

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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F000000	<p>This visit was for the Investigation of Complaint IN00162694.</p> <p>Complaint IN00162694 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F323.</p> <p>Survey dates: January 23, 26 and 27, 2015</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 125 Residential: 80 Total: 205</p> <p>Census payor type: Medicare: 24 Medicaid: 57 Other: 44 Total: 125</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in this survey report are accurate or reflect accurately the provision of nursing care and service to the Residents of Westminster Village North.	

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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F000279 SS=D	<p>16.2-3.1.</p> <p>Quality review completed on February 02, 2015 by Cheryl Fielden, RN</p> <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 interview and record review, the facility failed to ensure a care plan for falls was developed for 1 of 3 residents, in a sample of 4, reviewed for falls, based upon the results of the comprehensive assessment. (Resident #A)</p>	F000279	<p>PLAN OF CORRECTION F 279: DEVELOP COMPREHENSIVE CARE PLANS REGARDING RESIDENT A Attachment # 1 is the second page of the admission orders for Resident A's initial admission on 12/9/14. Review of said orders denotes</p>	02/26/2015

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	<p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 1-23-15 at 10:40 a.m. Her diagnoses included, but were not limited to, chronic respiratory failure, COPD (chronic obstructive pulmonary disease) with acute exacerbation, bibasilar pneumonia (December, 2014), cachexia (weight loss and muscle wasting related to chronic disease processes) related to COPD, chronic aspiration pneumonia, dysphagia, protein-calorie malnutrition, high blood pressure and CHF (congestive heart failure).</p> <p>In review of Resident #A's initial/admission nursing assessment, dated 12-9-14, it indicated she was alert and oriented to person, place, time and event; she was weak with poor balance and an unsteady gait; was unable to bear weight for more than a few seconds at a time and her family had communicated she had periods of hallucinations when her carbon dioxide levels were elevated. Her admission weight was listed as 79.6 pounds. She had a history of 1-2 falls in the last 3 months. She required 1-2 persons to assist her with mobility, transfers, personal hygiene and toileting.</p> <p>In review of Resident #A's admission Minimum Data Set (MDS) assessment,</p>		<p>that all of the following fall interventions were in place for this Resident at the time of admission: <i>bilateral ½ siderail to promote bed mobility; padded mat at bedside; PPA to bed.</i> The fact that the Resident <i>incurred no falls during this admission is positive validation of both the efficacy and appropriateness of all of the aforementioned fall interventions, constituting a plan of care to minimize the risk of falls, for this Resident.</i></p> <p>Additionally, Attachment # 1 denotes that orders were secured at the time of admission for both Physical Therapy and Occupational Therapy, both of which are <i>treatment modalities designed to enhance a Resident's stamina and independence; thus helpful in minimizing the Resident's risk for falls.</i> Physical Therapy and Occupational Therapy are additional interventions to assist in the prevention of falls. The Resident was readmitted from the hospital on 1/3/15 and returned to the hospital on 1/10/15. The Resident was in the facility a mere seven days for this second admission. Please refer to Attachment # 2. Attachment # 2 is the second page of the admission orders for this Resident. Review of said orders denotes that all of the fall interventions <i>that had been demonstrated to be successful</i></p>				

