STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VILLAGE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 19, 20, 23, 24, and 25, 2015 Facility number: 004700 Provider number: 155741 AIM number: 100266630 Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN Patsy Allen, SW Census bed type: SNF/NF: 24 Total: 24 Census payor type: Medicare: 5 Medicaid: 17 Other: 2 Total: 24 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 03, 2015; by Kimberly Perigo, RN.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure plans of care were followed for a resident receiving antipsychotic medications (Resident #14); and for a resident requiring blood pressure monitoring (Resident #6). Findings include: 1. The clinical record of Resident #14 was reviewed on 2/23/15 at 3:33 p.m. Diagnoses for the resident included, but were not limited to, dementia with delusions and psychotic disorder. A care plan for Resident #41, initiated 1/26/15 and current through 4/26/15, indicated Resident #14 was at risk for adverse side effects related to the use of psychotropic medications. Approaches included, "AIMS assessment two times per year."	F 282	F282 Whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice. An AIMS was completed for Resident#6 by the DNS. Resident #6 had blood pressurechecked and reported to Nurse Practitione by the DNS . Nurse Practitioner determined no furtherchecks were necessary. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken. All other residents receiving an antipsychoticmedication were evaluated to ensure allhad a current AIMS completed and thatcare plans were being followed. All orders were reviewed and therewere no other residents with orders to monitor blood pressure and report to thenurse practitioner. Inservices on AIMS, care plans and	03/11/2015

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	A physician's order, dated 1/23/15, indicated Resident #14 was to be receiving Risperdal, 2 mg (milligrams) twice per day. A physician's order, dated 2/10/15, indicated the Risperdal was to be increased to 3 mg twice a day. Risperdal is an antipsychotic medication used to treat schizophrenia and bipolar disorder. Serious side effects of Risperdal can be abnormal involuntary movements. The 34th Edition Nursing 2014 Drug Handbook, copyrighted 2014, indicated a resident receiving Risperdal should be watched for signs and symptoms of neuroleptic malignant syndrome, including extrapyramidal effects, as well as tardive dyskinesia. Tardive dyskinesia can be characterized by involuntary movements. An Abnormal Involuntary Movement Scale (AIMS) assessment was not found in Resident #14's record. On 2/23/15 at 4:45 p.m., the Director of Nursing Services indicated an AIMS assessment had not been performed on the resident. On 2/20/15 at 1:56 p.m., the Executive Director provided a policy, titled Psychotropic Management Policy, dated May, 2014, and indicated it was the current policy used by the facility. The		blood pressuremonitoring and reporting were completed by the DNS/designee on 3/11/15. What measures will be put in place or what systemic changeswill be made to ensure that the deficient practice does not recur. Any time a resident has a new orderor a change in order for antipsychotics, it will be reported in am clinicalmeeting. DNS/designee will follow up toensure an AIMS was completed and that care plan interventions were beingfollowed. Any time a resident has an orderfor blood pressure monitoring, it will be discussed in am clinicalmeeting. DNS/designee will reviewdocumentation to ensure blood pressure has been taken and reported as ordered. An inservice of nursing staff was completedon 3/11/15 by the DNS/designee regarding completing AIMS/ antipsychotics,following care plans and blood pressure monitoring and reporting. How the corrective action will be monitored to ensure thedeficient practice will not recur… DNS/designee will complete theContinuous Quality Improvement tool on antipsychotic medications, blood pressuremonitoring and reporting, weekly times 4 weeks, and monthly times 6. The results of the audit will be reviewed by the CQI committee overseenby the ED.	

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	policy indicated, "...3. An AIMS assessment is required for resident who are taking antipsychotic medication. The assessment should be completed within 48 hours of a new order to initiate an antipsychotic and then every six months...." 2. The clinical record review, completed on 2/20/15 at 1:32 p.m., indicated Resident #6 had diagnoses including, but not limited to, dementia and orthostatic hypotension (low blood pressure when standing up). An Admission Minimum Data Set assessment (MDS) completed 1/29/15, indicated the resident had moderately impaired cognition and poor decision making ability. On 1/23/15 the nurse practitioner wrote an order to check the resident's blood pressure lying, sitting and standing every day for 3 days and fax the results to the office. The clinical record lacked documentation of blood pressure results for 1/23, 1/24, 1/25, and 1/26/15. During an interview with the Director of Nursing Services (DNS) on 2/20/15, the DNS indicated the resident refused to allow staff to check the blood pressures		If threshold of 90% is not achieved an action plan will bedeveloped.	

