

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2013
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303
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F000000	<p>This visit was for the Investigation of Complaint IN00130859.</p> <p>Complaint IN00130859 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F309, F328 and F514.</p> <p>Survey dates: June 20 and 24, 2013</p> <p>Facility number: 000013 Provider number: 155038 AIM number: 100266100</p> <p>Survey team: Betty Retherford RN, TC Karen Koeberlein RN (June 24, 2013)</p> <p>Census bed type: SNF/NF: 63 SNF: 1 Total: 64</p> <p>Census payor type: Medicare: 10 Medicaid: 54 Total: 64</p> <p>Sample: 5</p> <p>These deficiencies also reflect state</p>	F000000	<p>Please find the attached plan of correction for a visit from you office on June 24th, 2013 survey event IN00130850 in accordance with state law. This plan of correction consitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admisson or agreemetn with the deficiencieis or consultations contained in the Department's inspection report. We repectfully request that your office will accept this plan as our facility's compliance and that you will consider a desk review in view there were no tags that were deemed to actual harm or immediately jeaporday. Please review our attachement as each cited deficiency has and audt tool. If you have any addition questions, please contact me at (765)289-3341. Thank you in advance for your immediate attention in this manner.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any defenciystatement ending with an asterisk (*) denotes a defidency which the institution may be excused from correcting providing it is determined that other safegaurds 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 completed by Debora Barth, RN.				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a comprehensive plan of care in regards to respiratory services and hospice services for 2 of 3 residents reviewed for comprehensive health care plan development in a sample of 5. (Resident #'s B and F)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 6/20/13 at 9:50 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus type</p>	F000279	Resident B no longer resides at the facility. Resident F has been re-assessed by the IDT with comprehensive care plans updated as deemed appropriate. A one time audit of resident's care plans has been completed to ensure residents care plans meet expectations. The Interdisciplinary Team has been re-educated on completing care plans upon admission, with condition change, or as needed. It is the responsibility of the IDT to ensure care plans are initiated and updated as determined necessary. The DON/designee	07/24/2013	

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	<p>2, schizophrenia, chronic obstructive pulmonary disease (COPD), chronic airway obstruction, congestive heart failure, and asthma.</p> <p>The clinical record indicated the resident had original hospice orders dated 1/14/13. The order for hospice services was discontinued on 2/22/13. Hospice services were reordered on 3/19/13.</p> <p>A health care plan problem, dated 3/23/13, indicated Resident #B received palliative/comfort care. The health care plan lacked any information related to the resident receiving hospice services and the need to coordinate her care with the hospice provider.</p> <p>During an interview with the Administrator and ADoN on 6/24/13 at 12:10 p.m., additional information was requested related to the lack of a comprehensive health care plan having been developed for Resident #B in regards to hospice services.</p> <p>During an interview on 6/24/13 at 1:10 p.m., the Administrator indicated the facility had no additional information to provide.</p> <p>Review of a current facility policy, revised December 2001, provided by the</p>		<p>will be responsible to audit 50% of resident care planning initiation or updating needs three times a week for 8 weeks, weekly for 12 weeks, and then monthly for 6 months. Any identified concerns will be immediately corrected, and will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will be responsible to review the results of the audits weekly for 20 weeks, monthly for 6 months. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly. Any further action will be as determined by the QPI Committee.</p>		

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	<p>ADoN on 6/24/13 at 12:55 p.m., titled "Hospice," included, but was not limited to, the following:</p> <p>"Procedure:</p> <ol style="list-style-type: none"> 1. Assess the unique needs of the resident. 2. Communicate, establish, and agree upon a coordinated Comprehensive Care Plan Review. ...3. Identify the care and services which the facility and hospice will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care. 4. Assure a registered nurse from hospice is designated to coordinate the implementation of the Plan of Care. ...7. Assure the facility and hospice are performing only their respective functions that have been agreed upon and included in the Plan of Care and for which they are responsible. <ol style="list-style-type: none"> a. Hospice retains overall professional management responsibility for directing the implementation of the Plan of Care. <p>2.) The clinical record for Resident #F was reviewed on 6/24/13 at 10:15 a.m.</p>				

