

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2012	
NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280			
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W0000	<p>This visit was for an initial certification and state licensure survey.</p> <p>Survey Dates: 8/22 and 8/23/12</p> <p>Facility Number: 12836 Provider Number: AIM Number:</p> <p>Survey Team: Paula Chika, Medical Surveyor III-Team Leader Claudia Ramirez, Public Health Nurse Surveyor III-RN</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 8/31/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed with this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and federal law that mandate submission of a Plan of Correction within specified days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), the governing body failed to exercise general policy and operating direction over the facility to develop a policy and procedure which included the Elder Justice Act to ensure each employee understood their rights and responsibilities pertaining to the Act.</p> <p>Findings include:</p> <p>During observations at the facility on 8/22/12 from 4:35 PM to 5:15 PM, clients #1 and #2 lived at the facility. During various times of the observation period, staff #1, staff #2, staff #3 and the Team Coordinator worked with clients #1 and #2.</p> <p>A list of employees, who worked at the facility with clients #1 and #2, was reviewed on 8/22/12 at 11:58 AM. The list indicated staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 currently worked in the facility.</p> <p>The facility's policy and procedures were reviewed on 8/22/12 at 2:43 PM. The facility's revised 8/12 policy and</p>	W0104	<p>W 0104- The requirements of the "Elder Justice Act" including system in place to notify police of a suspicious crime have been incorporated into the Warner Transitional Services (WTS) "Reporting and Investigation" policy by the Director of Quality Assurance on 9/6/12.</p> <p>Attachment #1- Administrator and Director of Quality Assurance will assure future policy updates are readily addressed and existing policies will be reviewed annually and updated as necessary. Responsible Parties: Administrator/Director of Quality Assurance Related Tag: W0189 below</p>	09/06/2012

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	<p>procedures entitled Reporting and Investigations did not indicate the Elder Justice Act had been incorporated/included in the facility's policy.</p> <p>Interview with administrative staff #2 on 8/22/12 at 3:00 PM and at 4:00 PM indicated she was not aware of the Elder Justice Act. Administrative staff #2 indicated the requirements of the Elder Justice Act had not been incorporated into the facility's policy and procedures. Administrative staff #2 indicated the facility did not have a system in place which would notify the police of a suspicious crime.</p> <p>3.1-13 (a)</p>				

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure the rights of the clients in regard to allowing the clients to have access to a locked laundry room (washer and dryer) on the unit.</p> <p>Findings include:</p> <p>During the 8/22/12 environmental observational walk through of the facility between 11:08 AM and 12:30 PM, at the facility, the laundry room on the Patoka unit was locked.</p> <p>Client #1's record was reviewed on 8/22/12 at 3:54 PM. Client #1's 8/20/12 Transition Support Plan (TSP) did not indicate client #1 had a need for the laundry room to be locked.</p> <p>Client #2's record was reviewed on 8/22/12 at 5:34 PM. Client #2's 8/20/12 TSP did not indicate client #2 had a need for the laundry room to be locked.</p>	W0125	<p>W0125- The recently completed keying system oversight on the laundry room (washer and dryer) was corrected by Administrator's direction to maintenance staff on 8/22/12.- WTS has initiated an accessibility assessment for all clients to be completed upon admission, at 14 days, 30 days, annually and as requested/need demonstrated to assure client rights are protected for accessibility as well as to protect the safety and well being of clients and others – completed by Administrator and team on 9/5/12. Attachment #2. The two current clients were assessed for accessibility by QSP/ team on 9/6/12. - Quality Assurance Committee will meet quarterly to review client accessibility with focus upon client rights, related competency levels and necessary protections to accessibility to assure client safety and the safety of others. Additionally Administrator will assure there is proper keying/access to facility areas – ongoing.</p>	09/06/2012			

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	<p>The Team Coordinator (TC) had to use a key to unlock the laundry room which housed a washer and dryer. Interview with the TC on 8/22/12 at 11:50 AM indicated clients #1 and #2 used the locked laundry room to wash their clothes. The TC indicated clients #1 and #2 did not have a key to the locked laundry room.</p> <p>3.1-3(a)(1)</p>						