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	<p>dated 12-19-14, it indicated she was moderately cognitively intact with little energy and trouble concentrating several days of the week; required extensive assistance of 1 person with bed mobility, dressing, personal hygiene and toileting; required extensive assistance of 2 or more persons with transfers; was dependent of 1 person with bathing; experienced shortness of breath with activity, sitting at rest or lying flat; utilized supplemental oxygen. This MDS assessment demonstrated a "triggered area" to develop a care plan for potential falls.</p> <p>A care plan for falls was not observed to be present in Resident A's clinical record. In an interview with the Assistant MDS Coordinator on 1-27-15 at 8:55 a.m., she indicated, "The MDS assessment triggered for care plan development for falls," for Resident #A and she was unable to locate a care plan for falls in Resident #A's electronic medical record. At 9:40 a.m., she responded she had been unable to locate a care plan for falls in the resident's "paper chart."</p> <p>On 1-27-15 at 2:15 p.m., the Director of Nursing provided a copy of a document entitled, "Resident Care Planning." This document had a development date of 1-7-07 and was indicated to be the</p>		<p><i>in the prevention of falls for this Resident during the previous admission were reinstated at the time of this second admission.</i> Therefore, a <i>plan of care designed to minimize the risk of falls for Resident A was, once again, initiated at the time of her second admission to the facility.</i> When the Resident was sent to the hospital on 1/10/15 for <i>evaluation of her respiratory status</i>, the nurse anticipated that the Resident would return to the facility, as evidenced by the fact that the nurse had secured an additional fall intervention for the Resident to be implemented upon her anticipated return from the hospital. Please refer to Attachment # 3. Therefore, it is clear that the facility acted appropriately by modifying the Resident's <i>plan of care in an effort to minimize the risk of future falls.</i> The facility clearly <i>initiated and revised the Resident's plan of care regarding falls.</i> However, this <i>obvious plan of care was not documented on a piece of paper entitled "FALLS CARE PLAN".</i> PLAN OF CORRECTION Resident A no longer resides in this facility. Therefore, no specific plan of correction can be instituted for this specific Resident. The facility will audit all of the Resident's charts and ensure that all Residents who are deemed to</p>		

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	<p>procedure in current use by the facility. It stated, "Purpose: To promote individualized resident care plan with specific plans from nursing and other disciplines. To provide for continuity of care. To provide guidelines for nursing assignments...The Comprehensive Assessment shall be performed to identify needs, problems, goals, based upon Admission Assessment, transfer records, lab reports and other assessments should be used. The comprehensive assessment will begin immediately on admission and be completed within the first fourteen days...A registered nurse shall be designated as the R.N. Coordinator and shall verify the completion of the assessment form within fourteen days of admission, annually and upon significant condition change...After each discipline identifies problems and goals, the inter-disciplinary team will develop the care plan...The care plan is the primary communication tool and should be a composite picture of the resident and all care to be given. The care plan will be maintained in the medical record..."</p> <p>This Federal tag relates to Complaint IN00162694.</p> <p>3.1-35(a)</p>		<p>be at risk for falls, based upon their most recent MDS, will have an appropriate Falls Care Plan in place. The Unit Coordinators are responsible. As a Quality Assurance Measure, the MDS Nurses will ensure that a Falls Care Plan is in place for all Residents for whom the area of falls is triggered on the MDS at the time of each MDS review. The MDS Nurses will provide the Administrator with a list of all of the MDS reviews conducted each week, denoting the presence of a Falls Care Plan for all Residents in need of same; thus, the Administrator will monitor for continued compliance. The MDS Nurses will review the findings of the aforementioned care plan audits during the facility's Quality Assurance Meetings for the next six months. At the end of the six month period, the Quality Assurance Committee may elect to cease review of said audits if 100% compliance is achieved. In an effort to facilitate the care planning process for falls, instructions have been placed in the admission packets regarding the development of a falls care plan, along with a sample which will allow the initiation of a basic Falls Care Plan at the time of admission—an added responsibility of the admitting nurse. The Unit Coordinator (or other Administrative Nurse) will then be responsible to modify the Falls Care Plan during the routine</p>	

