was dark. Resident #55 had a gait belt around his waist that fit loosely and was laying around his upper thighs.</p> <p>On 11/30/12 at 9:15 a.m., resident was in dining room after breakfast CNA #4 tightened resident #55's gait belt that was on loosely and assisted Resident #55 back to his room and to his chair. Resident #55 ambulated with short, unsteady steps, leaned forward and to the left.</p> <p>On 11/30/12 at 12:03 p.m., Resident #55 was observed up in his chair in his room. The room was dark and Resident #55's gait belt was not around his waist but loosely laying on his upper thighs.</p> <p>During an interview on 11/29/12 at 2:24 p.m., LPN #3 indicated the intervention for Resident #55 after his last fall was to leave a gait belt on him all the time he was out of the bed so the staff could grab him quickly if he started to fall. She also indicated Resident #55 liked the room dark and did not like to attend very many activities, and that is why he spends a lot of his time in his room sitting in his chair.</p> <p>3.1-45(a)(1)</p>				

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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received a sufficient amount of fluids between meals as recommended by the Registered Dietician (RD), for 1 of 1 resident who met the criteria for hydration (Resident #22)</p> <p>Finding include:</p> <p>Interview with Resident #22 on 11-26-12 at 1:06 p.m. indicated she did not receive fluids between meals. Resident #22 indicated it was difficult for her to drink fluids and her fluids had to be thickened because she chokes on regular fluids. Resident #22 indicated she could not hold the water pitchers that the facility served the water in because of her hands. Resident #22 indicated staff do not come in her room and offer drinks between meals. Resident #22 indicated she did get thirsty between meals. During observation at this time, the resident had no fluids in her room.</p> <p>During observation on 11-28-12 on</p>	F0327	<p>To accomplish corrective actions for resident #22 the nurse offered a glass of thickened liquids. To ensure that no other residents are affected by the practice, the records of all residents requiring thickened liquids, have risk factors for dehydration have been reviewed. Any resident at risk will have the fluid consumption documented at the meal and in-between the meals. To ensure that the practice does not recur, the facility has created the following systemic changes. For residents at risk for dehydration, the physician orders have been changed to include fluids offered in-between meals and the amount consumed. Nurses will be instructed on the new orders and reminded of the expectation to offer and document fluid consumption. The DNS will conduct the training for the nurses by 12/22/2012 Compliance will be monitored to ensure that the practice does not recur, during daily clinical startup meeting through review of the medication administration sheets daily times four weeks and two times per week times eight weeks and weekly for 12 additional weeks. Non-compliance will be</p>	12/30/2012	

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	<p>9:30 a.m., Resident #22 was eating breakfast. The resident had two small plastic cups of thickened fluid and a carton of chocolate milk. The resident's hands and fingers were bent inward, but the resident was able to hold the small plastic cups of fluids and milk carton by holding them on the outside of her bent hands. The resident drank 360 milliliters of fluid for breakfast.</p> <p>Review of the record of Resident #22 on 11-28-12 at 9:38 a.m. indicated the resident's diagnoses included, but were not limited to, renal failure, depression, anxiety, congestive heart failure (CHF), dysphasia (difficulty swallowing), urinary retention and hypertension.</p> <p>The physician recapitulation, dated November 2012 indicated the resident was ordered lasix (diuretic) 40 milligrams one time a day.</p> <p>The most recent Speech Therapy plan of care for Resident #22 dated 10-12-2011, indicated the resident had dysphasia and was on nectar thick liquids.</p> <p>The Minimum Data Set (MDS) assessment for Resident #22, dated 9-5-12, indicated the resident's BIMS</p>		addressed immediately. The non-compliance will be reviewed during the monthly QAPI meeting and the next two quarterly QAPI meetings including the Medical Director for any corrective recommendations.				

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	<p>(Brief Interview for Mental Status) was a 12, moderately impaired cognition, and the resident required extensive assistance from one person for eating and drinking.</p> <p>The care plan for Resident #22, dated 2-15-11, indicated the resident had potential for alteration in hydration related to diuretic use. The resident stated she knew she did not drink enough. The interventions included, but were not limited to, encourage fluids.</p> <p>Interview with CNA #1 on 11-28-12 at 11:37 a.m. indicated the facility did not have any certain times the residents were given fluids. CNA #1 indicated the aides filled up water pitchers "whenever." CNA #1 indicated if a resident was on thickened liquids they could get thickened liquids from the kitchen or leave the thickened liquids in the resident's room. CNA #1 indicated Resident #22 refuses to have fluids in her room. CNA #1 indicated it was too hard for Resident #22 to hold the water pitchers because they were too big.</p> <p>Interview with Resident #22 on 11-28-12 at 11:40 a.m. indicated it would be good to have cranberry juice</p>				