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	<p>Diagnoses for the resident included, but were not limited to, diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD), cerebrovascular accident, tracheostomy, and respiratory failure.</p> <p>A recapitulation of physician orders, signed 6/20/13, indicated Resident #F had respiratory related orders which included, but were not limited to, nebulizer treatment orders, tracheostomy care orders, and oxygen therapy orders.</p> <p>The clinical record contained a health care plan problem for Resident #F which indicated the resident had a potential/actual alteration in oxygen exchange related to a tracheostomy, need for oxygen therapy, and shortness of breath with exertion. The right side of the health care plan form contained 29 possible interventions. Each intervention had a box next to it for the staff to place a checkmark if this intervention was in use for this resident's individualized plan of care. There were no interventions marked for Resident #F. Each area was blank.</p> <p>During an interview with the Administrator and ADoN on 6/24/13 at 12:10 p.m., additional information was requested related to the lack of development of a comprehensive plan of</p>						

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	<p>care in regards to the resident's respiratory related needs.</p> <p>During an interview on 6/24/13 at 1:10 p.m., the Administrator indicated the facility had no additional information to provide.</p> <p>This federal tag relates to Complaint IN00130859.</p> <p>3.1-35(a)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 hospice provider was contacted regarding a hospice resident with a decline in condition who was subsequently sent to the emergency room for treatment for 1 of 2 closed clinical records reviewed for hospice services in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 6/20/13 at 9:50 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus type 2, schizophrenia, chronic obstructive pulmonary disease (COPD), chronic airway obstruction, congestive heart failure, and asthma.</p> <p>The clinical record indicated the resident had original hospice orders dated 1/14/13. The order for hospice services was discontinued on 2/22/13. Hospice services were reordered on 3/19/13.</p>	F000309	<p>Resident B no longer resides at the facility. A one time audit of residents receiving Hospice Services has been completed. Licensed Nursing Staff have been re-educated on the need to contact hospice regarding a change of condition or prior to transporting a hospice resident to the hospital. It is the responsibility of the Licensed Supervisory Nurse to notify Hospice Services should there be a change in a resident condition receiving Hospice Services. The DON/designee will be responsible to review 50% of residents on hospice services weekly for 20 weeks, monthly for 2 months, and then quarterly for 2 quarters to ensure Hospice services is coordinated with Nursing staff. Any identified concern will be immediately addressed, 1:1 re-education, and disciplinary action up to and including termination as per policy. The ADM/designee will be responsible to review the results of the audits weekly for 20 weeks, monthly for 6 months. Results of the reviews will be forwarded to the Quality</p>	07/24/2013	

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	<p>The May 2013 recapitulation of physician's orders, signed 5/2/13, indicated the resident received hospice services with a reorder date of 3/19/13.</p> <p>The June 2013 recapitulation of physician's orders, signed 5/30/13, contained the same hospice order noted previously, but someone had marked through the order and indicated it was an error.</p> <p>The clinical record did not contain any order to discontinue hospice services after they were reordered on 3/19/13.</p> <p>During an interview on 6/20/13 at 1:45 p.m., the Assistant Director of Nursing (ADoN) indicated the resident was a hospice resident from the reorder date of 3/19/13 through her transfer to the hospital on 6/8/13.</p> <p>A health care plan problem, dated 3/23/13, indicated Resident #B received palliative/comfort care. The health care plan lacked any information related to the resident receiving hospice services and the need to coordinate her care with the hospice provider.</p> <p>A nursing note, dated 6/8/13 at 6:45 a.m., indicated the resident's vital signs and O2</p>		Performance Improvement Committe for review monthly. Any further action will be as determined by the QPI Committee.		