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F000323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision of a resident during a nebulizer treatment (type of breathing treatment) while sitting in her wheelchair. The resident fell from the wheelchair and was subsequently hospitalized related to respiratory-related issues. This deficient practice relates to 1 of 3 residents reviewed for falls in a sample of 3. (Resident #A)	F000323	review of the charts for newly admitted Residents. The Director of Nursing will audit future admissions to ensure that an appropriate Falls Care Plan is in place in a timely manner. Documentation of these audits will be forwarded to the Administrator for review. The results of said audits will also be reviewed during the facility's monthly Quality Assurance Meetings for the next six months. At the end of the six month period, the Quality Assurance Committee may elect to cease the review of said audits if 100% compliance has been achieved. F 323: FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES REGARDING RESIDENT A It must be noted that the surveyor's comment " <i>She had a history of 1-2 falls in the last three months.</i> " references falls incurred by Resident A prior to her admission to the facility. In fact, the fall of 1/10/15 was the <i>first and only fall incurred by the Resident during her two admissions to the facility.</i> Also, the fall on 1/10/15 <i>caused no</i>	02/26/2015

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	<p>Findings include:</p> <p>The clinical record of Resident #A was reviewed on 1-23-15 at 10:40 a.m. Her diagnoses included, but were not limited to, chronic respiratory failure, COPD (chronic obstructive pulmonary disease) with acute exacerbation, bibasilar pneumonia (December, 2014), cachexia (weight loss and muscle wasting related to chronic disease processes) related to COPD, chronic aspiration pneumonia, dysphagia, protein-calorie malnutrition, high blood pressure and CHF (congestive heart failure).</p> <p>In review of Resident #A's initial/admission nursing assessment, dated 12-9-14, it indicated she was alert and oriented to person, place, time and event; she was weak with poor balance and an unsteady gait; was unable to bear weight for more than a few seconds at a time and her family had communicated she had periods of hallucinations when her carbon dioxide levels were elevated. Her admission weight was listed as 79.6 pounds. She had a history of 1-2 falls in the last 3 months. She required 1-2 persons to assist her with mobility, transfers, personal hygiene and toileting.</p> <p>In review of Resident #A's admission</p>		<p><i>injury to the Resident.</i> The Resident's condition readily improved. As noted by the surveyor, the Resident was hesitant to go to the hospital for evaluation. Resident A only consented to hospital transfer after a ten minute discussion with staff and paramedics. It must also be noted that the Resident's most recent BIMS=10. <i>The sole purpose for the Resident's transfer to the hospital at this time was to allow a physician to assess her respiratory status—not to evaluate or render treatment related to the fall.</i> As noted by the surveyor, <i>the facility policy and procedure regarding nebulizer treatments stated "Remain with the resident sufficiently long enough to ensure technique and use of all medication...."</i> Therefore, R.N. #3 did, in fact, adhere to the facility policy. The surveyor's commentary regarding her conversation with R.N. #3 indicates that this nurse was very familiar with Resident A and was able to give a detailed synopsis of her condition and care. A further testament to R.N. #3's knowledge of Resident A's condition and treatment is the fact that the interview conducted by the surveyor with this nurse was conducted via phone. Therefore, R.N. #3 was able to provide detailed information to the surveyor from her memory of the Resident and without the benefit</p>		

