

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2014
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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the Investigation of Complaint IN00158186.</p> <p>Complaint IN00158186 Substantiated. Federal /State deficiencies related to the allegations are cited at F202, F314, F323, F328.</p> <p>Survey dates: October 22 & 23 , 2014</p> <p>Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690</p> <p>Survey Team: Mary Jane G. Fischer RN TC</p> <p>Census Bed Type: SNF/NF: 69 Total: 69</p> <p>Census Payor Type: Medicare: 15 Medicaid: 40 Other: 14 Total: 69</p> <p>Sample: 7 Supplemental Sample: 2</p> <p>These deficiencies reflect state findings</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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F000202 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on October 30, 2014.</p> <p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>Based on record review the facility failed to ensure a complete discharge summary, in that when a resident's family member decided to transfer the resident to another Extended Care Facility, the record lacked a complete assessment of the resident's condition upon discharge. This deficient practice affected 1 of 1 resident reviewed for transfer/discharge in a sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 10-22-14 at 11:00 a.m.</p>	F000202	<p>F202 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident A discharged from the facility on 9/23/2014.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents that discharge from the facility have the potential to be affected by the same alleged deficient practice. Nursing staff will be re-educated on completing an assessment of resident condition upon discharge.</p>	11/17/2014

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	<p>Diagnoses included, but were not limited to, dementia, hypertension, debility and contractures. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Nursing Admission Assessment," dated 07-24-14, indicated the resident was a fall risk as the resident had a history of falls and contractures of bilateral lower extremities. The Fall Risk Evaluation, dated 07-24-14, indicated the resident "total score" equaled "10," with a "total score of 10 or above represents HIGH RISK for falls."</p> <p>At the time the resident was admitted to the facility the record indicated the resident demonstrated "poor intake with drooling and pooling and a weight loss, a high risk for skin breakdown, with an overall progressive decline."</p> <p>The Nurses notes, dated 07-23-14, indicated the resident "required total care with transfers and activities of daily living and was "spoon fed by staff."</p> <p>The record indicated the resident had two unwitnessed falls and after the last fall on 08-25-14, the resident's condition began to decline even further.</p> <p>A review of the Intake for meal consumption indicated the resident</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? Nursing staff will be re-educated on completing an assessment of resident condition upon discharge. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? IDT will conduct an audit of nursing documentation for all discharged residents to ensure documentation of resident condition at time of discharge was completed. The IDT will review the results of this audit for four weeks, then monthly thereafter until substantial compliance has been demonstrated.</p>	

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	<p>consumption waned from approximately 80 % to approximately 12 % daily from 07-24-14 thru 09-23-14.</p> <p>The resident's record indicated the resident required 1316 ml (milliliters) to 1410 ml of fluid daily. A review of the Intake for fluid consumption indicated the resident consumed approximately 343 ml of fluids daily from 07-24-14 thru 08-19-14, and approximately 239 ml of fluids daily from 08-20-14 thru 09-23-14.</p> <p>The resident required physician intervention for hydration with included clysis (subcutaneous hydration) therapy which started on 09-11-14.</p> <p>The nurses notes dated 09-12-14 at 5:50 p.m., indicated the "resident continues to refuse food et [and] fluids and unable to swallow and does not respond verbally to name or stimulation." The nurses note dated 09-12-14 at 6:45 p.m., indicated the nursing staff received additional instructions related to intravenous therapy and the nurse indicated "will continue to follow."</p> <p>The next nurses note, dated 09-23-14, 11 days later indicated, "Res. [resident] transferred to new facility transported by [name of transportation company], v/s [vital signs] 97.1 [temperature, 82 [pulse]</p>			