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	<p>or something to drink in her room, but the drinks would have to be thickened.</p> <p>The nutritional assessment for Resident #22, completed by the R.D. on 6-11-12, indicated the resident's estimated fluid needs were 1300-1500 milliliters (ml) a day.</p> <p>The fluid consumption intake record for Resident #22 indicated the following:</p> <p>11-2-12 the resident consumed 700 ml in a 24 hour period 11-3-12 the resident consumed 600 ml in a 24 hour period 11-4-12 the resident consumed 1080 ml in a 24 hour period 11-5-12 the resident consumed 840 ml in a 24 hour period 11-6-12 the resident consumed 1080 ml in a 24 hour period 11-7-12 the resident consumed 840 ml in a 24 hour period 11-8-12 the resident consumed 720 ml in a 24 hour period 11-9-12 the resident consumed 720 ml in a 24 hour period 11-10-12 the resident consumed 600 ml plus "sips" in a 24 hour period 11-11-12 the resident consumed 960 ml in a 24 hour period 11-12-12 the resident consumed 840 ml in a 24 hour period</p>			

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	<p>11-13-12 the resident consumed 1120 ml in a 24 hour period</p> <p>11-14-12 the resident consumed 480 ml in a 24 hour period</p> <p>11-15-12 the resident consumed 960 ml in a 24 hour period</p> <p>11-16-12 the resident consumed 840 ml in a 24 hour period</p> <p>11-17-12 the resident consumed 840 ml in a 24 hour period</p> <p>11-18-12 the resident consumed 960 ml in a 24 hour period</p> <p>11-19-12 the resident consumed 840 ml in a 24 hour period</p> <p>11-20-12 the resident consumed 840 ml in a 24 hour period</p> <p>11-21-12 the resident consumed 600 ml in a 24 hour period</p> <p>11-22-12 the resident consumed 600 ml in a 24 hour period</p> <p>11-23-12 the resident consumed 480 ml in a 24 hour period</p> <p>11-24-12 the resident consumed 720 ml in a 24 hour period</p> <p>11-25-12 the resident consumed 480 ml in a 24 hour period</p> <p>11-26-12 the resident consumed 960 ml in a 24 hour period</p> <p>11-27-12 the resident consumed 800 ml in a 24 hour period</p> <p>11-28-12 the resident consumed 480 ml in a 24 hour period</p> <p>11-29-12 the resident consumed 1080 ml in a 24 hour period</p> <p>This indicated from 11-2-12 to</p>			

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	<p>11-29-12 Resident #22 did not receive the fluid requirements recommended by the R.D.</p> <p>During observation on 11-30-12 from 9:30 a.m. to 12:20 p.m., Resident #22 did not have any fluids in her room.</p> <p>Interview with Resident #22 on 11-30-12 at 12:26 p.m. indicated no staff had come in her to offer her fluids today. Resident #22 indicated she had drinks with her breakfast this morning.</p> <p>Interview with Director of Nursing (DON) on 11-30-12 at 1:30 p.m. indicated residents' fluids were documented on the meal and fluid consumption sheet. The DON indicated there was no documentation of resident fluid intake given with medication or what was offered by the CNAs when giving care. When queried how does the facility determine if a resident was receiving the recommended amount of fluid a day, the DON indicated she did not have an answer for that. The DON indicated the physician and the dietician did review the food/fluid intake logs.</p> <p>The hydration policy, provided by the DON on 11-30-12 at 10:40 a.m.,</p>						

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	<p>indicated the dietitian calculates daily fluid requirements for all patients annually or with changes in condition. The dehydration risk risk factor included, but were not limited to, functional impairments making it difficult to drink, reach for fluids or communicate fluid needs (e.g. aphasia, thickened liquids). The reasons for increased fluid needs included, but were not limited to, diuretic use.</p> <p>3.1-46(b)</p>			

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to assess 1 resident with a high rate of respirations for respiratory distress for 1 of 1 resident reviewed for respiratory care. (Resident #73)</p> <p>Findings include:</p> <p>The record of Resident #73's was reviewed on 11/28/12 at 9:00 a.m. Resident #73's diagnoses included, but were not limited to, acute and chronic respiratory failure, COPD (chronic obstructive pulmonary disease), pneumonia and asthma.</p> <p>Resident #73 MDS (Minimum Data Set) assessment, dated 10/22/12, indicated a BIMS (Brief Interview for Mental Status) score of 11, with a score of 8-12 indicating moderately impaired cognition. The MDS also indicated Resident #73 was on</p>	F0328	To accomplish corrective actions the unit nurse measured the vital signs and respiratory status of resident #73 to ensure that her respiratory status was stable at the time and no further interventions were required. To ensure that no other residents are affected by the practice, all residents with physician orders for nebulizer treatments were audited to ensure that no other occurrence of high respiratory rate was present requiring reassessment and physician notification. To ensure that the practice does not recur, the facility has created systemic changes. The medication administration orders were revised to require that nurses document respiratory assessments pre and post nebulizer treatments including respiratory rate, pulse, oxygen saturation, and minutes of treatment. Additionally the physician will give orders setting parameters on when they want to	12/30/2012			