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	<p>Minimum Data Set (MDS) assessment, dated 12-19-14, it indicated she was moderately cognitively intact with little energy and trouble concentrating several days of the week; required extensive assistance of 1 person with bed mobility, dressing, personal hygiene and toileting; required extensive assistance of 2 or more persons with transfers; was dependent of 1 person with bathing; experienced shortness of breath with activity, sitting at rest or lying flat; utilized supplemental oxygen.</p> <p>The care plan for Resident #A included a focus (area of concern) related to the resident's history of COPD and 12-29-14 diagnosis of a respiratory infection with treatments for this of "added duoneb [nebulizer treatment], mucinex and levaquin [antibiotic]."[sic] The goals for these areas of concern included, but were not limited to, optimal breathing patterns daily and resolution of the respiratory infection. The interventions for these areas of concern included, but were not limited to, "...Give aerosol or bronchodilator's as ordered. Monitor/document any side effects and effectiveness...Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. Monitor for s/sx [signs and symptoms] of respiratory insufficiency:</p>		<p>of a chart review. R.N. #3 had cared for Resident A prior to 1/10/15. R.N. #3 had administered nebulizer treatments in the past to this Resident. These facts lend credibility to the comment by R.N. #3 which is quoted in the survey findings of <i>"I felt, based on my nursing judgment, that (name of Resident A) was stable enough to leave unattended for her neb treatment"</i>. Respiratory Specialists, the facility's former provider of Respiratory Therapy equipment had, in fact, provided the facility with an inservice regarding various aspects of respiratory care <i>and procedures that are used exclusively by this company. Respiratory Specialists is a private entity that is in no way affiliated with Westminster Village North or its policies.</i> As noted in the surveyor's commentary, the documents provided by Respiratory Specialists are simply <i>"information"—not policy statements—that are provided to the staff.</i> Also, the informational packet from Respiratory Specialists regarding nebulizer treatments contains no caveat within the body of the document suggesting that the Resident must be attended by the nurse for the duration of a nebulizer treatment. The facility is not in agreement with the surveyor's statement that <i>"...the facility failed to ensure</i></p>				

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	<p>Anxiety, Confusion, Restlessness, SOB [shortness of breath] at rest, Cyanosis [blue cast to skin, suggestive of oxygen deficiency], Somnolence [sleepiness]..."</p> <p>In an interview on 1-23-15 at 2:45 p.m., the Administrator described Resident #A as a frail-looking woman with many breathing problems. The Director of Nursing (DON) indicated Resident #A as a person with end-stage COPD. The Administrator indicated Resident #A was no longer a resident of the facility as she transferred to another nursing facility upon her discharge from the hospital.</p> <p>In an interview with CNA #1 on 1-26-15 at 10:05 a.m., she recalled assisting Resident #A with care. She recalled this resident was usually cognitively intact with occasional periods of confusion; was on supplemental oxygen at all times; "would get winded easily; was a "very small" person; "took all her breath away to go to the bathroom"; had poor balance and required the use of a wheelchair for all transportation.</p> <p>In an interview with CNA# 2 on 1-26-15 at 10:19 a.m., she recalled assisting Resident #A with care. She recalled this resident was usually alert and oriented, but had periods of confusion; preferred to remain in her room; preferred to stay in</p>		<p>adequate supervision of a resident during a nebulizer treatment (type of breathing treatment) while sitting in her chair. Furthermore, the facility is not in agreement that this event warrants the scope and severity associated with a Level G citation. A level G citation indicates that Resident A incurred actual harm. The facility contends that there was no harm to the Resident subsequent to this "accident". The Resident was not injured. As noted by the surveyor, Resident A's respiratory issues are well documented as being chronic in nature. Therefore, the Resident's respiratory issues were present prior to the incident. Due to the swift and appropriate intervention on the part of R.N. #3, the Resident's acute episode of a low oxygen saturation level was, in fact, quickly reversed, as indicated the surveyor's commentary. Again, R.N. #3, administered the nebulizer treatment in accordance with facility policy. By virtue of the fact that this citation is embedded in the category of an "accident" it is also noteworthy that the definition of an "accident" is "an event that is not planned or intended; an event that occurs by chance", according to the Merriam-Webster Dictionary. One can only speculate regarding the ability of R.N.#3 to</p>				