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	<p>100/56 [blood pressure] 14 BPM [beats per minute] <sic>."</p> <p>The record lacked an assessment of the resident's condition from 09-12-14 thru the date of transfer/discharge, or the condition of the resident upon discharge.</p> <p>A review of the facility policy on 10-23-14 at 2:00 p.m., titled "Discharge/Transfer of Resident," indicated the following:</p> <p>"Purpose - to provide safe departure from the facility. To provide sufficient information for after care of the resident."</p> <p>"Equipment - Discharge summary and post discharge plan of care form(s). (For discharge to home, lower levels of care or other long term care facility. Complete a discharge summary and post discharge plan of care form."</p> <p>"Documentation Guidelines - Documentation may include: date, time, condition of the resident on discharge or transfer, discharge summary and post discharge plan of care if resident is discharged to another nursing facility or a lower level of care. ..."</p> <p>This Federal tag relates to Complaint IN00158186.</p>						

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F000314 SS=G	<p>3.1-12(a)(3)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident received interventions to prevent the development and progression of pressure ulcers. When a resident was identified at risk for the development of pressure ulcers, the facility failed to provide a pressure reducing cushion to aide in the off loading of pressure while at the facility and while receiving dialysis treatments which resulted in the deterioration of the ulcer for 1 of 3 residents reviewed for pressure ulcers in a sample of 7. (Resident "E").</p> <p>Findings include:</p> <p>The record for Resident "E" was</p>	F000314	<p>F314 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Prior to survey, Resident E was provided a wheelchair cushion. She routinely refused to utilize the wheelchair cushion over her preference to use standard bed pillows. Although weekly wound records do not support the allegation of wound deterioration between 10/6/14 and 10/20/14, Resident E has had her care plan reviewed and updated. She has also been offered various types of other cushion options, and has declined to utilize these options as well, despite documented education. The facility maintains that these negligible changes in</p>	11/17/2014

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	<p>reviewed on 10-23-14 at 10:00 a.m. Diagnoses included, but were not limited to, ESRD (end stage renal disease), hypertension, malaise and fatigue. These diagnoses remained current at the time of the record review.</p> <p>The resident received hemodialysis treatments three times a week at a local dialysis clinic.</p> <p>During the initial tour of the facility on 10-22-14 at 9:15 a.m., Licensed Nurse #3 identified the resident with an "acquired" pressure ulcer.</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 08-24-14, indicated the resident was at risk for the development of a pressure ulcer, but at the time of the assessment the resident did not have a pressure ulcer. The MDS further indicated the "Skin and Ulcer Treatments" included a "pressure reducing device for chair."</p> <p>A review of the resident's "Prevention - Skin Integrity Care Plan," originally dated 06-10-14, indicated the resident had the "potential for impaired skin integrity related to: requires assist with turning and repositioning - two staff members for assistance." Interventions to this plan of care included "pressure</p>		<p>measurements to the wound do not substantiate the allegation of harm. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents with pressure ulcers have the potential to be affected by the same alleged deficient practice. An audit has been completed for all residents with pressure ulcers to ensure appropriateness of interventions and had their care plans updated as needed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? Nursing staff will be re-educated on ensuring that recommended interventions are in place for residents with pressure ulcers. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The wound nurse or her designee will conduct a weekly audit of all residents with pressure ulcers to ensure recommended interventions are in place. Resident education will be provided as needed and care plans will be updated as needed. The Interdisciplinary Team will review the results of the weekly wound- intervention audit for four weeks, then monthly thereafter until substantial compliance has been demonstrated.</p>	

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	<p>reducing mattress to bed, and pressure reducing cushion - w/c [wheelchair]."</p> <p>A review of the "Change of Condition - Skin Condition," report dated 09-19-14 at 8:00 p.m., the resident had a "new onset" of a "pressure ulcer - location coccyx with redness and measured 1.0 cm [centimeters] in length by 0.5 cm in width by .2 cm in depth. Resident c/o [complained of] pain at coccyx area. Noted wound. Wound bed yellow slough tissue. Surrounding tissue normal. Resident educated on importance sleeping in bed to reduce pressure; however resident refused."</p> <p>A current plan of care titled "Episodic Care Plan" Pressure Ulcer(s)," and dated 09-25-14 indicated the resident had an "actual pressure ulcer to right inner upper buttock," and "updated" on 10-06-14, when the resident developed a second pressure ulcer to the "right inner buttock lower." Prevention interventions included "pressure reducing cushion in wheelchair, encourage resident to reposition as able - sleeps in recliner, refuses to sleep in bed. Unable to elevate feet d/t [due to] no foot rests on recliner."</p> <p>The resident had a Physician Order dated 10-03-14 for a "pressure reducing wheelchair cushion."</p>			

