STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 00 B. WING	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This Visit was for the Investigation of Complaint IN00422135. Complaint IN00422135 -- Federal/State deficiencies related to the allegations are cited at F580, F684, F690 and F776. Survey dates: November 29 and 30, 2023 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 2 Medicaid: 32 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on December 4, 2023	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the the plan of correction be considered effective December 13, 2023 to the complaint survey completed on November 30, 2023. The facility also requests that our plan of correction be considered for paper review. The facility would be happy to submit to you any additional paperwork that you would need for review.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Nodley	Regional Nurse	12/19/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to			

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	room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the attending physician of stat (immediate) radiology testing that had not been conducted in a timely manner for 2 of 3 residents reviewed for completion of physician orders. (Resident B and D) Findings include: 1. The clinical record of Resident B was reviewed on 11-29-23 at 10:50 a.m. Her diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, ventilator dependency and constipation. Her most recent Minimum Data Set assessment, dated 9-24-23, indicated she was severely cognitively impaired, had no speech, was dependent for all activities of daily living and utilized a ventilator to assist in breathing. In an interview with a family member of Resident B on 11-29-23 at 10:37 a.m., indicated she was notified by an unnamed staff member on 10-14-23, Resident B was scheduled for an xray of her abdomen on a "stat," or immediate basis by the physician and the contracted radiology company would conduct the xray at the facility, for the purpose of checking out her bowels, due to no recent bowel movements. She indicated this test was not conducted until Monday, 10-16-23, after she spoke with LPN 3. In an interview with LPN 3 on 11-29-23 at 12:20 p.m., she recalled on Monday, 10-16-23, the daughter of Resident B had contacted her about getting the test results from the weekend. "When I reviewed the orders, the KUB [non-invasive xray procedure of the abdomen, specifically of the	F 0580	F580 Notification of Changes (Injury/Decline/Room, etc) It is the practice of this facility to assure that the resident's attending physician is notified when any (stat) radiology testing has not been conducted in a timely manner. The correction action taken for the residents found to be affected by the deficient practice include: Resident D - It would not be possible to correct the past notifications for untimely completion of radiology services, please refer to systems changes and monitoring below. Resident B has been discharged from the facility on 10/17/23. Other residents that have the potential to be affected have been identified by: All resident with (stat) radiology testing could potentially be affected. Please see system changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nurses have all been in-serviced related to MD/NP notification when (stat)	12/14/2023

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	kidneys, ureters and bladder and the supporting structures to assist in determining causes of abdominal pain] had been ordered stat and still wasn't done. The radiology company that we use has been having some of the same problem other healthcare businesses have been having of being understaffed. So, I immediately reached out to them to let them know we had a stat KUB from the weekend that had not been done yet. They told me they have been having staffing problems and would get to it as soon as they could. I explained to them we had a resident that we were concerned with and needed this done as soon as possible. They were able to get to us and get the test done within a matter of hours. They told me that because of the staffing problems, they were treating all orders as stats and they would get to it as soon as possible. My thinking is that if all the orders are being handled as stats, then none of them are being done as a stat order." She indicated she notified the daughter she had spoken with radiology company and they were working on getting the testing done. I did tell her that if they didn't get here soon, we could send her mother out to the hospital and have the testing done." In an interview with the Executive Director (ED) on 11-30-23 at 9:21 a.m., he indicated he is aware the current contracted radiology company has been having issues with getting xrays conducted in a timely manner, including stat orders. He added Resident B "was one of those affected by this." He indicated he had not personally spoken with the contracted radiology company, but the corporate nurse had done so. "My understanding is they are having problems with having enough staff to get the xrays done, especially stat orders, because of the staffing problems. I am not aware of them telling us this when we order labs or		radiology services are not completed in a timely manner. The in-service also covers that a nurse progress note must be completed regarding the notification. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that reviews all residents with (stat) radiology services to assure the test is completed in a timely manner and if not, MD/NP will be notified and notification documented. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: December 14, 2023	