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W0135	<p>483.420(a)(10) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to allow the clients to have access to a telephone with privacy.</p> <p>Findings include:</p> <p>During the 8/22/12 observational walk trough of the facility between 11:08 AM and 12:30 PM, on the Patoka unit, clients #1 and #2 did not have access to a telephone. No phone was on the unit. On other units, there were wooden boxes with pad locks on the outside of the boxes.</p> <p>Client #1's record was reviewed on 8/22/12 at 3:54 PM. Client #1's 8/20/12 Transition Support Plan (TSP) did not indicate the client had a need to be restricted from access to a telephone.</p> <p>Client #2's record was reviewed on 8/22/12 at 5:34 PM. Client #2's 8/20/12 TSP did not indicate the client had a need to be restricted from access to a</p>	W0135	<p>W0135- There was no indication noted to restrict telephone access to the two current clients. These two individuals were granted full accessibility to the telephone in the private foyer area of the unit office suite just off the corridor adjoining their rooms by their respective QSPs and Transition Team Coordinator on 8/23/12.- WTS has initiated an accessibility assessment for all clients to be completed upon admission, at 14 days, 30 days, annually and as requested/need demonstrated to assure client rights are protected for accessibility as well as to protect the safety and well being of clients and others – completed by Administrator and team on 9/5/12. Attachment #2. The two current clients were assessed for accessibility by QSP/ team on 9/6/12. Responsible Parties: Administrator / Transition Team Coordinator - Quality Assurance Committee will meet quarterly to review client accessibility with focus upon client rights, related competency levels and necessary protections to accessibility to assure client safety and the safety of others.</p>	09/06/2012			

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	<p>telephone.</p> <p>Interview with Team Coordinator (TC) and the administrator on 8/22/12 at 12:05 PM indicated a phone was located inside the wooden box. The TC indicated clients #1 and #2 had to ask a staff and/or the Qualified Mental Retardation Professional (QMRP) to have access to the telephone located in the QMRP office/area. The TC indicated the QMRP's office was located on the Patoka unit down a locked hallway which clients #1 and #2 did not have access to. The TC indicated clients #1 and #2 could also use a phone which was located in a room for family/visitors. The room used for family/visitors was located off the unit behind a locked door.</p> <p>3.1-3(f)</p>						

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), the facility failed to provide each current employee with initial training regarding the Elder Justice Act to ensure each employee understood their rights and responsibilities pertaining to the Act.</p> <p>Findings include:</p> <p>During observations at the facility on 8/22/12 from 4:35 PM to 5:15 PM, clients #1 and #2 lived at the facility. During various times of the observation period, staff #1, staff #2, staff #3 and the Team Coordinator worked with clients #1 and #2.</p> <p>A list of employees, who worked at the facility with clients #1 and #2, was reviewed on 8/22/12 at 11:58 AM. The list indicated staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 currently worked in the facility.</p> <p>The facility's training records were reviewed on 8/22/12 at 11:55 AM. The facility's 2012 training records did not</p>	W0189	<p>W0189- Training to report abuse and neglect that specifically includes the "Elder Justice Act", including system in place to notify police of a suspicious crime has been incorporated into the WTS training/orientation protocol by Director of Human Resources on 9/6/12. Attachment #3.- Director of Human Resources & Training Coordinator have trained all current employees on the "Elder Justice Act", including system in place to notify police of a suspicious crime. Training to be completed 9/12/12. Responsible Party: Director of Human Resources Attachment #4 (all employees trained on "Elder justice Act", except one to be completed by 9/12/12).NOTE: All employees were trained previously on components outlined in the "Elder Justice Act" and system for notifying police of a suspicious crime; however, this wasn't identified specifically as the "Elder Justice Act".- Director of Human Resources will assure all future employees have been trained on the "Elder Justice Act" and system of reporting of suspicious crimes to police - ongoing.- Quality Assurance Committee will on quarterly basis</p>	09/10/2012			

