

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaint IN00149439.</p> <p>Complaint IN00149439 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, F315, F327, and F328.</p> <p>Survey dates: June 2, 4 & 5 2014</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 17 SNF/NF: 119 Total: 136</p> <p>Census Payor Type: Medicare: 21 Medicaid: 102 Other: 13 Total: 136</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings</p>	F000000	The facility respectfully requests the Plan of Correction, Form 2567, be used as the Credible Letter of Compliance for the listed alleged deficiencies.	
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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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F000157 SS=D	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on June 11, 2014.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights</p>				

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	<p>under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review the facility failed to ensure a resident's physician was notified, in that when a resident began to have signs and symptoms of respiratory/breathing changes, the nursing staff failed to ensure the physician was notified for possible intervention for 1 of 3 sampled residents. (Resident "A")</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 06-04-14 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, dysphagia, multiple cerebral vascular accidents, pulmonary hypertension, fever, shortness of breath, bladder disorder, recurrent urinary tract infections, and recurrent aspiration pneumonia. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital and admitted to the facility the same date, 05-02-14.</p> <p>A review of the "discharge summary" received on 05-02-14, indicated the</p>	F000157	<p>F157</p> <p>Notify of Changes</p> <p>It is the practice of this provider to ensure that the resident's physician and responsible party are promptly notified regarding a significant change in condition.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident A does not reside in the facility any longer. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents with a change 	06/24/2014

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	<p>resident had physician orders for Albuterol (a bronchodilator medication) nebulizer 2.5 mg (milligrams) / 0.5 mg (3 ml) (milliliters) per nebulizer every 6 hours scheduled as well as every 4 hours as needed for wheezing or dyspnea.</p> <p>The record indicated the resident had a physician order dated 05-04-14 for a chest x-ray. The results were conveyed to the physician that the results were clear.</p> <p>A review of the Interdisciplinary Progress notes indicated the following from 05-05-14 thru 05-09-14:</p> <p>"05-06-14 8:03 a.m. - Suctioned for thick secretions with a yankers."</p> <p>"05-08-14 3:27 p.m. - Suctioned times 1, rec'd [received] thick white secretions."</p> <p>"05-09-14 8:28 a.m. - Neb. [nebulizer] tx. [treatment] done per order. Resident with noted increased congestion to right upper lobe. Suctioned times 4 small amount of thick whitish sputum obtained."</p> <p>A review of the Medication Administration History from 05-05-14 through 05-09-14 indicated the following:</p>		<p>in condition have the potential to be effected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Progress notes are reviewed daily by Nursing Management to identify changes Monday through Friday and by the Weekend manager on Saturday and Sunday. Any changes in condition will be reviewed for physician notification. · All staff received corporate directed re-education on identifying and reporting changes in resident condition. · Nurse consultant will randomly audit identified changes upon her weekly visit. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>				

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	<p>"Day 4 after admission to the facility - 05-05-14 6:00 p.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - coarse."</p> <p>Day 5 after admission to the facility - "05-06-14 12:00 a.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - slightly coarse."</p> <p>"05-06-14 6:00 a.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - slightly coarse."</p> <p>"05-06-14 6:00 p.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - coarse."</p> <p>Day 6 after admission to the facility - "05-07-14 12:00 a.m. "Lung sounds before treatment - diminished. Lung sounds after treatment - diminished."</p> <p>"05-07-14 6:00 a.m. "Lung sounds before treatment - diminished. Lung sounds after treatment - diminished."</p> <p>"05-07-14 6:00 p.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - coarse."</p> <p>Day 7 after admission to the facility - "05-08-14 12:00 a.m. "Lung sounds</p>		<p>into place?</p> <ul style="list-style-type: none"> · An audit tool will be used by DON/Admin/designee when change of condition is identified daily. · Any identified concerns from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <p>Compliance Date: June 24, 2014</p>		