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	<p>saturation (sat) were taken. The resident's O2 sat was 86%. The note indicated the resident was in bed with her eyes closed and oxygen on at 2 L per nasal cannula. The note indicated the resident made a statement of wanting to "go smoke." The note indicated the nurse would "continue to monitor" the resident. The resident was left in bed and did not get up for breakfast.</p> <p>The next nursing note, dated 6/8/13 at 8:45 a.m., indicated the resident's O2 sat was now 74%. Her respirations were even and nonlabored, but "gurgling sounds" were noted. The physician was called and an order was received to send the resident to the emergency room for treatment. The resident's family and emergency room staff were notified of the transfer. The note lacked any information related to contact with the hospice provider regarding the resident's decline in condition.</p> <p>During an interview with RN #1 (the nurse working the 6 a.m. to 2 p.m. shift on 6/8/13) on 6/20/13 at 1:15 p.m., she indicated she checked Resident #B at 6:45 a.m. on 6/8/13 because the night shift nurse had told her the resident "wasn't doing well." She indicated the night shift nurse told her the resident's O2 sat level dropped if the head of her bed was</p>						

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	<p>lowered. She indicated she checked the resident and her O2 sat was 86%. She indicated this was not entirely unusual for the resident. She turned her oxygen up a to around 2.5 L per minute. She indicated she then went to the dining room to help with the breakfast meal. She indicated she came back during breakfast at 8:45 a.m. and found the resident as noted in her nursing note. The resident was then sent out for treatment. RN#1 indicated she had not contacted hospice services because she did not know if the resident was a hospice resident or not. She knew she had been at one time, but did not know if she was currently receiving hospice services or not.</p> <p>The transfer form sent out with the resident to the hospital on 6/8/13 lacked any information related to the resident being a hospice resident.</p> <p>During an interview with the Administrator and ADoN on 6/24/13 at 12:10 p.m., additional information was requested related to the order for hospice services being marked out on the June 2013 recapitulation of physician's orders, the nursing staff not being aware of the resident being hospice, and the failure to contact the hospice provider when the resident had a decline in condition.</p>				

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	<p>During an interview on 6/24/13 at 1:10 p.m., the Administrator indicated the facility had no additional information to provide.</p> <p>Review of a current facility policy, revised December 2001, provided by the ADoN on 6/24/13 at 12:55 p.m., titled "Hospice", included, but was not limited to, the following:</p> <p>"Procedure:</p> <ol style="list-style-type: none"> 1. Assess the unique needs of the resident. 2. Communicate, establish, and agree upon a coordinated Comprehensive Care Plan Review. ...3. Identify the care and services which the facility and hospice will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care. 4. Assure a registered nurse from hospice is designated to coordinate the implementation of the Plan of Care. ...7. Assure the facility and hospice are performing only their respective functions that have been agreed upon and included in the Plan of Care and for which they are 			

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	<p>responsible.</p> <p>a. Hospice retains overall professional management responsibility for directing the implementation of the Plan of Care.</p> <p>This federal tag relates to Complaint IN00130859.</p> <p>3.1-37(a)</p>			

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F000328 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 record review and interview, the facility failed to ensure residents requiring respiratory services received the services as ordered and were assessed and monitored as needed during respiratory treatments and/or a decline in condition for 2 of 3 residents reviewed for respiratory care services in a sample of 5. (Resident #'s B and F)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 6/20/13 at 9:50 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus type 2, schizophrenia, chronic obstructive pulmonary disease (COPD), chronic airway obstruction, congestive heart failure, and asthma.</p> <p>The clinical record indicated the resident</p>	F000328	Resident B no longer resides at the facility. Resident F has been reviewed by the Interdisciplinary team with care plan updates as deemed appropriate. A one time audit of residents receiving respiratory treatments has been completed to ensure Licensed Supervisory Nurses are documenting physician ordered treatments on the appropriate form. Licensed Nurses have been re-educated on documentation of respiratory treatments and documentaton of change of condition pertaining to the decline related to respiratory status. It is the responsibility of the Licensed Supervisory Nurse to conduct the respiratory treatments, whether scheduled or as an as needed treatment, and to document the assessment of the resident and care received. The DON/designee will be responsible to review resident documentation of respiratory treatments daily for 14 days, weekly for 20 weeks, monthly for 2 months, and	07/24/2013			