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	updating us when they realize they are running behind and may not get the test done in a timely manner," as would give the facility an opportunity to get hold of the physician or nurse practitioner (NP) to make other arrangements. "My definition of stat is immediately, usually for an xray, within a few hours." In an interview with the ED on 11-30-23 at 1:05 p.m., he indicated his understanding of stat testing for a long term care facility for testing conducted on-site would be within 4 hours of the test order provided to the provider. "I can't speak to why our staff did not reach out to [name of contracted radiology provider] to find out why they hadn't shown up yet to do the tests. Maybe they did, but didn't document it." A review of the nursing progress notes failed to reflect any documentation by the facility staff of notification to the medical provider of Resident B's stat testing not being conducted as ordered, prior to 10-16-23. 2. The clinical record of Resident D was reviewed on 11-29-23 at 2:25 p.m. His diagnoses included, but were not limited to, acute respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit, quadriplegia, ventilator dependency, unspecified intracranial injury and unspecified neck fracture. His admission Minimum Data Set assessment, dated 11-6-23, indicated he is in a coma. In an interview with a family member on 11-29-23 at 2:40 p.m., she indicated she did have some concerns from some time ago in which the company that is contracted for labs and xrays was having problems being able to get the ordered tests done in a timely manner. She recalled at one			

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	point, the resident had some tests ordered and the contracted company was very delayed in getting them done. "We found out it seemed to be a problem on the weekends and holidays, as far as getting tests done like they were supposed to be done. We ended up having to send [name of Resident D] to the hospital to get the tests done. I don't know if it would have made a difference in the long run, but it was a big issue at the time." In an interview with LPN 3 on 11-30-23 at 10:10 a.m., she indicated, "[Name of Resident D] was another resident that was impacted by the radiology company not getting a stat chest xray done when it should have been done. It was around the same time [name of Resident B] didn't get her stat xray done on time. When I came into work on 10-16-23, I found out that [name of Resident D] had a stat chest xray ordered on 10-14-23 and it wasn't done yet. So, I got on the phone and called [name of the contracted radiology provider] to find out when they were going to be getting [it] done. It ended up we had to send him out to the hospital because they did not get here like they should have." She indicated the contracted radiology provider did tell her when she called about when to expect them to be in building that they were short-staffed. "So now what I do when I have a stat xray is to send the order electronically, which is routine, then follow-up with a phone call to let them know it is stat and to request when to expect them." A review of the nursing progress notes failed to reflect any documentation by the facility staff of notification to the medical provider of the stat testing for Resident D not being conducted as ordered, prior to 10-16-23. In an interview with the Executive Director (ED)			

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	on 11-30-23 at 9:21 a.m., he indicated he is aware the current contracted radiology company has been having issues with getting xrays conducted in a timely manner, including stat orders. He indicated he had not personally spoken with the contracted radiology company, but the corporate nurse had done so. "My understanding is they are having problems with having enough staff to get the xrays done, especially stat orders, because of the staffing problems. I am not aware of them telling us this when we order labs or updating us when they realize they are running behind and may not get the test done in a timely manner," as would give the facility an opportunity to get hold of the physician or nurse practitioner to make other arrangements. "My definition of stat is immediately, usually for an xray, within a few hours." In an interview on 11-30-23 at 1:05 p.m., with the Executive Director, (ED), he indicated it was his understanding of stat testing for a long term care for on-site testing should be within 4 hours of the test order being provided to the provider. "I can't speak to why our staff did not reach out to [name of contracted radiology provider] to find out why they hadn't shown up yet to do the tests. Maybe they did, but didn't document it." The ED provided an emailed copy of a policy entitled, "Notification of Change in Resident's Condition or Status Policy and Procedure," on 12-1-23 at 10:02 a.m. This policy was indicated to be the policy currently utilized by the facility. This policy indicated, "Our facility shall promptly notify the Resident, his or her Physician/Physician Assistant/Nurse Practitioner, and Resident Representative/interested family member of changes in the Resident's medical/mental condition and/or status. The			