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	<p>before treatment - congested. Lung sounds after treatment - congested."</p> <p>"05-08-14 6:00 a.m. "Lung sounds before treatment - congested. Lung sounds after treatment - diminished."</p> <p>"05-08-14 12:00 p.m. "Lung sounds before treatment - congested. Lung sounds after treatment - clear."</p> <p>"05-08-14 6:00 p.m. "Lung sounds before treatment - wheezing. Lung sounds after treatment - wheezing."</p> <p>A review of the Medication Administration History for May 2014 lacked documentation the resident received any of the PRN (as needed) treatments for shortness of breath or wheezing.</p> <p>On Day 8, 05-09-14, after the admission to the facility, the resident had a significant change in condition which required 911 to be activated. The physician was notified of the change in condition on 05-09-14 at 10:11 a.m.</p> <p>The EMS (emergency medical services) 911 documentation was reviewed and noted as follows upon arrival at the facility: "Unresponsive, diaphoresis - hot,</p>				

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	<p>retraction of accessory muscles, left upper and lower lobe wheezing, right upper and lower lobe wheezing. CPAP [Continuous Positive Airway Pressure] applied with a flow rate of 25 liters per minute."</p> <p>At the time the resident arrived at the local area hospital emergency room, the resident was examined by the emergency room physician who indicated, "the patient presents with difficulty breathing and respiratory problem. Degree at onset moderate. Degree at present severe. Heart rate 130 bpm [beats per minute] HI, respiratory rate 22 HI, Oxygen saturation level 79 %." The "respirations are tachypneic, respiratory distress severe, labored, with breath sounds bilateral diminished, rhonchi present retractions severe."</p> <p>"Upon presentation to the emergency department, patient was impending respiratory failure. Patient had elective intubation done by myself. Pneumonia was likely on chest x-ray. The patient is currently sedated and on the vent. [ventilator]."</p> <p>The clinical record lacked documentation the physician was notified of the change in the resident's chest congestion during suctioning or routine breathing treatments</p>				

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	<p>from 05-05-14 thru 05-09-14 when the resident was found with "skin warm and clammy, resp. [respirations] increased and labored. Resident noted gripping sheets. BP [blood pressure] WNL [within normal limits], HR [heart rate] 140, Temp. [temperature] 103.4 at this time, cold clothes <sic> applied to pulse points. O2 [oxygen] saturation] 79 %, neb. treatment given at this time. UN [unit manager], ADON [assistant director of nurses] notified. MD [Medical Doctor] paged at this time."</p> <p>A review of the facility policy on 06-04-14 at 12:35 p.m., and dated as "revised October 2010, indicated the following:</p> <p>"Policy Statement - Our facility shall promptly notify the resident's, his or her attending physician and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, residents rights etc.)."</p> <p>"Policy Interpretation and Implementation - The Nurse Supervisor/Charge Nurse will notify the resident's attending physician or on-call physician when there has been: d. A significant change in the resident's physical/emotional/mental condition."</p>			

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F000309 SS=G	<p>This Federal tag relates to Complaint IN00149439.</p> <p>3.1-5(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview the facility failed to ensure a resident received the necessary care and services to maintain the highest practicable physical well being, in that when a resident had a history of recurrent aspiration pneumonia and shortness of breath, the nursing staff failed to ensure the resident received physician ordered breathing treatments. This deficient practice resulted in a resident's condition to decline and 911 had to be notified for transport to the local area hospital for 1 of 3 sampled residents. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was</p>	F000309	<p>F309 Provide Care/Services for highest well being It is the practice of this provider to ensure that residents receive the necessary care and treatment to maintain the highest practicable physician well-being. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident A does not reside in the facility any longer. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who have scheduled and PRN breathing treatment orders have the</p>	06/24/2014			

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	<p>reviewed on 06-04-14 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, dysphagia, multiple cerebral vascular accidents, pulmonary hypertension, fever, shortness of breath, bladder disorder, recurrent urinary tract infections, and recurrent aspiration pneumonia. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital and admitted to the facility the same date, 05-02-14.</p> <p>A review of the "discharge summary" received on 05-02-14, indicated the resident had physician orders for Albuterol nebulizer 2.5 mg (milligrams) / 0.5 mg (3 ml) (milliliters) per nebulizer every 6 hours scheduled as well as every 4 hours as needed for wheezing or dyspnea.</p> <p>A review of the Interdisciplinary Progress notes indicated the following from 05-05-14 thru 05-09-14:</p> <p>"05-06-14 8:03 a.m. - Suctioned for thick secretions with a yankers."</p> <p>"05-08-14 3:27 p.m. - Suctioned times 1, rec'd [received] thick white secretions."</p> <p>"05-09-14 8:28 a.m. - Neb. [nebulizer] tx.</p>		<p>potential to be effected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Progress notes are reviewed daily by Nursing Management to identify changes Monday through Friday and by the Weekend manager on Saturday and Sunday. · Physician orders are reviewed daily by Nursing Management to identify new orders/changes in condition. · Administration compliance records will be reviewed daily by Nursing Management and by the Weekend supervisor Saturday and Sunday. · Nurse consultant will randomly audit identified residents who receive breathing treatments upon her weekly visit. · All staff were re-educated on identifying change of condition on June 17, 2014 by corporate Clinical Director. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · An audit tool will be used to identify if all interventions were exhausted prior to change of condition and the tool will be used as education with nursing staff. · Any identified areas from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to 		