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	<p>was receiving hospice services and palliative care.</p> <p>A health care plan problem, dated 3/23/13, indicated Resident #B had a "potential/actual alteration in oxygen exchange related to congestive heart failure and chronic obstructive pulmonary disease." Interventions for this problem included, but were not limited to, vital signs with nebulizer treatment, oxygen saturation levels (O2 sat) every shift and as needed, monitor for shortness of breath and change in level of consciousness, and medications and treatments as ordered.</p> <p>A recapitulation of physician orders, signed 5/30/13, indicated Resident #B had respiratory related orders which included, but were not limited to, the following:</p> <p>Albuterol 0.083% inhalation solution (a medication given per breathing treatment to help improve respirations) - inhale 3 milliliters (ml) via nebulizer every two hours as needed for wheezing.</p> <p>Oxygen (O2) at 2-5 L (liters) per minute per nasal cannula with humidity to keep sats above 90%</p> <p>Duoneb (a medication given per breathing treatment to help improve respirations) - 3 ml via nebulizer treatment three times a</p>		<p>then quarterly for 2 quarters ensure that each accurate documentation of the resident's respiratory treatments is completed as well as per expectation. Any identified concern will be immediately addressed, will have 1:1 re-education completed, with disciplinary action as deemed appropriate, as per policy. The ADM/designee will be responsible to review the results of the audits weekly for 20 weeks, monthly for 6 months. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly. Any further action will be as determined by the QPI Committee.</p>				

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	<p>day at 4:30 a.m., 12:30 p.m., 8:30 p.m. for COPD and asthma.</p> <p>Pulmicort (a medication given per breathing treatment to help improve respirations) - inhale 2 ml via nebulizer bid for COPD at 12:30 a.m. and 4:30 p.m.</p> <p>The June medication administration record (MAR) for Resident #B indicated the resident's O2 sats were being checked every shift and ranged from 90 to 96 from June 1st thru June 8th, 2013 except for four shifts. The MAR lacked any documentation of the resident's O2 sat having been taken on the midnight shift on June 2 and 3rd and the second shift on June 4 and 7, 2013.</p> <p>The June 2013 MAR contained a form titled "Respiratory Treatment and Trach Care Record." During an interview on 6/20/13 at 1:45 p.m., the Assistant Director of Nursing (ADoN) indicated a line on this form was to be completed each time a nebulizer treatment was given. This form was used to record the date and times of the treatments, the vital signs before, during, and after the treatments, and information about the resident's breath sounds.</p> <p>The MAR indicated the resident was given one of her routine breathing</p>				

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	<p>treatments on the following dates and times without the necessary assessment information having been obtained and completed on the" Respiratory Treatment and Trach Care Record."</p> <p>June 1, 2013 at 8:30 p.m. June 2, 2013 at 12:30 a.m. and 4:30 p.m. June 3, 2013 at 12:30 a.m., 4:30 a.m., 12:30 p.m., and 8:30 p.m. June 5, 2013 at 12:30 p.m. June 6, 2013 at 4:30 a.m. June 7, 2013 at 12:30 a.m., 4:30 a.m., 12:30 p.m.</p> <p>Both the MAR and breathing treatment record lacked documentation of any breathing treatments having been given at 4:30 p.m. and 8:30 p.m. on 6/7/13 as ordered by the physician.</p> <p>A nursing note, dated 6/8/13 at 6:45 a.m., indicated the resident's vital signs and O2 sat were taken. The resident's O2 sat was 86%. The note indicated the resident was in bed with her eyes closed and oxygen on at 2 L per nasal cannula. The note indicated the resident made a statement of wanting to "go smoke." The note indicated the nurse would "continue to monitor" the resident.</p> <p>The next nursing note, dated 6/8/13 at 8:45 a.m., indicated the resident's O2 sat</p>				