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	Nurse will notify the Resident's Physician/Physician Assistant/Nurse Practitioner when there has been (including, but not limited to)...A need to alter the Resident's medical treatment significantly...Notification of appropriate individuals will occur in a timely manner. The Nurse will record in the Resident's medical record information relative to changes in the Resident's medical/mental condition or status, as well as notification of appropriate individuals." The ED provided an emailed copy of a contract with the contracted radiology provider on 12-1-23 at 10:02 a.m., with a signature date of 2-6-2019. The contract did not specify time parameters for obtaining stat xrays. On 11-30-23 at 3:33 p.m., the ED provided an apparent updated, but unsigned, "Standard Service Terms and Conditions," document from the current contracted radiology provider. It indicated, "Non-STAT Imaging Exams. Every effort will be made to complete Services within a day of when the Services are ordered. In the event that Provider is unable to complete Services within a day of when the Service is ordered, Customer will be notified and the exam will be performed as scheduled. Special Services/On-Call Emergency Provider Services. If requested by Customer and where available, Provider shall be available 24 hours a day, seven (7) days a week for "STAT" (emergency) requests. A "STAT" services is provided for critical situations requiring rapid results, and "STAT" orders shall be honored by Provider only when requested by the physician or non-physician practitioner. Customer shall use its best efforts to limit "STAT" orders to urgent situations where the absence of such an order could reasonably be believed to place the Patient's health in serious jeopardy..."			

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	This Federal deficiency relates to Complaint IN00422135. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure physician orders for the administration of a laxative were conducted as ordered for 1 of 3 residents reviewed for following physician orders. (Resident B) Findings include: The clinical record of Resident B was reviewed on 11-29-23 at 10:50 a.m. Her diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, ventilator dependency and constipation. Her most recent Minimum Data Set assessment, dated 9-24-23, indicated she was severely cognitively impaired, had no speech, was dependent for all activities of daily living and utilized a ventilator to assist in breathing. In a review of nursing progress notes, dated 10-15-23 at 4:15 p.m., indicated Resident B's daughter had provided a bed bath to the resident	F 0684	F684 Quality of Care It is the practice of this facility to assure that physician orders for administration of laxatives are administered as ordered. The correction action taken for the residents found to be affected by the deficient practice include: Resident B has been discharged from the facility on 10/17/23. Other residents that have the potential to be affected have been identified by: All residents with orders for laxatives and bowel medications have the potential to be affected. Please see system changes below to prevent reoccurrence.	12/14/2023

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	and had observed the resident's right and left lower quadrants of the abdomen felt "firm and moderately distended," and the last bowel movement had been on 10-12-23. The documentation reflected the nurse auscultated Resident B's abdomen and denoted the presence of bowel sounds. A notation indicated at 4:30 p.m., the daughter informed the nurse Resident B had vomited, to which the nurse responded by raising the resident's head of the bed, turned the resident onto the side and suctioned the resident's tracheotomy. At 4:37 p.m., the notes reflect the nurse notified the on-call NP (nurse practitioner) of the resident's status with her vital signs and emesis in which estimated suctioned less than 100 milliliters of emesis. New orders were provided by the NP for a chest xray, a KUB and to administer the resident's as needed order for Miralax (a laxative) and to hold/stop the enteral feedings for one hour and then to verify any gastric residual and to resume the enteral feeding for one hour and then recheck the gastric residual. Further review of the clinical record failed to locate any documentation in the narrative portion or the medical administration record (MAR) the resident had received the Miralax. Resident B's physician orders did include an order for "polyethylene glycol [generic form of Miralax] 3350 Powder 17 grams per scoop, give 17 grams via G-tube every 24 hours as needed for constipation." This medication was not documented as administered on the MAR or in the narrative progress notes at any time during the October, 2023 time frame. This Federal tag relates to Complaint IN00422135. 3.1-37(a)		The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nurses have been in-serviced on administering and charting laxatives and other bowel medications in accordance with the MD orders. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that all resident's who have laxatives and other bowel medications are being administer in accordance with the MD order. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: December 14, 2023	

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to routinely document the bowel elimination for 2 of 3 non-verbal and dependent residents	F 0690	F690 Bowel/Bladder Incontinence, Catheter, UTI It is the practice of this facility to	12/14/2023