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	<p>During an observation on 10-22-14 at 2:00 p.m., a body assessment was requested and granted by the resident. The resident was observed seated in a chair, with multiple bed pillows placed to the resident's back, and buttocks areas. The resident was assisted to a standing position by Licensed Nurse #3, and the resident's slacks were removed in order to observe the pressure ulcer. During this observation the resident indicated the areas were "sore," and that while at dialysis on 10-20-14 the resident requested to discontinue the treatment early. "Those chairs are so hard and it hurt so bad, I just couldn't stay on dialysis any longer so they pulled me off." When further interviewed the resident indicated she was unable to lie in bed due to being unable to turn independently from side to side and the difficulty she had with breathing.</p> <p>During this observation, the resident's wheelchair was adjacent to the resident's bed and lacked a pressure reducing cushion.</p> <p>During a subsequent interview on 10-23-14 at 1:00 p.m., the resident indicated she did not have a cushion for her wheelchair. When interviewed if the facility sent a cushion to the dialysis</p>			
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	<p>center for her to use during treatments, the resident indicated "no that's why I had to come off the machine early on Monday. They made me sign a paper that said I should stay on the machine, but it hurt too bad and I didn't care."</p> <p>A review of the Dialysis Treatment record for 10-20-14 indicated the resident was scheduled for a treatment of 3 hours and 45 minutes. The record indicated the resident signed off her treatment 45 minutes early.</p> <p>A review of the Pressure Ulcer Evaluation Records on 10-23-14 at 1:45 p.m., indicated the following measurements:</p> <p>Right Inner Buttock Lower Wound "10-06-14 - Stage Three [full thickness tissue loss] - 0.3 cm [centimeters] in length by 0.3 cm. in width and < [less than] 0.1 cm in depth. The area had "scant" drainage - and indicated the resident had "no pain."</p> <p>"10-13-14 - Stage Three - 0.4 cm in length by 0.2 cm in width and <0.1 cm in depth. The area had serosanguineous drainage."</p> <p>"10-20-14 - Stage Three - 0.4 cm in length by 0.4 cm in width and <0.1 cm in</p>			

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F000323 SS=D	<p>depth."</p> <p>Right Inner Buttock Upper Wound "10-13-14 - Stage Three - 0.8 cm in length by 0.6 cm in width and <0.1 cm in depth."</p> <p>"10-20-14 - Stage Three - 0.7 cm in length by 0.9 cm in width by <0.1 cm in depth."</p> <p>A request was made to measure the areas on 10-23-14 at 2:00 p.m.</p> <p>The Unit Manager remeasured the areas and indicated the Right Inner Buttock Lower Wound measured 0.8 cm in length by 0.6 cm in width by 0.2 cm in depth and the Right Inner Buttock Upper Wound measured 0.3 cm in length by 0.2 cm in width and <0.1 cm. in depth."</p> <p>This Federal tag relates to Complaint IN00158186.</p> <p>3.1-40(a)(2)</p> <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</p>			