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	<p>[treatment] done per order. Resident with noted increased congestion to right upper lobe. Suctioned times 4 small amount of thick whitish sputum obtained."</p> <p>A review of the Medication Administration History from 05-05-14 through 05-09-14 indicated the following:</p> <p>"05-05-14 6:00 p.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - coarse."</p> <p>"05-06-14 12:00 a.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - slightly coarse."</p> <p>"05-06-14 6:00 a.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - slightly coarse."</p> <p>"05-06-14 6:00 p.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - coarse."</p> <p>"05-07-14 12:00 a.m. "Lung sounds before treatment - diminished. Lung sounds after treatment - diminished."</p> <p>"05-07-14 6:00 a.m. "Lung sounds before treatment - diminished. Lung sounds after treatment - diminished."</p>		<p>and including termination. · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: June 24, 2014</p>				

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	<p>"05-07-14 6:00 p.m. "Lung sounds before treatment - coarse. Lung sounds after treatment - coarse."</p> <p>"05-08-14 12:00 a.m. "Lung sounds before treatment - congested. Lung sounds after treatment - congested."</p> <p>"05-08-14 6:00 a.m. "Lung sounds before treatment - congested. Lung sounds after treatment - diminished."</p> <p>"05-08-14 12:00 p.m. "Lung sounds before treatment - congested. Lung sounds after treatment - clear."</p> <p>"05-08-14 6:00 p.m. "Lung sounds before treatment - wheezing. Lung sounds after treatment - wheezing."</p> <p>A review of the Medication Administration History for May 2014 lacked any documentation the resident received the PRN (as needed) treatments for shortness of breath or wheezing.</p> <p>On 05-09-14 the resident had a significant change in condition which required 911 emergency to be activated and the resident transported to the local hospital emergency room.</p> <p>The EMS (emergency medical services)</p>			

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	<p>911 documentation was reviewed and noted as follows:</p> <p>"Unresponsive, diaphoresis - hot, retraction of accessory muscles, left upper and lower lobe wheezing, right upper and lower lobe wheezing. CPAP [Continuous Positive Airway Pressure] applied with a flow rate of 25 liters per minute."</p> <p>At the time the resident arrived at the local area hospital emergency room, the resident was examined by the emergency room physician who indicated, "the patient presents with difficulty breathing and respiratory problem. Degree at onset moderate. Degree at present severe. Heart rate 130 bpm [beats per minute] HI, respiratory rate 22 HI, Oxygen saturation level 79 %." The "respirations are tachypneic, respiratory distress severe, labored, with breath sounds bilateral diminished, rhonchi present retractions severe."</p> <p>"Upon presentation to the emergency department, patient was impending respiratory failure. Patient had elective intubation done by myself. Pneumonia was likely on chest x-ray. The patient is currently sedated and on the vent. [ventilator]."</p> <p>A review of the IP (Inpatient) Admission</p>						

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	<p>Note H & P (History and Physical) indicated "acute respiratory failure: hypoxic in ED (emergency department) in setting of septic shock, intubated."</p> <p>The clinical record lacked documentation of any additional interventions in regard to administering the PRN breathing treatments to the resident.</p> <p>The physician was not notified of the change in the resident's chest congestion during suctioning or routine breathing treatments from 05-05-14 thru 05-09-14 when the resident was found with "skin warm and clammy, resp. [respirations] increased and labored. Resident noted gripping sheets. BP [blood pressure] WNL [within normal limits], HR [heart rate] 140, Temp. [temperature] 103.4 at this time, cold clothes <sic> applied to pulse points. O2 [oxygen] saturation] 79 %, neb. treatment given at this time. UN [unit manager], ADON [assistant director of nurses] notified. MD [Medical Doctor] paged at this time."</p> <p>This Federal tag relates to Complaint IN00149439.</p> <p>3.1-37(a)</p>						