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	reviewed for constipation. (Residents B and C) Findings include: 1. The clinical record of Resident B was reviewed on 11-29-23 at 10:50 a.m. Her diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, ventilator dependency and constipation. Her most recent Minimum Data Set assessment, dated 9-24-23, indicated she was severely cognitively impaired, had no speech, was dependent for all activities of daily living and utilized a ventilator to assist in breathing. Her most recent Minimum Data Set assessment, dated 9-24-23, indicated she was severely cognitively impaired, had no speech, was dependent for all activities of daily living, including toileting needs. It indicated she was incontinent of her bowels. A review of Resident B's records for documentation of bowel elimination was conducted for September and October, 2023. Twenty (20) of 30 days for September had no documentation conducted regarding bowel elimination. Twelve (12) of 17 days for October had no documentation conducted regarding bowel elimination. In an interview with the Executive Director (ED) on 11-30-23 at 1:05 p.m., he indicated he would expect the documentation for bowel and bladder elimination would be conducted routinely. 2. The clinical record of Resident C was reviewed on 11-29-23 at 12:10 p.m. Her diagnoses included, but were not limited to acute respiratory failure with hypoxia, ventilator dependency, cognitive communication deficit, anoxic brain damage,moderate protein-calorie malnutrition and		assure that all bowel eliminations are routinely documented for all residents. The correction action taken for the residents found to be affected by the deficient practice include: Resident B has been discharged from the facility on 10/17/23. Resident C past bowel documentation is unable to be corrected, however the facility is assuring that all bowel eliminations are being appropriately documented every shift. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. Please see system changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nurses and CNAs have been in-serviced on documenting bowel eliminations appropriately every shift. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents point of care charting to ensure	

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	postviral fatigue syndrome. Her most recent Minimum Data Set assessment, dated 11-9-23, indicated she is severely cognitively impaired. Her care plans indicated she is dependent for activities of daily living, including toileting. In an interview with a family member on 11-29-23 at 11:40 a.m., he indicated Resident C has diarrhea on a regular basis. A review of Resident C's records for documentation of bowel elimination was conducted for November, 2023. Eight (8) of 27 days for November had no documentation conducted regarding bowel elimination. In an interview with the Executive Director (ED) on 11-30-23 at 1:05 p.m., he indicated he would expect the documentation for bowel and bladder elimination would be conducted routinely. On 11-30-23 at 3:33 p.m., the ED provided a copy of a policy entitled, "Effective Bowel Elimination Policy and Procedure." This policy was identified as the current policy in use by the facility and did not have an effective date. It indicated, "It is the intent of the facility nursing personnel to document, monitor and implement appropriate measures relative to the management of bowel function. The bowel function regimen will be initiated by the Licensed Nurse with the approval from the attending Physician as indicated. All residents will be assessed upon admission and at least quarterly based on the Resident Assessment Instrument schedule and PRN [as needed] for bowel continence. If a problem is identified, orders for interventions will be determined by the physician. When a problem e.g., constipation or diarrhea is identified, orders for intervention will be determined by the physician. Certified Nursing		that bowel eliminations are being documented every shift. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: December 14, 2023	

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	Assistant will document the resident bowel movement daily in the resident's record...Documentation should reflect size...The number of bowel movements should also be noted. Observation of bowel movements should include color, consistency, size or presence of blood or mucous...report any abnormalities to the Charge Nurse for documentation and physician notification as indicated. The Nurse will review the resident's ADL [activities of daily living] documentation in regard to bowel movements..." This Federal tag relates to Complaint IN00422135. 3.1-41(a)(2) 3.1-50(a)(1) 3.1-50(a)(2)			
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on interview and record review, the facility failed to ensure radiology services ordered by the attending physician and/or nurse practitioner	F 0776	F776 Radiology/Other Diagnostic Services It is the practice of this facility to	12/14/2023