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	<p>bed most of the time; "had real bad breathing problems,"; during assistance with care requiring the resident to be turned in bed, the resident would have to take rest periods in order to catch her breath, often requiring up to 25 minutes to be able to turn and reposition in bed; wore supplemental oxygen and did not recall the resident removing it; the resident "still had a rough time breathing" despite wearing her supplemental oxygen.</p> <p>In review of the nursing notes, dated 1-10-15 at 2:40 p.m. and signed by RN #3, the notes indicated Resident #A was seated in her wheelchair with her bedside table in front of her. An unnamed CNA notified RN #3 of the resident making "random confusing comments" and yelling out for her daughter. RN #3 documented she assessed the resident and found her oxygen saturation level at 94% (acceptable range), was "increasingly confused," with no complaints of pain, but lung sounds denoted increased wheezing (abnormal lung sounds). "Scheduled neb [nebulizer] treatment was applied. Minutes later, CNA alerted writer to resident's room. Resident was found lying on her back, next to her wheelchair and bedside table. Neb mask and NC [nasal cannula] oxygen had been removed. 3 staff members assisted</p>		<p>have successfully thwarted Resident A's fall, had R.N.#3 been in the room at the time of the incident: there are too many variables that come into play which make it impossible to make that determination. This incident is definitely an isolated event. The facility cannot recall any other episode of a Resident fall during the administration of a nebulizer treatment. In view of all of the above facts, the facility is requesting an opportunity for IDR for this citation. PLAN OF CORRECTION In the spirit of cooperation, the facility is submitting the following plan of correction. As noted in the survey, Resident A is no longer a Resident of this facility. Therefore, there can be no specific plan of correction devised for Resident A. All other Residents in the facility requiring the use of nebulizer treatments have been identified. 1. The facility policy and procedure regarding the administration of nebulizer treatments has been revised, denoting the need for a licensed nurse to remain with the Resident for the duration of the treatment. Please refer to Attachment #4. Licensed nursing personnel are being advised of this change. Staff compliance with the new policy and procedure will be monitored. The results of said monitoring will be reviewed during the facility's monthly Q.A. Meeting for the next six months.</p>	

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	<p>resident into the bed. O2 [oxygen] was applied via mask. HOB [head of the bed] was elevated. O2 [oxygen saturation rate] registered at 48% [extremely/dangerously low level]. O2 quickly rose up to 90% [acceptable range] on 5L [liters of oxygen]. Resident still was having SOB [shortness of breath] and gasping for air. Resident's body was checked for any bruises. No injury present. Resident denies any pain. ROM [range of motion] intact. 911 [emergency services] was contacted, related to resident's oxygen saturation being low and resident's increased chest congestion." The notes continued to include the attending physician's office was notified and a message was left for the family of the resident's change in condition. The notes continued to include the resident initially refused to go to the hospital, but agreed to go to the hospital after 10 minutes of discussion by staff with the resident.</p> <p>In an interview with RN #3 on 1-26-15 at 3:33 p.m., she indicated Resident #A was usually alert and oriented with periods of confusion. She recalled the resident had multiple diagnoses, but the primary problem was her respiratory problems. She recalled the resident experienced a great deal of shortness of breath with transfers, such as to the bathroom, which</p>		<p>At the end of the six month period, the Quality Assurance Committee may elect to cease review of this topic if 100% compliance is achieved. The monitoring will consist of documented observation of licensed nurses as they administer nebulizer treatments. The monitoring will consist of at least three random observations per week. Administrative Nursing staff will be responsible for the observations. The written reports shall be forwarded to the Administrator to monitor for ongoing completion of the monitoring. 2. The documents provided by Respiratory Specialists have been removed from the orientation packet given to newly hired nurses. This document has been replaced by the facility policy regarding the administration of nebulizer treatments. All remaining copies of the documents that had been provided by Respiratory Specialists have been purged from the facility. The Quality Assurance Nurse is responsible. In so much as this represents a permanent solution to this problem (destruction of the information packets from Respiratory Specialists) there is no follow-up activity required for this particular aspect of the plan of correction. -- IDR -- F 323: FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES REGARDING RESIDENT</p>	