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	<p>indicate staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11 had been trained in regard to the Elder Justice Act.</p> <p>Interview with administrative staff #2 on 8/22/12 at 3:00 PM and at 4:00 PM indicated she was not aware of the Elder Justice Act. Administrative staff #2 indicated the facility staff had been trained to report any allegations of abuse/neglect to the administrator. Administrative staff #2 indicated the facility staff had not been trained in regard to the requirements of the Elder Justice Act.</p> <p>3.1-13(b)(2)</p>		<p>review training records for completeness and all reports of abuse/neglect and reports of suspicious crimes. Responsible Parties: Administrator/Director of Quality Assurance/Director of Human Resources Related Tag: W0104 above</p>				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on review and interview for 1 of 2 sample clients (client #1) with a behavior plan, the facility failed to address the client's history of elopement.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 08/22/12 at 2:00 PM. Client #1's record contained the following dated documents:</p> <p>Historical information prior to admission on 08/20/12:</p> <p>03/30/12: Client #1's previous placement's Individualized Interdisciplinary Comprehensive Treatment Plan (ICTP) dated 03-30-12 indicated client #1 was an elopement risk.</p> <p>08/15/12: Facility's Admission Review Form included client #1's ICTP which indicated client #1's behaviors included, but was not limited to elopement. The form indicated, "Special Requirements." "[Client #1] is an elopement risk & (and) should be closely monitored when he is outside of [facility] for activities, outings, appointments."</p>	W0240	<p>W0240 - Client #1's Team, including input from legal guardian addressed the history of elopement in a revised TBSP (Transitional Behavior Support Plan) Completed 9/5/12 Responsible Party: Psychologist/QSPs/Transition Team Coordinator. Attachment # 5 & Attachment # 6 (Missing Client Policy) - Transitional Behavioral Support Plans (TBSPs) and Behavioral Support Plans (BSPs) for any client referred to WTS with a reported/known history of elopement, per Admission Review Form or other referral information, will include risk for elopement behavior and contain specific ways in which staff should respond if client should engage in this behavior (elopement from facility or in community while participating in off-site activity). Responsible Party: Psychologist (Behavioral Services Coordinator) and QSP/Team/legal representative - Interdisciplinary Team will in quarterly reviews review client assessments for quality/accuracy to assure that relevant historical information is assessed to include interventions are in place to support clients needs toward independence. Responsible</p>	09/05/2012			

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	<p>08/20/12: Admission to facility.</p> <p>08/20/12: The Transition Behavior Support Plan (TBSP) indicated client #1's behaviors included: physical aggression, inappropriate touching and verbal aggression. The TBSP did not include client #1's elopement risk behavior. The plan did not include what staff should do if client #1 attempted to elope from the facility or when he was in the community.</p> <p>On 08/22/12 at 6:40 PM an interview with the Administrator and the Team Coordinator (TC) was conducted. Both the Administrator and the TC indicated the agency had previous knowledge of client #1's history of elopement. They indicated it was not in the plan client #1 came from a locked facility. The TC also stated client #1 would be going into the community "probably tomorrow" to the local grocery store and would be outside of the facility. The TC indicated client #1's TBSP did not include this behavior nor did it give staff any plan as to what to do, if client #1 attempted to elope.</p> <p>3.1-37(a)</p>		Parties: QSPs/ Transition Team Coordinator/ Psychologist.		