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	<p>was now 74%. Her respirations were even and nonlabored, but "gurgling sounds" were noted. The physician was called and an order was received to send the resident to the emergency room for treatment. The resident's family and emergency room staff were notified of the transfer. An emergency room nurse contacted the facility a short while later requesting responsible party phone numbers. The emergency room nurse indicated the resident expired while in route to the hospital.</p> <p>During an interview with RN #1 (the nurse working the 6 a.m. to 2 p.m. shift on 6/8/13) on 6/20/13 at 1:15 p.m., she indicated she checked Resident #B at 6:45 a.m. on 6/8/13 because the night shift nurse had told her the resident "wasn't doing well." She indicated the night shift nurse told her the resident's O2 sat level dropped if the head of her bed was lowered. She indicated she checked the resident and her O2 sat was 86%. She indicated this was not entirely unusual for the resident. She turned her oxygen up a to around 2.5 L per minute. She indicated she then went to the dining room to help with the breakfast meal. She indicated she came back during breakfast at 8:45 a.m. and found the resident as noted in her nursing note. The resident was then sent out for treatment.</p>				

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	<p>The nursing notes for Resident # B lacked any entries for the night shift from 10 p.m. on 6/7/13 through 6 a.m. on 6/8/13.</p> <p>During an interview with LPN #2 (the nurse working from 10 p.m. on 6/7/13 through 6 a.m. on 6/8/13) on 6/20/13 at 1:50 p.m., he indicated the resident had seemed to be weaker that morning and was not able to hold onto the bar of the "standing lift" when the CNAs attempted to get the resident up. He indicated he told the CNAs to keep the resident in bed. He indicated he gave the resident an "as needed" Albuterol breathing treatment because she seemed to have increased shortness of breath. He indicated he failed to document this information in the nursing notes and medication administration record because it all occurred close to shift change. He indicated he did not remember if he told the day shift nurse he gave the resident the "as needed" breathing treatment.</p> <p>During an interview with the Administrator and ADoN on 6/20/13 at 1:45 p.m., additional information was requested related to the missing oxygen saturation levels, the lack of assessments when nebulizer treatments were given, the lack of documentation of breathing treatments having been given on the</p>			

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	<p>evening of 6/7/13, and the lack of monitoring from 6:45 a.m. on 6/8/13 when a decline in the resident's condition was noted through 6/8/13 at 8:45 a.m. when the resident required a transfer to the hospital.</p> <p>During an interview on 6/24/13 at 1:10 p.m., the Administrator indicated the facility had no additional information to provide.</p> <p>2.) The clinical record for Resident #F was reviewed on 6/24/13 at 10:15 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD), cerebrovascular accident, tracheostomy, and respiratory failure.</p> <p>A recapitulation of physician orders, signed 6/20/13, indicated Resident #F had respiratory related orders which included, but were not limited to, the following:</p> <p>Albuterol 0.083% inhalation solution - inhale 3 ml via nebulizer three times a day for COPD at 12:30 a.m., 8:30 a.m., and 4:30 p.m. Original order date 2/21/13.</p> <p>Ipratropium (a medication given per breathing treatment to help improve</p>			