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F000315 SS=G	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview the facility failed to ensure a resident with an indwelling catheter received treatment to ensure/prevent infections, in that when a resident was admitted to the facility with an indwelling catheter, the nursing staff failed to follow the hospital physician discharge orders for the maintenance of the catheter to aid in the prevention of a urinary tract infection for 1 of 3 sampled resident. (Resident "A"). The resident was sent to the hospital and admitted for Urinary Tract Infection and Sepsis.</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 06-04-14 at 10:00 a.m.</p> <p>Diagnoses included, but were not limited</p>	F000315	<p>F315</p> <p>No catheter/prevent UTI/ restore bladder</p> <p>It is the practice of this provider to ensure that residents with catheters receive the treatment to prevent infections.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident A does not reside</p>	06/24/2014	

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	<p>to, dementia, dysphagia, multiple cerebral vascular accidents, pulmonary hypertension, fever, shortness of breath, bladder disorder, recurrent urinary tract infections, and recurrent aspiration pneumonia. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital and admitted to the facility the same date, 05-02-14.</p> <p>A review of the "discharge orders" received on 05-02-14, indicated the resident required "Oxychlorosene sodium [a topical antiseptic for treating localized infections] 0.2 % intra BLADDER IRRIGATION," every week. Start 05-01-14 10:00 a.m."</p> <p>In addition the Hospital Discharge Summary, dated 05-02-14, indicated the resident "will have a weekly (every Monday) bladder irrigation with Clorpactin 0.2 % concentration, 200 ml instilled with a dwell time of 5 minutes and then evacuated. This is for UTI [urinary tract infection] prophylaxis."</p> <p>Further review of the "Discharge Instructions prompted the nursing staff "weekly (every Monday), bladder irrigations as ordered. Oxychlorosene sodium 0.2% intra-bladder. Dose = 4</p>		<p>in the facility any longer.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents who have an indwelling catheter have the potential to be effected by the alleged deficient practice. · An audit was completed for 100% of current residents with indwelling catheters to ensure their orders were correct for foley catheter care. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All new admissions medications are audited by 2 floor nurses at admission time. · All licensed personnel were educated by corporate staff on the new admission audit process 				

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	<p>times 50 ml syringes - total dose of 200 ml. Dwell time: 5 minutes."</p> <p>A review of the facility physician orders, transcribed and entered into the computer by licensed nurse #6 lacked this treatment for the resident. A review of the Treatment Administration Record for May 2014 indicated "General Catheter irrigation - Special Instructions: Irrigate catheter with _____ mls. [milliliters] or _____ for _____ as needed." The areas were blank and therefore lacked instruction to the nursing staff for this treatment."</p> <p>The facility also had physician orders for a CBC (complete blood count) which was obtained on 05-06-14. The "verified results" of the WBC (white blood cell count) was 8.4 (normal range of 4.00 - 10.50).</p> <p>A review of the Progress Notes indicated the following:</p> <p>"05-06-14 11:13 p.m. FC [foley catheter] drained for 375 c.c. [cubic centimeters] of clear yellow urine with some sediment noted."</p> <p>The record lacked any documentation the resident received the physician ordered irrigation. The irrigation should have</p>		<p>on 6-17-2014.</p> <ul style="list-style-type: none"> · Nursing management audits the record within 24 hours to ensure all orders/paperwork have been reviewed/are correct. · Medical Records / Designee reviews orders for accuracy daily. · Nurse number 6 is no longer employed. <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · An admission audit tool will be reviewed by the Director of Nursing / designee 7 days a week. · Any identified areas from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. · The results of these audits will be discussed at the monthly 	