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W0276	<p>483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior.</p> <p>Based on record review and interview for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure specific restraint methods/techniques utilized by the facility were specified in the facility's policy and procedures regarding behavior management.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 08/22/12 at 3:54 PM. Client #1's Transitional Support Plan (TSP) dated 08/20/12 included a behavior plan for the following targeted behaviors: physical aggression, inappropriate touching/interpersonal boundaries and sexual aggression. The plan indicated, "Level Three" "When a crisis situation occurs with [client #1], staff may use the 'Handle with Care' procedures...If [client #1] refuses, continues to escalate, and presents a danger to himself or others, staff may employ PRT (Primary Restraint Techniques)...". Client #1's plan also indicated a "calm space" (room) could be utilized to assist the client to calm down.</p>	W0276	<p>W0276 - The Physical Restraint Policy was revised to define the specific Primary Restraint Techniques (PRT) in the Handle With Care program. Attachment # 7 Completed by: Quality Assurance Director on 8/31/12. - The Interactive Treatment Techniques policy was revised to define the utilization of the "clam space room" and list specific approved PRTs in the Handle With Care program. Attachment # 8 Completed by: Quality Assurance Director on 8/31/12. - TBSPs were revised to reflect consistency with the revised Physical Restraint policy. Completed by: Psychologist on 9/3/12. Attachment # 9 - Transition Behavior Support Plans (TBSPs) and Behavior Support Plans (BSPs) for any client residing at WTS will clearly define and indicate facility approved interactive treatment techniques to be used in teaching self-control and appropriate behaviors to the specific individual. These will be reviewed for quality and current appropriateness at approved implementation and in quarterly interdisciplinary team meetings.</p>	09/03/2012			

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	<p>Client #2's records were reviewed on 08/22/12 at 5:31 PM. Client #2's TSP dated 08/20/12 included a behavior plan for the following targeted behaviors: physical aggression, hostile behaviors, inappropriate touching/interpersonal boundaries and sexual aggression. The plan indicated, "Level Three" "When a crisis situation occurs with [client #2], staff may use the 'Handle with Care' procedures...If [client #2] refuses, continues to escalate, and presents a danger to himself or others, staff may employ PRT (Primary Restraint Techniques)...". Client #2's plan also indicated a "calm space" could be utilized to assist the client to calm down.</p> <p>The facility's policy and procedures were reviewed on 8/22/12 at 2:43 PM. The facility's June 2012 policy entitled Interactive Treatment Techniques did not include/list the Primary Restraint Techniques and/or specifically define/list the Handle with Care procedures/techniques which were used by the facility. The facility's June 2012 behavior policy did not include, clearly define and/or indicate how a "calm space/room" would be utilized as the facility's policy used terms of "Personal Time Out (Time Out)...Isolation...."</p>		<p>Responsible Parties: Psychologist / QSPs / Transition Team Coordinator</p>				

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	<p>Interview with the administrator and the Team Coordinator (TC) on 8/22/12 at 6:40 PM stated "calm space was the same as a quiet room." The administrator indicated the clients could go to the calm space on their own to calm down and/or may have to be assisted to the room. The administrator indicated the facility's behavior management policy did not include and/or use the terminology of calm space. The administrator indicated the facility's behavior management policy and procedure included restraints which were used when the facility served kids/children. The administrator and the TC indicated the facility's behavior management policy would need to be updated to include all restraints used with the Handle With Care/Primary Restraint Techniques.</p> <p>3.1-13(i)(4)</p>						

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on record review and interview, the facility failed to clearly define the specific techniques utilized in the Transitional Behavior Support Plan (TBSP) for 2 of 2 clients (clients #1 and #2), as a part of the client's treatment plans.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 08/22/12 at 3:54 PM. Client #1's Transitional Support Plan (TSP) dated 08/20/12 included a behavior plan for the following targeted behaviors: physical aggression, inappropriate touching/interpersonal boundaries and sexual aggression. The plan indicated, "Level Three" "When a crisis situation occurs with [client #1], staff may use the 'Handle with Care' procedures...If [client #1] refuses, continues to escalate, and presents a danger to himself or others, staff may employ PRT (Primary Restraint Techniques)...". The plan failed to define the techniques.</p>	W0289	<p>W0289 - Transitional Behavior Support Plans (TBSPs) and Behavior Support Plans (BSPs) for any client who may require 'Level Three' restrictive behavioral controls, to be used only in a 'crisis situation', -[defined as any situation, where a client continues to behave dangerously (i.e., engages in behaviors that represent an imminent physical danger to him/herself and/or others in his/her proximity)], will identify specific restraint methods/techniques (as defined in facility's policies and procedures) that may be utilized by staff to help ensure the safety of the client or others involved. - The Physical Restraint Policy was revised to define the specific Primary Restraint Techniques (PRT) in the Handle With Care program. Attachment # 7 Completed by: Quality Assurance Director on 8/31/12. - Psychologist amended the TBSP's on the two clients to include clearly defined physical restraint techniques/proper implementation on 9/3/12. Attachment # 9. - Transition Behavior Support Plans (TBSPs)</p>	09/03/2012			