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	and the physician was notified on 1/26/15. The DNS indicated the clinical record lacked documentation of attempts to obtain the blood pressures from 1/23/15 through 1/26/15. 3.1-35(g)(2)			
F 323 SS=D Bldg. 00	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 record review and interview, the facility failed to ensure a resident received adequate supervision to prevent accidents. (Resident #33) Findings include: The clinical record of Resident #33 was reviewed on 2/24/15 at 10:53 a.m. Diagnoses for the resident included, but were not limited to, psychosis and dementia. An annual Minimum Data Set assessment dated 9/22/15, indicated Resident #33 was severely impaired in his ability to make decisions.	F 323	F323 Whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice. Resident# 16 suffered no long term effects fromthe altercation with Resident # 33. Resident #33 was provided directsupervision (1:1 supervision then 15 min checks) to ensure the safety of Others. No other residents were affected by thedeficient practice. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe	03/11/2015

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	A nurse's note, dated 2/2/15, indicated, "Resident wandered into [Resident #16's] [room] and hit him open handed while res[ident] in bed." The note indicated the residents were immediately separated and then 5 minutes later Resident #33 wandered back into Resident #16's room and hit Resident #16 again. The note indicated Resident #33 was then taken to an activity and he was placed on 1:1 supervision, after the second incident. On 2/24/15 at 2:00 p.m., the Executive Director provided a policy titled Abuse Prohibition, Reporting, and Investigation, dated February, 2010, and indicated it was the current policy used by the facility. The policy indicated, "Resident-to-Resident Abuse...Procedure: If resident-resident abuse is identified...4. Staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained." On 2/25/15 at 9:45 a.m., the Director of Nursing Services (DNS) indicated, after the first incident, Resident #33 was not placed under direct supervision. The DNS indicated she was working with the staff to figure out what they were going to do with Resident #33, when the resident returned to Resident #16's room		taken. All residents have the potential tobe affected. In all future resident altercations , direct supervision will beprovided until the initial investigation is completed. Inservice for the nursing staffregarding resident altercations,interventions and documentation werecompleted by 3/11/15 by theDNS/designee. What measures will be put in place or what systemic changeswill be made to ensure that the deficient practice does not recur. Anyresidents involved in a resident to resident altercation will receive directsupervision until it isdetermined by the DNS/designee that residents are safe or until the initialinvestigation is complete.. DNS/designee will review daily staffing sheetand/or progress notes to ensuredirect supervision was provided as necessary. An inservice of nursing staff was completedon 3/11/15 by the DNS/designee regarding resident altercations,interventions and documentation. How the corrective action will be monitored to ensure thedeficient practice will not recur… DNS/designee will complete theContinous Quality Improvement tool on all residents involved in an	

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	and hit him again. The DNS and the Executive Director indicated, if direct supervision of Resident #33 had been provided after the first incident, he would not have returned to Resident #16's room to hit him again. 3.1-45(a)(2)		altercation,weekly times 4 weeks, and monthly times 6. These results will be reviewed bythe CQI committee overseen by the ED. Ifthreshold of 90% is not achieved an action plan will bedeveloped.	
F 329 SS=E Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to monitor residents receiving antipsychotic medications for	F 329	F329 Whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient	03/11/2015

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	abnormal involuntary movements (Resident #6, Resident #24, Resident #41, and Resident #14); failed to monitor blood pressures as ordered by the physician (Resident #6); failed to document the administration of prn (as needed) medications (Resident #6 and Resident #24); and failed to administer as needed medications according to physician's orders (Resident #24) for 4 of 5 residents reviewed for unnecessary medication use. Findings include: A. 1. The clinical record review, completed on 2/20/15 at 1:32 p.m., indicated Resident #6 had diagnoses including, but not limited to, dementia and insomnia (difficulty sleeping). An Admission Minimum Data Set assessment (MDS) completed 1/29/15, indicated the resident had moderately impaired cognition and poor decision making ability. A physician's order dated 2/10/15 at 0330 (3:30 a.m.), indicated the resident could have Haldol (an antipsychotic medication which may cause abnormal involuntary movements) 1 mg (milligram) by mouth every 6 hours as needed for 72 hours for agitation.		practice. An AIMS was completed for thefollowing residents: #6, #24, #41,and #14 by the DNS Resident #6 had blood pressurechecked and reported to Nurse Practitioner by the DNS. Nurse Practitionerdetermined no further checks were necessary. All orders were reviewed and therewere no other residents with orders to monitor blood pressure and report to thenurse practitioner. Documentation for Prn medicationsfor Residents #6 and #24 werereviewed. Documentation was completedper policy. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken. All residents have the potential tobe affected. All other residents receiving an antipsychotic medication wereevaluated to ensure all had a current AIMS completed. Care/Behavior plans werereviewed to ensure the interventions were being followed and non-pharmacologicalattempts were being made prior to admistration of medications.. All orders were reviewed and therewere no other residents with orders to monitor blood pressure and report to thenurse practitioner. All residents were reviewed for documentation of PRN medicationsto ensure time of	