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	<p>been completed on Monday 05-05-14.</p> <p>On 05-09-14 the resident had a change in condition with noted wheezing, labored breathing, increased heart rate (140 beats per minute) and an elevated temperature of 103.4 Fahrenheit. The resident was transported to the local area hospital for evaluation and treatment via 911 emergency.</p> <p>A review of the local area hospital record on 06-04-14 at 2:00 p.m., indicated the following:</p> <p>The resident arrived at the hospital at 10:35 a.m., on 5/9/14, to the Emergency Room. At the time the resident arrived he was unresponsive. The resident's "heart rate was 130 bpm [beats per minute], respiratory rate of 22, oxygen saturation level at 79 % and blood pressure 76/57." Laboratory testing was completed in the Emergency Room, and the resident was found to have a WBC (white blood cell count) of 15.1 "H" [high]."</p> <p>A review of the "Critical Care Staff Initial Consult," dated 05-09-14, indicated "Impression and Plan - * Urinary Tract Infection - sepsis."</p> <p>The results of the "Urine culture -</p>		<p>facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: June 24, 2014</p>		

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F000327 SS=G	<p>Microbiology indicated the resident had > (greater than) cfu [colony forming units]/ml Gram Negative Rod, and > 100,000 cfu/ml Enterococcus species."</p> <p>The "Impression and Plan" indicated Shock unspecified and urinary tract infection - sepsis."</p> <p>A review of the "IP (In Patient) Note H & P (History and Physical),"Final Report," indicated, "severe sepsis <sic> septic shock likely due to UTI..."</p> <p>During an interview on 06-05-14 at 11:00 a.m., the Administrator verified the resident did not receive the physician ordered treatments to aid in the prevention of urinary tract infections and further indicated the licensed nurse failed to transcribe the physician orders completely.</p> <p>This Federal tag relates to Complaint IN00149439.</p> <p>3.1- 41(a)(2)</p>						
	483.25(j) SUFFICIENT FLUID TO MAINTAIN						

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	<p>HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview the facility failed to ensure the hydration needs of a dependent resident, in that when a resident required the facility nursing staff to provide sufficient fluids to meet hydration needs the facility failed to ensure adequate hydration which resulted in the resident transported to the local area hospital with a diagnoses of dehydration. This deficient practice effected 1 of 3 sampled residents reviewed with a gastrostomy feeding tube and the need for additional hydration. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 06-04-14 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, dysphagia, multiple cerebral vascular accidents, pulmonary hypertension, fever, shortness of breath, bladder disorder, recurrent urinary tract infections, and recurrent aspiration pneumonia. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital and admitted to the facility the same date, 05-02-14.</p>	F000327	<p>F327 Sufficient Fluid to maintain hydration It is the practice of this provider to ensure that residents receive sufficient fluid intake to maintain proper hydration and health. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident A does not reside in the facility any longer. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who have a g-tube have potential to be affected by the alleged deficient practice. · An audit was completed for 100% of current residents with g-tubes to ensure appropriate feeding/fluid orders are correct. · Nurse #6 is no longer employed by the facility. · The RD received education regarding reviewing residents with g-tubes. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The RD will ensure all new admissions are seen within 72 hours of admission. · Residents with g-tubes are</p>	06/24/2014	

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	<p>A review of the "discharge orders" received on 05-02-14, indicated the resident required "Adult non Fiber Formula," to be infused at 70 c.c. [cubic centimeters] continuously" through the feeding tube, with the addition of "125 ml [milliliters] water bolus every three hours."</p> <p>This water bolus would calculate to be 1000 c.c. over a 24 hour period.</p> <p>A review of the facility physician orders, transcribed and entered into the computer by licensed nurse #6 indicated "Water flush 150 c.c. Special Instruction: Give additional 150 c.c. of water flush QID [four times a day] 8:00 a.m., 2:00 p.m., 4:00 p.m. and 10:00 a.m."</p> <p>A review of the Nursing Admission Assessment, dated 05-02-14 indicated the resident was "at risk for dehydration."</p> <p>The resident had physician orders at the time of admission for a "General Chemistry" which was drawn on 05-06-14. The resident results were reported to the facility on 05-06-14, and the resident's Sodium was 146 "H" (high) (normal range 135 - 145) and BUN (blood urea nitrogen) "H" at 26 (normal range 8 - 21).</p>		<p>reviewed by the RD at least monthly. · Licensed staff were re-educated via a corporate directed inservice on Prevention of Sepsis/Change of Condition on June 17, 2014. · Nursing management will review the Administration Compliance report 7 days per week. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>· An audit tool will be utilized by the RD and reviewed by the DON/ADON Monday through Friday to ensure g-tube feedings / flushes are appropriate as well as those with physician order changes for g-tubes. The weekend nurse manager will review new enteral/flush orders with the RD via phone on the weekends to ensure correct fluids maintained. · Any identified areas from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: June 24, 2014</p>				