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	<p>respirations) 0.02% - inhale 2.5 ml via nebulizer three times daily at 12:30 a.m., 8:30 a.m., and 4:30 p.m. for COPD. Original order date 2/21/13.</p> <p>Oxygen (O2) at 2 L per minute with 28% humidity via trach as needed for shortness of breath and to keep sats above 90%</p> <p>Budesonide (a medication given per breathing treatment to help improve respirations) - 2 ml via nebulizer treatment two times a day at 12:30 p.m. and 8:30 p.m. for COPD. Original order date 2/21/13.</p> <p>Check O2 saturations (sats) every shift. Original order date 5/1/13.</p> <p>Change trach tie daily, trach care two times daily, change disposable inner cannula twice daily and as needed, and trach suction every shift and as needed. Original order date 2/21/13.</p> <p>The June medication administration record (MAR) for Resident #F indicated the resident's routine O2 sats ranged from 91 to 97 from June 1st thru June 24th, 2013. The MAR lacked any documentation of the resident's O2 sat having been taken on the second shift on June 12, 2013, the night shift on 6/15/13 and the day shift on 6/16 and 6/21/13.</p>			

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	<p>The June 2013 MAR contained a form titled "Respiratory Treatment and Trach Care Record." During an interview on 6/20/13 at 1:45 p.m., the Assistant Director of Nursing (ADoN) indicated a line on this form was to be completed each time a nebulizer treatment was given. This form was used to record the date and times of the treatments, the vital signs before, during, and after the treatments, and information about the resident's breath sounds.</p> <p>The MAR indicated the resident was given one of his routine breathing treatments on the following dates and times without the necessary assessment information having been obtained and completed on the "Respiratory Treatment and Trach Care Record:"</p> <p>June 3, 2013 at 12:30 p.m. June 4, 2013 at 4:30 p.m. June 6, 2013 at 12:30 a.m. and 12:30 p.m. June 7, 2013 at 4:30 p.m., 8:30 p.m. June 8, 2013 at 12:30 a.m. June 9, 2013 at 12:30 a.m. and 12:30 p.m. (these treatments were not documented on the MAR or the respiratory treatment record) June 10, 2013 at 12:30 p.m. and 8:30 p.m. June 11, 2013 at 8:30 a.m. and 12:30 p.m. June 13, 2013 at 4:30 p.m. and 8:30 p.m.</p>			

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	<p>June 14, 2013 at 12:30 p.m. June 16, 2013 at 8:30 a.m. and 12:30 p.m. (these treatments were not documented on the MAR or the respiratory treatment record) June 18, 2013 at 12:30 p.m., 4:30 p.m., and 8:30 p.m.</p> <p>The June 2013 MAR lacked any indication of trach care being given, the trach tie being changed, suctioning being completed, or the inner cannula having been changed as ordered on the day shift on June 6 and 7, 2013.</p> <p>During an interview with the Administrator and ADoN on 6/24/13 at 12:10 p.m., additional information was requested related to the lack of oxygen saturations being completed on the dates noted above, the lack of trach services being completed on June 6 and 7, 2013, and the lack of breathing treatments being given and assessments having been completed related to nebulizer treatments as noted above.</p> <p>During an interview on 6/24/13 at 1:10 p.m., the Administrator indicated the facility had no additional information to provide.</p> <p>3.) Review of a current facility policy, revised July 2011, provided by the ADoN</p>				

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	<p>on 6/24/13 at 9:15 a.m., titled "Respiratory Treatment Record" included, but was not limited to, the following:</p> <p>"Policy</p> <p>The Respiratory Treatment Record (Non-Trach) will be used to assist the Licensed Nurse and Respiratory Therapist in maintaining accurate documentation of the resident's clinical data relevant to the delivery of respiratory care....</p> <p>Procedure</p> <p>1. Note the respiratory therapy order and prescribed respiratory medications in the designated section of the form.</p> <p>...4. Monitor and record the pulse and respiratory rate in the "Before", "During", and "After" sections.</p> <p>5. Note the before and after breath sounds in the designated spaces....</p> <p>6. Enter your initials in the appropriate section...."</p> <p>This federal tag relates to Complaint IN00130859.</p> <p>3.1-47(a)(4)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure each resident's clinical record was complete and accurately documented for 1 of 2 hospice residents reviewed who had a decline in condition and administration of an "as needed" breathing treatment in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 6/20/13 at 9:50 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus type 2, schizophrenia, chronic obstructive pulmonary disease (COPD), chronic airway obstruction, congestive heart failure, and asthma.</p>	F000514	Resident B no longer resides at the facility. A one time audit of residents receiving respiratory treatments has been completed to ensure Licensed Supervisory Nurses are documenting physician ordered treatments on the appropriate form. Licensed Nurses have been re-educated on documentation of respiratory treatments and documentation of change of condition pertaining to the decline related to respiratory status. It is the responsibility of the Licensed Supervisory Nurse to conduct the respiratory treatments, whether scheduled or as an as needed treatment, and to document the assessment of the resident and care received. The DON/designee will be responsible to review resident documentation of respiratory treatments daily for 14 days, weekly for 20 weeks, monthly for	07/24/2013			