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	<p>oxygen therapy.</p> <p>Resident #73's care plan, dated 3/12/12, indicated "Problem, alteration in respiratory status due to chronic obstructive pulmonary disease, acute/chronic respiratory failure. Goal, resident will have no shortness of breath unrelieved by nursing or medical interventions. Interventions, administer medication as order oxygen 2-3 liters nasal cannula, continuously per nasal cannula or masks inhalation to keep saturations 88-90%, do not increase oxygen over 3 liters nasal cannula, encourage resident to follow instructions given to increase breathing efficiency, labs per physician order, observe for shortness of breath, upon exertion, observe for sputum production, amount color, odor and report significant finds to physician and provide reassurance when having respiration difficulties."</p> <p>Resident #73's physician's orders, dated 11/27/12, indicated DuoNeb 0.5-2.5 (3) mg (milligrams/3 ml (milliliters) Ipratropium-Albuterol, (to prevent bronchospasm) 0.5 Solution inhalation two times a day.</p> <p>Resident #73's "Respiration</p>		<p>be called. Documentation of the notifications as appropriate will be located in the interdisciplinary notes. Retraining for the licensed nurses will be conducted by the DNS, ADNS, and DCE to be completed by December 22, 2012. Compliance will be monitored three times per week for four weeks, weekly for twelve weeks and ongoing for an additional 12 weeks to ensure that the practice does not recur, through daily review of the Change of Condition reports during daily clinical startup. Additionally audits of the record reports will be included in the monthly QAPI meeting agenda for 3 months and the next two quarterly QAPI meetings including the Medical Director.</p>				

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	<p>Summary" indicated on 11/18/12, respirations were 44 (per minute), on 11/18/12, respirations 36, and 11/18/12, respirations 36.</p> <p>Resident #73's schedule for November 2012 indicated DuoNeb 0.5-2.5 (3) mg/3ml Ipratropium-Albuterol inhalation dose: 0.5-2.5 (3) mg/ml two times a day. Take heart rate, respiration rate, oxygen saturation, and lung sounds prior to administering. The document indicated on 11/18/12 at 5:00 a.m., respirations were 44 and on 11/19/12 at 5:00 a.m., respirations 36.</p> <p>Review of Mosby's Clinical Nursing, 5th edition, indicated normal respirations were 12-20 respirations/minute.</p> <p>Resident #73's record lacked any nursing notes for 11/18/12. Nursing notes dated 11/19/12 at 10:55 p.m., indicated "resident skin note, no new skin issues noted at this time." This was the only documentation in the nursing notes for 11/19/12.</p> <p>Resident #73's nursing notes for 11/20/12 include the following: - 4:03 a.m., Guaifenesin-DM (cough medication), (100-10 mg/5ml)-given 10 ml, by mouth at 4:00 a.m. for</p>			

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	<p>non-productive moist cough</p> <p>- 4:20 a.m., routine neb (nebulizer) treatment administered per nebulizer times 15 minutes and tolerated treatment well. Oxygen saturation at 91%, pulse, 85, respirations, 20, on continuous oxygen at 2 liters nasal cannula. Respirations remain labored</p> <p>- 4:50 a.m., resident has moist non-productive cough and labored breathing-more than usual. Resident states "I can't breathe." Assessment blood/pressure 127/65, pulse, 87, respirations, 22, temperature 98.5 oral, oxygen saturation 84-91% on continuous oxygen at 2.5 nasal cannula. Respiration even, labored, breath sounds with rales (abnormal breath sounds) noted. Response (physician) contacted. New order received for Levaquin (antibiotic) 500 mg, 1 tablet, by mouth, 4 times a day times 10 days</p> <p>- 5:00 a.m., initial dose Levaquin given. Resident took medication without difficulty</p> <p>- 5:16 a.m., resting quietly in bed at this time</p> <p>- 6:08 a.m., resident calling out loudly "help, I need help, I can't breathe, help me." Resident noted sitting up in bed, anxious, respirations labored. Calmed resident by sitting with her and talking to her. Nasal cannula replaced with a simple mask as</p>			

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	<p>resident was mouth breathing/panting and is purse lipped. Contacted (physician) again, order received to have resident transported to (local hospital) for evaluation.</p> <p>During an interview on 11/30/12 at 12:10 p.m., the DON (Director of Nursing) indicated she did not know why the physician was not notified, and she did not know why there was not a nursing note of a follow up assessment for the high respirations documented on 11/18/12 and 11/19/12. The DON indicated the resident fluctuates a lot, and they did send her out a day or two later.</p> <p>3.1-47(a)(6)</p>			