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	were conducted in a timely manner for 2 of 3 residents reviewed for radiology services. (Residents B and D) Findings include: 1. The clinical record of Resident B was reviewed on 11-29-23 at 10:50 a.m. Her diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, ventilator dependency and constipation. Her most recent Minimum Data Set assessment, dated 9-24-23, indicated she was severely cognitively impaired, had no speech, was dependent for all activities of daily living and utilized a ventilator to assist in breathing. In an interview with a family member of Resident B on 11-29-23 at 10:37 a.m., she indicated she was notified by an unnamed staff member on 10-14-23, Resident B was scheduled for an xray of her abdomen on a "stat," or immediate basis by the physician and the contracted radiology company would conduct the xray at the facility, for the purpose of checking out her bowels, due to no recent bowel movements. She indicated this test was not conducted until Monday, 10-16-23, after she spoke with LPN 3. In an interview with LPN 3 on 11-29-23 at 12:20 p.m., she recalled on Monday, 10-16-23, the daughter of Resident B had contacted her about getting the test results from the weekend. "When I reviewed the orders, the KUB [non-invasive xray procedure of the abdomen, specifically of the kidneys, ureters and bladder and the supporting structures to assist in determining causes of abdominal pain] had been ordered stat and still wasn't done. The radiology company that we use has been having some of the same problem other		assure that all MD/NP ordered radiology services are conducted in a timely manner. The correction action taken for the residents found to be affected by the deficient practice include: Resident B has been discharged from the facility on 10/17/23. Resident D past radiology service is unable to be corrected, however the facility is assuring that all radiology services are being conducted in a timely manner. Other residents that have the potential to be affected have been identified by: All residents that have ordered radiology services have the potential to be affected. Please see system changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nurses have been in-serviced on ensuring that all radiology services are being conducted in a timely manner. The corrective action taken to monitor performance to assure compliance through the quality assurance is: A Performance Improvement Tool has been initiated that reviews all residents with	

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	healthcare businesses have been having of being understaffed. So, I immediately reached out to them to let them know we had a stat KUB from the weekend that had not been done yet. They told me they have been having staffing problems and would get to it as soon as they could. I explained to them we had a resident that we were concerned with and needed this done as soon as possible. They were able to get to us and get the test done within a matter of hours. They told me that because of the staffing problems, they were treating all orders as stats and they would get to it as soon as possible. My thinking is that if all the orders are being handled as stats, then none of them are being done as a stat order." She indicated she notified the daughter she had spoken with radiology company and they were working on getting the testing done. I did tell her that if they didn't get here soon, we could send her mother out to the hospital and have the testing done." LPN 3 described the daughter as being very involved in her care and seemed very knowledgeable regarding healthcare in general. In an interview with the Executive Director (ED) on 11-30-23 at 9:21 a.m., he indicated he is aware the current contracted radiology company has been having issues with getting xrays conducted in a timely manner, including stat orders. He added Resident B "was one of those affected by this." He indicated he had not personally spoken with the contracted radiology company, but the corporate nurse had done so. "My understanding is they are having problems with having enough staff to get the xrays done, especially stat orders, because of the staffing problems. I am not aware of them telling us this when we order labs or updating us when they realize they are running behind and may not get the test done in a timely manner," as would give the facility an opportunity		radiology services are being conducted in a timely manner. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: December 14, 2023	

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	to get hold of the physician or nurse practitioner (NP) to make other arrangements. "My definition of stat is immediately, usually for an xray, within a few hours." He shared the daughter of Resident B was very involved in her mother's care and has not approached him regarding any of these concerns. In an interview with the ED on 11-30-23 at 1:05 p.m., he indicated his understanding of stat testing for a long term care facility for testing conducted on-site would be within 4 hours of the test order provided to the provider. "I can't speak to why our staff did not reach out to [name of contracted radiology provider] to find out why they hadn't shown up yet to do the tests. Maybe they did, but didn't document it." In a review of nursing progress notes, dated 10-15-23 at 4:15 p.m., indicated Resident B's had provided a bed bath to the resident and had observed the resident's abdomen right and left lower quadrants of the abdomen felt "firm and moderately distended," and the last bowel movement had been on 10-12-23. The documentation reflected the nurse auscultated Resident B's abdomen and denoted the presence of bowel sounds. A notation indicated at 4:30 p.m., the daughter informed the nurse Resident B had vomited, to which the nurse responded by raising the resident's head of the bed, turned the resident onto the side and suctioned the resident's tracheotomy. At 4:37 p.m., the notes reflect the nurse notified the on-call NP of the resident's status with her vital signs and emesis in which estimated suctioned less than 100 milliliters of emesis. New orders were provided by the NP for a chest xray, a KUB and to administer the resident's as needed order for Miralax (a laxative) and to hold/stop the enteral feedings for one hour			