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	The Medication Administration Record (MAR) for February 2015, indicated the resident received Haldol 1 mg on 2/11/15, and on 2/12/15. The MAR lacked documentation of non pharmacological interventions attempted prior to the administration of the medication, lacked time of administration, and lacked effectiveness of the medication administration. The clinical record of Resident #6 lacked an AIMS (Abnormal Involuntary Movement Scale) assessment. On 2/20/15 at 2:23 p.m., the Executive Director (ED) indicated the AIMS assessment was not completed prior to the administration of the Haldol. 2. The clinical record review, completed on 2/23/15 at 10:24 a.m., indicated Resident #24 had diagnoses including, but not limited to, dementia with behavioral disturbances. A Quarterly Minimum Data Set (MDS) assessment completed 12/24/14, indicated the resident was moderately cognitively impaired and had poor decision making abilities. On 1/10/15, the physician ordered		administration and effectiveness was included on the MAR bythe DNS/designee. Inservices on AIMS, blood pressure monitoring and reporting, prn medications:(non pharmacologicalinterventions were attempted per behavior plan prior to administration ofantipsychotic medications, time of administration and effectivenss ofmedication and, following physician orders were completed by the DON/designeeon 3/11/15. What measures will be put in place or what systemic changeswill be made to ensure that the deficient practice does not recur: Any time a resident has a new orderor a change in order for antipsychotics, it will be reported in am clinicalmeeting. DNS/designee will follow up toensure an AIMS was completed. Any time a resident has an orderfor blood pressure monitoring, it will be discussed in am clinicalmeeting. DNS/designee will reviewdocumentation to ensure blood pressure has been taken and reported as ordered. At shift change, staff nurses willvalidate all documentation regarding prn medications is complete, regardingdate and time of administration, andnon-pharmacological attempts as well as effectivenss of medications.	

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	risperidone (an antipsychotic medication which can cause abnormal involuntary movements) 1 mg (milligram) by mouth twice a day. An AIMS (Abnormal Involuntary Movement Scale) assessment dated 10/8/14, was present in the clinical record. During an interview with Director of Nursing Services (DNS) on 2/23/15 at 2:45 p.m., the DNS indicated the last AIMS assessment was completed 10/8/14 and was not updated when the risperidone was started. 3. The clinical record of Resident #41 was reviewed on 2/23/15 at 11:44 a.m. Diagnosis for the resident included, but were not limited to, dementia with delusions and sexual aggressiveness. A physician's order, dated 12/14/14, indicated Resident #41 was to begin taking Zyprexa, 5 mg (milligrams) twice a day. A physician's order, dated 1/11/15, indicated Zyprexa, 5 mg. was to be increased to 3 times per day due to continued behaviors. Zyprexa is an antipsychotic medication. Serious side effects of this medication can include abnormal involuntary movements.		An inservice of nursing staff wascompleted on 3/11/15 by theDNS/designee regarding completing AIMS/antipsychotics, blood pressure monitoring and reporting, documentation of refusal of vital signs, prn medications(non pharmacologicalinterventions prior to administration of medications, time of administrationand effectivenss of medication) and following physician's orders. How the corrective action will be monitored to ensure thedeficient practice will not recur… DNS/designee will complete theContinuous Quality Improvement tool on AIMScompletion, documentation of vital signsand prn medications weekly times 4 weeks, and monthly times 6. These resultswill be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved an action plan will be developed.	