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	<p>assistance devices to prevent accidents. Based on interview and record review the facility failed to ensure supervision and assist devices to alert the staff of unassisted transfer or ambulation for 1 of 3 residents reviewed for falls in a sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 10-22-14 at 11:00 a.m. Diagnoses included, but were not limited to, dementia, hypertension, debility and contractures. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Nursing Admission Assessment," indicated the resident was a fall risk as the resident had a history of falls and contractures of bilateral lower extremities.</p> <p>The Fall Risk Evaluation, dated 07-24-14, indicated the resident "total score" equaled "10," with a "total score of 10 or above represents HIGH RISK for falls."</p> <p>A review of the resident's MDS (Minimum Data Set) Assessment, dated 07-30-14, indicated the resident had cognitive impairment, and required extensive assistance and 2 staff members,</p>	F000323	<p>F 323 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident A discharged from the facility on 9/23/2014. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Residents at risk for falls were reviewed for adequate interventions and adjustments were made as indicated. Care plans were updated as needed. What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? The Interdisciplinary Team (IDT) will review new admissions for their risk for falling and implement measures as indicated. IDT post-occurrence rounds will occur after each fall in accordance with facility policy. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Nursing management will review IDT post-occurrence rounds to ensure appropriate interventions have been implemented weekly for four weeks and monthly thereafter until substantial compliance has been demonstrated.</p>	11/17/2014

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	<p>with transfer, bed mobility, and toileting. In addition the assessment indicated the resident was only able to stabilize with staff assistance in moving on and off the toilet, and that "activity did not occur" in regards to moving from seated to standing position, standing, walking, turning around and surface to surface transfer.</p> <p>A review of the "Fall Risk Care Plan," dated 07-24-14, indicated the resident was at risk for falls and injuries related to cognitive impairment and history of falls. Interventions to this plan of care included "provide adequate lighting, observe for side effects of medication and keep call light within reach."</p> <p>A review of the "Report of Incident - actual or suspected fall," dated 07-26-14 at 9:00 p.m., indicated, "Nurse found resident on floor couldn't verbalize what happen. Resident responds when asked are you in pain. When asked where couldn't verbalize. Nurse asks did head hurt. Responds 'no.' Nurse went on down and residents responded left leg was hurting. As if she hit her head responded 'no.' No visible injuries or bruises. Doctor was notified - resident had vomit on clothes."</p> <p>Further review of the resident's plan of</p>						

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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>care lacked additional interventions.</p> <p>A review of the "Report of Incident - actual or suspected fall," dated 08-25-14 at 4:45 p.m., indicated the following: "Resident is non-verbal most times et [and] unable to verbalize what happened. Found resident lying on floor on left side." The report indicated the resident fell from the "chair" while in her "room." Function level prior to fall "dependent." "Possible Contributing Factors - sliding or positioning issue, resident did not use assistive device."</p> <p>The Nurses Note dated 08-25-14 at 4:45 p.m., indicated the resident was "sitting up in geri-chair previously reclined. Resident then noted to be lying on floor next to bed et in front of geri-chair on her left side. Resident is non-verbal at this time et unable to explain what happened."</p> <p>A review of the IDT (Interdisciplinary Team) Post Occurrence Assessment and Plan Review dated 08-26-14 indicated the resident was unable to "self perform bed mobility, transfer, ambulating, dressing, eating, toileting or hygiene. History of falls in the last 30 days and no safety devices currently is use at the bedside."</p>			

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	<p>Further review of this Post Occurrence Plan review, indicated the "care plan updated with IDT Plan to Prevent Recurrence."</p> <p>Further review of the resident's plan of care lacked documentation of interventions after the first time the resident was found on the floor on 07-26-14 and lacked any new interventions after the fall on 08-26-14.</p> <p>During an interview on 10-23-14 at 1:00 p.m., Licensed Nurse #7 indicated the resident was able to "move a little when she first came but as she continued to decline she couldn't move at all by herself."</p> <p>A review of the facility policy on 10-23-14 at 8:15 a.m., titled "Fall Management," and dated 08-2014, indicated the following:</p> <p>"Purpose - To evaluate risk factor and provide interventions to minimize risk, injury and occurrences."</p> <p>"Equipment - Fall prevention Equipment may include, but is not limited to : Alarms, sensor mats, transfer poles, floor pads, non skid mats, hand rails, grab bars, trapeze, adaptive equipment, transfer lifts, etc."</p>						