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	<p>Client #2's records were reviewed on 08/22/12 at 5:31 PM. Client #2's Transitional Support Plan (TSP) dated 08/20/12 included a behavior plan for the following targeted behaviors: physical aggression, hostile behaviors, inappropriate touching/interpersonal boundaries and sexual aggression. The plan indicated, "Level Three" "When a crisis situation occurs with [client #2], staff may use the 'Handle with Care' procedures...If [client #2] refuses, continues to escalate, and presents a danger to himself or others, staff may employ PRT (Primary Restraint Techniques)...". The plan failed to define the techniques.</p> <p>On 08/22/12 at 6:40 PM an interview with the Team Coordinator (TC) was conducted. The TC indicated client #1 and #2's TSPs failed to include the specific interventions clearly defined for the staff to follow.</p> <p>3.1-35(b)(1)</p>		<p>and Behavior Support Plans (BSPs) for any client residing at WTS will clearly define and indicate facility approved interactive treatment techniques to be used in teaching self-control and appropriate behaviors to the specific individual. These will be reviewed for quality and current appropriateness at implementation and in quarterly interdisciplinary team meetings. Responsible Parties: Psychologist / QSPs / Transition TeamCoordinator</p>				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2) by not ensuring clients received nursing services according to their medical needs, by not ensuring nursing services documented medical needs timely, by not ensuring the physician completed the physical examination form timely, by lack of a policy and procedure for nursing notes and by failing to follow pharmacy recommendation for client #1's eye drops for glaucoma.</p> <p>Findings include:</p> <p>1. Observation of medication administration for client #1 was conducted on 08/22/12 from 7:21 PM until 7:34 PM. Client #1's medication orders included three different eye drops and were administered by RN #1. At 7:26 PM client #1 received his Artificial Tears Drops (dry eyes). The bottle contained a pharmacy information sticker which indicated to wait 5 minutes between eye drops. At 7:30 PM client #1 received his Combigan Eye Drops (glaucoma). The bottle contained a pharmacy information sticker which indicated to wait 10 minutes</p>	W0331	<p>W0331 All nursing personnel have been instructed by DON/HSC (Health Serv. Coord.) to follow specific label directions on the administration of medication. Additionally, the Omincare/PRN Pharmacist, will conduct a mandatory training on ophthalmic medication administration for all nursing personnel on 9/13/12. Training schedule confirmation attached. Attachment # 10 All residents will be administered medications as directed. To be completed: 9/13/12 Responsible Party: DON (HSC) - DON (HSC) or designee will monitor the administration of client medications per intermittent monthly audits to ensure safe, accurate and timely medication administration. Any medication & medication administration variance will be reported immediately to the DON (HSC) and Medical Director. Health Services Quality Assurance Committee for monthly review. Attachment: # 11 Responsible Party: DON (HSC) on-going. Nurse notes policy (Legal Requirements for Nursing Documentation) has been implemented. All nursing staff have been trained. Date Completed: 9/10/12 Responsible Party: DON (HSC) Attachment # 12 The DON (HSC) will review</p>	09/13/2012