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	and then to verify any gastric residual and to resume the enteral feeding for one hour and then recheck the gastric residual. No additional entries were noted, prior to a late entry for an unknown date and time, dated 10-16-23 at 7:00 p.m., indicated the chest xray nor KUB had been conducted. It indicated the resident's abdomen was "minimally distended and moderately firm," with bowel sounds described as present in each quadrant of the abdomen with the left and right lower quadrants having being hypoactive and distant. A second late entry, for an unknown date and time, dated 10-17-23 at 7:00 a.m., indicated a faxed report for the chest xray and KUB had been sent to the facility, and the facility staff were attempting to reach the medical provider. The notes indicated the resident's daughter was notified of the test results being received on 10-17-23 at 9:36 a.m. and the medical provider was notified of the test results on 10-17-23 at 11:37 a.m. At this time, the notes reflect the nurse was notified of Resident B having mustard-colored tracheotomy secretions, which she shared with the NP. The NP, in turn, ordered for the resident to be sent to the local emergency room for emergent care. The nurse updated the daughter of these changes at that time and was in agreement with the transfer. In a phone interview with a customer service representative of the contracted radiology provider on 11-30-23 at 3:34 p.m., she indicated the contracted radiology provider defines the response time to fulfil a stat order as within 4 hours of receipt of the order, dependent upon weather conditions, traffic conditions. She indicated it is policy their staff will attempt to			

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	contact the ordering facility to update them on an expected arrival time for test performance if there is a delay or to re-schedule. She indicated her records for Resident B's show "the chest xray and KUB was done and completed on 10-16-23, after having received the orders on 10-15-23." She indicated there was a notation their staff had attempted to notify the facility on 10-15-23 around 11:00 p.m., but there was no answer. The corresponding test report reflected the chest xray and KUB were conducted on 10-16-23 at 7:54 p.m., interpreted by the radiologist on 10-16-23 at 8:13 p.m. and reported on 10-16-23 at 8:13 p.m. 2. The clinical record of Resident D was reviewed on 11-29-23 at 2:25 p.m. His diagnoses included, but were not limited to, acute respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit, quadriplegia, ventilator dependency, unspecified intracranial injury and unspecified neck fracture. His admission Minimum Data Set assessment, dated 11-6-23, indicated he is in a coma. In an interview with a family member on 11-29-23 at 2:40 p.m., she indicated she did have some concerns from some time ago in which the company that is contracted for labs and xrays was having problems being able to get the ordered tests done in a timely manner. She recalled at one point, the resident had some tests ordered and the contracted company was very delayed in getting them done. "We found out it seemed to be a problem on the weekends and holidays, as far as getting tests done like they were supposed to be done. We ended up having to send [name of Resident D] to the hospital to get the tests done. I don't know if it would have made a difference in the long run, but it was a big issue at the time."			

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	In an interview with LPN 3 on 11-30-23 at 10:10 a.m., she indicated, "[Name of Resident D] was another resident that was impacted by the radiology company not getting a stat chest xray done when it should have been done. It was around the same time [name of Resident B] didn't get her stat xray done on time. When I came into work on 10-16-23, I found out that [name of Resident D] had a stat chest xray ordered done on 10-14-23 and it wasn't done yet. So, I got on the phone and called [name of the contracted radiology provider] to find out when they were going to be getting done. It ended up we had to send him out to the hospital because they did not get here like they should have." She indicated the contracted radiology provider did tell her when she called about when to expect them to be in building that they were short-staffed. "So now what I do when I have a stat xray is to send the order electronically, which is routine, then follow-up with a phone call to let them know it is stat and to request when to expect them." A review of progress notes for Resident D indicated he returned to the facility from a hospital stay on 10-14-23 at 4:00 p.m. At 5:01 p.m., tracheal suctioning obtained approximately 150 milliliters of fluids that appeared to be possible enteral feeding and 30 milliliters of "bright red blood." The nurse notified the on-call medical provider, who ordered a stat (immediate) chest xray. The notes reflect the contracted radiology provider provided a confirmation of the order and included the confirmation number for this test. A note, dated 10-15-23 at 10:13 a.m. stated the stat chest xray "planned for 12pm on Oct 15." An entry, dated 10-15-23 at 4:39 p.m., indicated the Respiratory Therapist notified the nurse of "pinkish bloody" secretions obtained with tracheal suctioning." A 10-16-23 at 10:04 a.m.			