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F000328 SS=D	<p>"Fall Prevention Procedure - 1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessment and while conducting interdisciplinary care plan reviews. 2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. 3. Review, revise and evaluate care plan effectiveness at minimizing falls and injuries during IDT [Interdisciplinary Team] walking rounds and as needed."</p> <p>"Care Plan Documentation Guidelines: Problems - identify fall risk and associated risk factors, Goal - Document goals for minimizing falls and injuries, Approaches - Outline fall prevention strategies and approaches."</p> <p>This Federal tag relates to Complaint IN00158186.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;</p>			

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	<p>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 a resident received intravenous therapy as ordered by the physician for 1 of 1 resident with hydration needs in a sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 10-22-14 at 11:00 a.m. Diagnoses included, but were not limited to, dementia, hypertension, debility and contractures. These diagnoses remained current at the time of the record review.</p> <p>The MDS (Minimum Data Set) Assessment, dated 07-30-14 indicated the resident required limited assistance with one staff member for eating.</p> <p>A review of the resident's plan of care, dated 08-18-14 and titled "Nutrition Care Plan," indicated the resident was "at risk for altered nutrition and hydration."</p> <p>A review of the Nutrition Screening and Assessment, dated 08-18-14 indicated the</p>	F000328	<p>F328 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident A discharged from the facility on 9/23/2014. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents with orders for continuous intravenous (IV) fluids have the potential to be affected by the same alleged deficient practice. An audit was completed to identify all residents with current orders for continuous IV fluids. No residents were identified. What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? All licensed nurses will be educated on proper order/schedule entry into the Electronic Medical Record (EMR) for residents with orders for continuous IV fluid orders. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Interdisciplinary</p>	11/17/2014

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	<p>resident's diet order was a pureed diet with fluids needs of 1316 ml (milliliters) to 1410 ml daily.</p> <p>A review of the Intake for fluid consumption indicated the resident consumed approximately 343 ml of fluid daily from 07-24-14 thru 08-19-14, and approximately 239 ml of fluid daily from 08-20-14 thru 09-23-14.</p> <p>The resident required physician intervention for hydration with included clysis (subcutaneous hydration) therapy which started on 09-11-14.</p> <p>The nursing staff received a physician order, dated 09-11-14 at 12:54 p.m., for Dextrose 5% in water (D5W) intravenous solution to infuse 75 milliliters every hour via pump. The physician changed the infusion rate to 50 ml per hour on 09-11-14 at 2:28 p.m.</p> <p>A review of the resident's Medication Administration Record for 09-2014 indicated the following infusion times rather than "continuous" as ordered by the physician.</p> <p>5:00 a.m. to 7:00 a.m. 1:00 p.m. to 3:00 p.m. 9:00 p.m. to 11:00 p.m. 12:00 a.m. to 12:00 a.m. <sic></p>		<p>Team will conduct a review at least 3 times per week of all new orders for continuous IV fluids to ensure proper order/schedule entry into EMR. This audit will continue for four weeks and then weekly until substantial compliance has been demonstrated.</p>				

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	<p>The record lacked documentation the resident received the physician ordered amount of infusion. Once the infusion rate was decreased from 75 ml per hour to 50 ml per hour, the resident should have received 1200 ml over a 24 hour period.</p> <p>During an interview on 10-23-14 at 11:00 a.m., the Corporate nurse consultant indicated she had no documentation to provide to ensure the resident received the physician ordered fluids.</p> <p>During the Exit Conference on 10-23-14 at 3:30 p.m., the Director of Nurses indicated the nurses entered the physician order incorrectly into the computer.</p> <p>This Federal tag relates to Complaint IN00158186.</p> <p>3.1-47(a)(2)</p>			