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	<p>between eye drops. At 7:34 PM client #1 received his Latanoprost Eye Drops (glaucoma). RN #1 failed to follow the specific administration related to the eye medications. An interview with RN #1 was conducted at 7:36 PM. The RN stated she did not wait 10 minutes because she was, "taught to do five minutes in between."</p> <p>Client #1's records were reviewed on 08/22/12 at 3:54 PM. Client #1's record contained the following dated document: 08/17/12: Pharmacy information related to Combigan Eye Drops. The information indicated, "How To Use This Medication: first, wash your hands...If you are using other eye drops, the drops should be used at least 10 minutes apart...".</p> <p>An interview with the DON (Director of Nursing) on 08/23/12 at 12:05 PM was conducted. The DON stated RN #1 "should have" followed the sticker instructions for the eye medications. She stated RN #1 "should have" waited 5 minutes between the first and second eye med and waited 10 minutes between the second and third eye med.</p> <p>2. Client #1's records were reviewed on 08/22/12 at 3:54 PM. Client #1's record contained the following dated documents:</p>		<p>nursing notes per intermittent monthly audits for timeliness/thoroughness and quality review. The nursing assessment has been revised to reflect patient/client plan of care, including need for specific follow-up referrals. Nurses trained. Attachment # 13 Date completed 9/10/12. Responsible Party: DON (HSC) DON (HSC) will monthly and as needed monitor for quality the nursing assessment and to to assure patient/client follow-up for referrals are addressed in a timely fashion. Documentation audit assessment tool was completed / nursing personnel trained. Completed: 9/10/12 Responsible Party: DON (HSC) Attachment # 14 (Audit tool & training documentation attached) All physicians' orders/ documentation related to patient/client care will be audited monthly by DON (HSC) or designee to assure all required elements of client medical documentation are complete and timely. Responsible Party: DON (HSC) All follow-up referrals for client #1 & #2 have been made. Date completed: 9/10/12 Responsible Party: DON (HSC)</p>				

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	<p>08/06/12: Certification by Physician for Long-Term Care Services and Physical Examination indicated a check in the box for "referral or special examination required." The form indicated client #1 was to be referred to "endocrinologist F/U (follow-up) for Hypothyroidism and occasional check of shunt."</p> <p>08/20/12: Nursing Progress Notes indicated client #1 was admitted to facility. The narrative failed to include a plan for the follow-up referrals.</p> <p>08/20/12: Admission Nursing Assessment which included review of systems failed to address the needed referrals indicated in the 08/06/12 physical examination.</p> <p>08/21/12: Physician's History and Physical. The left side of the form contained the History and the right side of the form was for the Physical Exam. The right side was not filled out.</p> <p>An interview with the DON (Director of Nursing) on 08/23/12 at 12:05 PM was conducted. The DON stated client #1's nursing progress notes and the admission nursing assessment should have included the need for the follow-up referrals and a plan to obtain them. She stated there was not a policy/procedure "at the current</p>			

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	<p>time" for the nursing notes but the information should have been in the notes. She further indicated nursing staff should have made sure the physician filled out the physical exam form upon completing the exam.</p> <p>3. Client #2's records were reviewed on 08/22/12 at 5:31 PM. Client #2's record contained the following dated documents:</p> <p>08/06/12: Certification by Physician for Long-Term Care Services and Physical Examination indicated a check in the box for "referral or special examination required." The form indicated client #2 was to be referred to "may consult with general surgeon for inguinal (protrusion of the abdominal cavity) hernia repairment."</p> <p>08/20/12: Nursing Progress Notes indicated client #1 was admitted to facility. The narrative failed to include a plan for the follow-up referrals.</p> <p>08/20/12: Admission Nursing Assessment which included review of systems failed to address the needed referral indicated in the 08/06/12 physical examination.</p> <p>08/21/12: Physicians History and Physical. The left side of the form</p>						

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	<p>contained the History and the right side of the form was for the Physical Exam. The right side was not filled out.</p> <p>An interview with the DON (Director of Nursing) on 08/23/12 at 12:05 PM was conducted. The DON stated client #1's nursing progress notes and the admission nursing assessment should have included the need for the follow-up referral and a plan to obtain it. She stated there was not a policy/procedure "at the current time" for the nursing notes but the information should have been in the notes. She further indicated nursing staff should have made sure the physician filled out the physical exam form upon completing the exam.</p> <p>3.1-17(a)</p>			