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	<p>required assistance of one person and she used a wheelchair to go from the bed to the bathroom. The resident wore oxygen at all times with the oxygen rate at 4 liter per minute via nasal cannula. She recalled the resident's oxygen saturation baseline rate was about 88% to 94% on the 4 liters of supplemental oxygen and she frequently had wheezes when she assessed her lungs.</p> <p>RN #3 recalled Resident #A's oxygen saturation level had been in the low 90's prior to the last nebulizer treatment she assisted her with on 1-10-15. She recalled she did not remain in the resident's room to supervise the nebulizer treatment. She indicated, "I felt, based on my nursing judgement, that [name of Resident #A] was stable enough to leave unattended for her neb treatment. She was not a fall risk, was fairly stable for her respiratory status and seemed to be in no distress at the time." She recalled she had stepped out of Resident #A's room to her medication cart in the hallway. She recalled, "Five minutes later, [name of CNA #6] notified me she [Resident #A] was on the floor. When I went, I found her flat on her back. She had no wheelchair alarms. Oxygen and neb mask was off. She was breathing, but blue. Alert to name, but unable to speak to us." She recalled, she assessed the</p>		<p>A It must be noted that the surveyor's comment "<i>She had a history of 1-2 falls in the last three months.</i>" references falls incurred by Resident A prior to her admission to the facility. In fact, the fall of 1/10/15 was the <i>first and only fall incurred by the Resident during her two admissions to the facility.</i> Also, the fall on 1/10/15 <i>caused no injury to the Resident.</i> The Resident's condition readily improved. As noted by the surveyor, the Resident was hesitant to go to the hospital for evaluation. Resident A only consented to hospital transfer after a ten minute discussion with staff and paramedics. It must also be noted that the Resident's most recent BIMS=10. <i>The sole purpose for the Resident's transfer to the hospital at this time was to allow a physician to assess her respiratory status—not to evaluate or render treatment related to the fall.</i> As noted by the surveyor, <i>the facility policy and procedure regarding nebulizer treatments stated "Remain with the resident sufficiently long enough to ensure technique and use of all medication...."</i> Therefore, R.N. #3 did, in fact, adhere to the facility policy. The surveyor's commentary regarding her conversation with R.N. #3 indicates that this nurse was very familiar with Resident A and was able to give a detailed synopsis of</p>				

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	<p>resident and found no injuries and was not grimacing as if pain. She recalled she alerted others for more help. She recalled the resident's oxygen saturation level was 48% and she applied an oxygen mask at 5 liters and the resident quickly responded by opening her eyes, speaking and being able to correctly identify the date and day of the week.</p> <p>In an interview with LPN #5 on 1-26-15 at 9:57 a.m., she indicated the facility's policies regarding nebulizer treatments included, but were not limited to, assessing lung sounds, checking the oxygen saturation level, obtaining vital signs before and after the treatment and remaining with the resident during the nebulizer treatment.</p> <p>In an interview with LPN #4 on 1-26-15 at 11:00 a.m., she indicated the facility's policies regarding nebulizer treatments included, but were not limited to, assessing lungs sounds, heart rate, respiration rate, oxygen saturation level before and after a nebulizer treatment. She stated, "We are supposed to stay with the resident to ensure [he/she] receives the full treatment."</p> <p>In an interview with RN #3 on 1-26-15 at 3:33 p.m., she indicated facility staff are to check the lungs and oxygen saturation</p>		<p>her condition and care. A further testament to R.N. #3's knowledge of Resident A's condition and treatment is the fact that the interview conducted by the surveyor with this nurse was conducted via phone. Therefore, R.N. #3 was able to provide detailed information to the surveyor from her memory of the Resident and without the benefit of a chart review. R.N. #3 had cared for Resident A prior to 1/10/15. R.N. #3 had administered nebulizer treatments in the past to this Resident. These facts lend credibility to the comment by R.N. #3 which is quoted in the survey findings of <i>"I felt, based on my nursing judgment, that (name of Resident A) was stable enough to leave unattended for her nebulizer treatment"</i>. Respiratory Specialists, the facility's former provider of Respiratory Therapy equipment had, in fact, provided the facility with an inservice regarding various aspects of respiratory care <i>and procedures that are used exclusively by this company. Respiratory Specialists is a private entity that is in no way affiliated with Westminster Village North or its policies.</i> As noted in the surveyor's commentary, the documents provided by Respiratory Specialists are simply <i>"information"—not policy statements—that are provided to the staff.</i> Also, the</p>	