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	<p>During an interview on 06-04-14 at 11:20 a.m., the Registered Dietician indicated she had not reviewed this residents chart or the orders for the feeding tube with the water flushes prior to the resident being discharged back to the local area hospital, but "he would need 600 c.c. flushes per day."</p> <p>A review of the "fluids and supplements" section of the resident record, indicated the resident received the following hydration:</p> <p>"05-03-14 560 c.c., 05-04-14 - no documentation, 05-05-14 480 c.c. and 560 c.c., 05-06-14 560 c.c., 05-07-14 400 c.c. and 560 c.c., 05-08-14 960 c.c."</p> <p>On 05-09-14 the resident had a change in condition and was transported to the local area hospital for evaluation and treatment via 911 emergency.</p> <p>A review of the local area hospital record on 06-04-14 at 2:00 p.m., indicated the following:</p> <p>The resident arrived at the hospital at 10:35 a.m. to the Emergency Room. At the time the resident arrived he was unresponsive. The resident's "heart rate</p>						

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	<p>was 130 bpm [beats per minute], respiratory rate of 22, oxygen saturation level at 79 % and blood pressure 76/57." Laboratory testing was completed in the Emergency Room, and the resident was found to have a BUN of 71 "H", and a Sodium level of 153 "HI."</p> <p>The Emergency Room Physician Notes dated 05-09-14 indicated "Patient with likely sepsis secondary to respiratory failure and hypertension. Patient was given multiple IV [intravenous] fluids boluses in emergency department." The record further indicated the resident received "6155 c.c. of fluids within the first 24 hours of hospitalization to rehydrate the resident."</p> <p>A review of the "Critical Care Staff Initial Consult," dated 05-09-14, indicated "Impression and Plan - * Shock. Plan fluid administration. Oliguria [diminished urine secretion in relation to fluid intake] and anuria [complete suppression of urine formation by the kidney] - Plan: Hydration metabolic corrections."</p> <p>The IP (Inpatient) Critical Care Staff Progress Note indicated the resident had "hyponatremia/dehydration."</p> <p>The resident was transferred from the</p>			

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	<p>Emergency Room to the Adult Intensive Care Unit "for severe sepsis/septic shock likely due to UTI [urinary tract infection], hypernatremia, AKI [acute kidney injury], dehydration and acute respiratory failure."</p> <p>During an interview on 06-06-14 at 11:00 a.m., the Administrator and the Corporate Nurse verified the resident did not receive the hydration needs aws indicated in the physician orders.</p> <p>A review of the facility policy on 06-04-14 at 12:35 p.m., dated as "revised 2008," indicated the following:</p> <p>"Policy Statement - This facility will endeavor to provide adequate hydration and to prevent and treat dehydration."</p> <p>"Policy Interpretation and Implementation - 1. The Dietician will assess all residents for hydration adequacy at least quarterly, and more often as necessary per resident need. The Dietitian, nursing staff and the physician will assess factors that may be contributing to inadequate fluid intake."</p> <p>This Federal tag relates to Complaint IN00149439.</p> <p>3.1-46(b)</p>			

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F000328 SS=G	<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 special needs of a resident in regard to hydration and enteral feedings, in that when the resident had specific physician orders for hydration and enteral feeding, the nursing staff limited the amount of water required to meet the hydration needs for a resident. This deficient practice effected 1 of 3 resident's reviewed for hydration and enteral feeding and resulted in the resident' being transported via 911 to the local area hospital with a diagnoses of dehydration. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 06-04-14 at 10:00 a.m.</p>	F000328	<p>F328 Treatment/Care for Special Needs It is the practice of this provider to ensure that residents receive proper treatments and care for residents with Enteral Feedings. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident A does not reside in the facility any longer. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who have enteral feedings have potential to be affected by the alleged deficient practice. · An audit was completed for 100% of current residents on enteral</p>	06/24/2014