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	entry indicated, "Order for stat chest x-ray placed 10-14-23 with [name of contracted radiology provider] due to possible bleeding and aspiration per RN. Writer contacted [name of contracted radiology provider] unable to give ETA [expected time of arrival] for stat order at this time due to increase demand and decrease in mobile techs. Due to RT [respiratory therapist] removing moderate amount of thick red secretions and temp 102.5 contacted on-call NP [nurse practitioner]. Gave orders to sent resident to ER [emergency room] due to delay in state chest x-ray and temp..." The notes reflected Resident D's mother was notified of the change in the resident's status and the resident was sent to a local emergency room the same date at 1:46 p.m. Resident D returned to the facility on 10-29-23. In an interview with the Executive Director (ED) on 11-30-23 at 9:21 a.m., he indicated he is aware the current contracted radiology company has been having issues with getting xrays conducted in a timely manner, including stat orders. He indicated he had not personally spoken with the contracted radiology company, but the corporate nurse had done so.. "My understanding is they are having problems with having enough staff to get the xrays done, especially stat orders, because of the staffing problems. I am not aware of them telling us this when we order labs or updating us when they realize they are running behind and may not get the test done in a timely manner," as would give the facility an opportunity to get hold of the physician or nurse practitioner to make other arrangements. "My definition of stat is immediately, usually for an xray, within a few hours." In an interview on 11-30-23 at 1:05 p.m., with the Executive Director, (ED), he indicated it was his			

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	understanding of stat testing for a long term care for on-site testing should be within 4 hours of the test order being provided to the provider. "I can't speak to why our staff did not reach out to [name of contracted radiology provider] to find out why they hadn't shown up yet to do the tests. Maybe they did, but didn't document it." In a phone interview with a customer service representative of the contracted radiology provider on 11-30-23 at 3:34 p.m., she indicated the contracted radiology provider defines the response time to fulfil a stat order as within 4 hours of receipt of the order, dependent upon weather conditions, traffic conditions. She indicated it is policy their staff will attempt to contact the ordering facility to update them on an expected arrival time for test performance if there is a delay or to re-schedule. She indicated her records for Resident D reflect a staff member had spoken with someone at the facility on 10-15-23 and spoke with a named staff member and rescheduled his testing for 10-16-23. The ED provided a emailed copy of a contract with the contracted radiology provider on 12-1-23 at 10:02 a.m., with a signature date of 2-6-2019. The contract did not specify time parameters for obtaining stat xrays. On 11-30-23 at 3:33 p.m., the ED provided an apparent updated, but unsigned, "Standard Service Terms and Conditions," document from the current contracted radiology provider. It indicated, "Non-STAT Imaging Exams. Every effort will be made to complete Services within a day of when the Services are ordered. In the event that Provider is unable to complete Services within a day of when the Service is ordered, Customer will be notified and the exam will be			

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	performed as scheduled. Special Services/On-Call Emergency Provider Services. If requested by Customer and where available, Provider shall be available 24 hours a day, seven (7) days a week for "STAT" (emergency) requests. A "STAT" services is provided for critical situations requiring rapid results, and "STAT" orders shall be honored by Provider only when requested by the physician or non-physician practitioner. Customer shall use its best efforts to limit "STAT" orders to urgent situations where the absence of such an order could reasonably be believed to place the Patient's health in serious jeopardy..." This Federal deficiency relates to Complaint IN00422135. 3.1-49(j)(1) 3.1-49(j)(2)			