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	<p>of a resident prior to beginning a nebulizer treatment. She commented that upon completion of a nebulizer treatment, the staff member is to recheck the resident's oxygen saturation level and lung sounds if the resident appears to be short of breath or having respiratory problems.</p> <p>On 1-26-15 at 1:45 p.m., the Director of Nursing provided a copy of procedure entitled, "Nebulized Mist Inhalation Treatment." This procedure had a development date of 5-22-1997 and was identified as the policy in current use by the facility. This procedure indicated, "Purpose: To deliver microscopic moisture droplets into the lower respiratory tract. To sooth irritated mucous membranes. To aid in removal of thick secretions from the lower respiratory tract...Remain with the resident sufficiently long enough to ensure technique and use of all medication..."</p> <p>On 1-26-15 at 4:00 p.m., the Director of Nursing provided copy of a packet of information entitled, "Respiratory Specialists Aerosolized Medication Therapy." The Director of Nursing indicated the information contained within the packet included the information the facility provides to new</p>		<p>informational packet from Respiratory Specialists regarding nebulizer treatments contains no caveat within the body of the document suggesting that the Resident must be attended by the nurse for the duration of a nebulizer treatment. The facility is not in agreement with the surveyor's statement that "...the facility failed to ensure adequate supervision of a resident during a nebulizer treatment (type of breathing treatment) while sitting in her chair. Furthermore, the facility is not in agreement that this event warrants the scope and severity associated with a Level G citation. A level G citation indicates that Resident A incurred actual harm. The facility contends that there was no harm to the Resident subsequent to this "accident". The Resident was not injured. As noted by the surveyor, Resident A's respiratory issues are well documented as being chronic in nature. Therefore, the Resident's respiratory issues were present prior to the incident. Due to the swift and appropriate intervention on the part of R.N. #3, the Resident's acute episode of a low oxygen saturation level was, in fact, quickly reversed, as indicated the surveyor's commentary. Again, R.N. #3, administered the nebulizer treatment in accordance with</p>	

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	<p>employees who are licensed nurses regarding breathing treatments. Included in the packet was a procedure entitled, "Procedure for Medicated Aerosol Treatment." This procedure was undated. This procedure indicated, prior to beginning the treatment, to assess the resident's breath (lung) sounds, pulse rate and instruct the resident on how to hold the hand-held nebulizer or determine if the resident needs a specialized mask for the nebulizer treatment. During the treatment, "Monitor pulse, respiratory rate and breath sounds. Stop treatment if pulse rate increases 20 BPM [beats per minute] or resident reveals intolerance..." Documentation includes, but is not limited to breath sounds pre and post treatment and resident's tolerance of the treatment. A copy of a test with the answer key included, entitled, "Respiratory Specialists Nebulizer & Oxygen Device Quiz," posed the statement of "The nurse should stay in the patient's room while the breathing treatment is nebulizing." The answer key indicated the corresponding correct response as "True."</p> <p>This Federal tag relates to Complaint IN00162694.</p> <p>3.1-35(a)(2)</p>		<p>facility policy. By virtue of the fact that this citation is embedded in the category of an "accident" it is also noteworthy that the definition of an "accident" is "an event that is not planned or intended; an event that occurs by chance", according to the <i>Merriam-Webster Dictionary</i>. One can only speculate regarding the ability of R.N.#3 to have successfully thwarted Resident A's fall, had R.N.#3 been in the room at the time of the incident: there are too many variables that come into play which make it impossible to make that determination. This incident is definitely an isolated event. The facility cannot recall any other episode of a Resident fall during the administration of a nebulizer treatment. In view of all of the above facts, the facility is requesting an opportunity for IDR for this citation.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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