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	<p>Diagnoses included, but were not limited to, dementia, dysphagia, multiple cerebral vascular accidents, pulmonary hypertension, fever, shortness of breath, bladder disorder, recurrent urinary tract infections, and recurrent aspiration pneumonia. These diagnoses remained current at the time of the record review.</p> <p>The resident was discharged from a local area hospital and admitted to the facility the same date, 05-02-14.</p> <p>A review of the "discharge orders" received on 05-02-14, indicated the resident required "Adult non Fiber Formula," to be infused at 70 c.c. [cubic centimeters] continuously" through the feeding tube, with the addition of "125 ml [milliliters] water bolus every three hours." This water bolus would calculate to be 1000 c.c. over a 24 hour period.</p> <p>A review of the facility physician orders, transcribed and entered into the computer by licensed nurse #6 indicated "Water flush 150 c.c. Special Instruction: Give additional 150 c.c. of water flush QID [four times a day] 8:00 a.m., 2:00 p.m., 4:00 p.m. and 10:00 a.m." This amount of fluid recorded allowed only 600 c.c. of the 1000 c.c. needed by the resident.</p> <p>The resident had physician orders at the</p>		<p>feedings. · Nurse #6 is no longer employed by the facility. · The RD has received education regarding assessing residents with enteral feedings. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The RD will ensure all new admissions are seen within 72 hours of admission. · Residents with g-tubes are reviewed by the RD at least monthly. · Licensed staff were re-educated via a corporate directed inservice on Prevention of Sepsis/Change of Condition on June 17, 2014. · Nursing management will review the Administration Compliance report 7 days per week. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · An audit tool will be utilized by the RD and reviewed by the DON/ADON Monday through Friday to ensure all orders are correct for those with g-tubes/enteral feedings. The weekend nurse manager will review all new enteral/flush orders with the RD via phone to ensure appropriate fluids are ordered. · Any identified areas from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including</p>				

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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>time of admission for a "General Chemistry" which was drawn on 05-06-14. The resident's laboratory results were reported to the facility and the resident's Sodium was 146 "H" (high) (normal range 135 - 145) and BUN (blood urea nitrogen) "H" at 26 (normal range 8 - 21).</p> <p>During an interview on 06-04-14 at 11:20 a.m., the Registered Dietician indicated she had not reviewed this residents chart or the orders for the feeding tube with the water flushes prior to his discharge to the hospital, but according to the orders "he would need 600 c.c. flushes per day."</p> <p>A review of the "fluids and supplements" section of the resident record, indicated the resident received the following hydration:</p> <p>"05-03-14 560 c.c., 05-04-14 - no documentation, 05-05-14 480 c.c. and 560 c.c., 05-06-14 560 c.c., 05-07-14 400 c.c. and 560 c.c., 05-08-14 960 c.c."</p> <p>On 05-09-14 the resident had a change in condition and was transported to the local area hospital for evaluation and treatment via 911 emergency.</p>		<p>termination. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: June 24, 2014</p>				

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	<p>A review of the local area hospital record on 06-04-14 at 2:00 p.m., indicated the following:</p> <p>The resident arrived at the hospital at 10:35 a.m. to the Emergency Room. At the time the resident "arrived he was unresponsive." The resident's "heart rate was 130 bpm [beats per minute], respiratory rate of 22, oxygen saturation level at 79 % and blood pressure 76/57." Laboratory testing was completed in the Emergency Room, and the resident was found to have a BUN of 71 "H", and a Sodium level of 153 "HI."</p> <p>The Emergency Room Physician Notes dated 05-09-14 indicated, "Patient with likely sepsis secondary to respiratory failure and hypertension. Patient was given multiple IV [intravenous] fluids boluses in emergency department." The record further indicated the resident received "6155 c.c. of fluids/hydration with in the first 24 hours of hospitalization."</p> <p>A review of the "Critical Care Staff Initial Consult," dated 05-09-14, indicated "Impression and Plan - * Shock. Plan fluid administration. Oliguria [diminished urine secretion in relation to fluid intake] and anuria [complete suppression of urine formation</p>			

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	<p>by the kidney] - Plan: Hydration metabolic corrections."</p> <p>The resident was transferred from the Emergency Room to the Adult Intensive Care Unit "for severe sepsis/septic shock likely due to UTI [urinary tract infection], hypernatremia, AKI [acute kidney injury], dehydration and acute respiratory failure."</p> <p>This Federal tag relates to Complaint IN00149439.</p> <p>3.1-47(a)(2)</p>				