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	<p>The clinical record indicated the resident had original hospice orders dated 1/14/13. The order for hospice services was discontinued on 2/22/13. Hospice services were reordered on 3/19/13.</p> <p>The May 2013 recapitulation of physician's orders, signed 5/2/13, indicated the resident received hospice services with a reorder date of 3/19/13.</p> <p>The June 2013 recapitulation of physician's orders, signed 5/30/13, contained the same hospice order noted previously, but someone had marked through the order and indicated it was an error.</p> <p>The clinical record did not contain any order to discontinue hospice services after they were reordered on 3/19/13.</p> <p>During an interview on 6/20/13 at 1:45 p.m., the Assistant Director of Nursing (ADoN) indicated the resident was a hospice resident from the reorder date of 3/19/13 through her transfer to the hospital on 6/8/13. The ADoN did not know why the order had been marked through on the June 2013 orders.</p> <p>During an interview with RN #1 on 6/20/13 at 1:15 p.m., she indicated she</p>		<p>2 months, and then quarterly for 2 quarters ensure that each accurate documentation of the resident's respiratory treatments is completed as well as per expectation. Any identified concern will be immediately addressed, will have 1:1 re-education completed, with disciplinary action as deemed appropriate, as per policy. The ADM/designee will be responsible to review the results of the audits weekly for 20 weeks, monthly for 6 months. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly. Any further action will be as determined by the QPI Committee.</p>		

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	<p>checked Resident #B at 6:45 a.m. on 6/8/13 because the night shift nurse had told her the resident "wasn't doing well." She indicated the night shift nurse told her the resident's O2 saturation (sat) level dropped if the head of her bed was lowered.</p> <p>The nursing notes for Resident # B lacked any entries for the night shift from 10 p.m. on 6/7/13 through 6 a.m. on 6/8/13.</p> <p>During an interview with LPN #2 (the nurse working from 10 p.m. on 6/7/13 through 6 a.m. on 6/8/13) on 6/20/13 at 1:50 p.m., he indicated the resident had seemed to be weaker that morning and was not able to hold onto the bar of the "standing lift" when the CNAs attempted to get the resident up. He indicated he told the CNAs to keep the resident in bed. He indicated he gave the resident an "as needed" Albuterol breathing treatment because she seemed to have increased shortness of breath. He indicated he failed to document this information in the nursing notes and medication administration record because it all occurred close to shift change.</p> <p>Review of the current facility policy, dated January 2004, provided by the Assistant Director of Nursing on 6/24/13 at 9:15 a.m., titled "Documentation,"</p>			

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	<p>included, but was not limited to, the following:</p> <p>"Policy</p> <p>...Documentation is designed to demonstrate the clinical picture of the resident, and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses.... Nursing documentation includes, but area not limited to, the following types of documents and records:</p> <p>Assessments... Vital Signs... Medication/Treatment...</p> <p>Procedure</p> <p>...1. Make all entries into the medical record as soon as possible after an observation, assessment, or intervention occurs..."</p> <p>This federal tag relates to Complaint #IN00130859</p> <p>3.1-(a)(1) 3.1-(a)(2)</p>				