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	An Abnormal Involuntary Movement Scale (AIMS) assessment was not performed on Resident #41 until 2/4/15. On 2/23/15 at 4:15 p.m., the Director of Nursing Services indicated the AIMS assessment was, "missed," when Zyprexa was first initiated and was completed at a later date. 4. The clinical record of Resident #14 was reviewed on 2/23/15 at 3:33 p.m. Diagnoses for the resident included, but were not limited to, dementia with delusions and psychotic disorder. A care plan for Resident #14, initiated 1/26/15 and current through 4/26/15, indicated Resident #14 was at risk for adverse side effects related to the use of psychotropic medications. Approaches included, "AIMS assessment two times per year." A physician's order, dated 1/23/15, indicated Resident #14 was to be receiving Risperdal 2 mg (milligrams) twice per day. A physician's order, dated 2/10/15, indicated the Risperdal was to be increased to 3 mg twice a day. Risperdal is an antipsychotic medication used to treat schizophrenia and bipolar disorder. Serious side effects of Risperdal			

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	can be abnormal involuntary movements. An Abnormal Involuntary Movement Scale (AIMS) assessment was not found in Resident #14's record. On 2/23/15 at 4:45 p.m., the Director of Nursing Services indicated an AIMS assessment had not been performed on the resident. On 2/20/15 at 1:56 p.m., the Executive Director provided a policy titled Psychotropic Management Policy, dated May, 2014, and indicated it was the current policy used by the facility. The policy indicated, "...3. An AIMS assessment is required for residents who are taking antipsychotic medication. The assessment should be completed within 48 hours of a new order to initiate an antipsychotic and then every six months...." B. The clinical record review, completed on 2/20/15 at 1:32 p.m., indicated Resident #6 had diagnoses including, but not limited to, dementia and orthostatic hypotension (low blood pressure when standing up). An Admission Minimum Data Set assessment (MDS) completed 1/29/15, indicated the resident had moderately impaired cognition and poor decision making ability.			

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	On 1/23/15 the resident was started on metoprolol 50 mg (milligrams) twice a day for high blood pressure. The nurse practitioner wrote an order to check the resident's blood pressure lying, sitting, and standing every day for 3 days and fax the results to the office. The clinical record lacked documentation of blood pressure results for 1/23, 1/24, 1/25, and 1/26/15. During an interview with the Director of Nursing Services (DNS) on 2/20/15, the DNS indicated the resident refused to allow staff to check the blood pressures and the physician was notified on 1/26/15. The DNS indicated the clinical record lacked documentation of attempts or refusals of blood pressure checks from 1/23/15 through 1/26/15. C. 1. The clinical record review, completed on 2/20/15 at 1:32 p.m., indicated Resident #6 had diagnoses including, but not limited to, dementia and insomnia (difficulty sleeping). An Admission Minimum Data Set assessment (MDS) completed 1/29/15, indicated the resident had moderately impaired cognition and poor decision making ability.			

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	A physician's order dated 2/10/15 at 0330 (3:30 a.m.), indicated the resident could have Haldol (an antipsychotic medication which may cause abnormal involuntary movements) 1 mg (milligram) by mouth every 6 hours as needed for 72 hours for agitation. The Medication Administration Record (MAR) for February 2015, had initials documented in the column for 2/11/15 and 2/12/15, indicating the resident had been given Haldol 1 mg. The back page of the MAR lacked documentation of the administration of the Haldol, including non pharmacological interventions attempted prior to the administration of the medication, lacked the time of administration, and lacked effectiveness of the medication administration. 2. The clinical record review, completed on 2/23/15 at 10:24 a.m., indicated Resident #24 had diagnoses including, but not limited to, dementia with behavioral disturbances. A Quarterly Minimum Data Set (MDS) assessment completed 12/24/14, indicated the resident was moderately cognitively impaired and had poor decision making abilities.			

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	A review of the physician's orders indicated Resident #24 had an order written 1/10/15, to start Ativan, an antianxiety medication, 1 mg (milligram) twice a day as needed for anxiety and trazodone, an antidepressant medication sometimes used to help with difficulty sleeping, 25 mg every bedtime as needed and was to be given by 10:00 p.m., if the resident was not asleep. A review of the Medication Administration Record (MAR) for January 2015, contained initials in the columns for Ativan on 1/12, 1/13, 1/15, and 1/20/15, indicating the resident was given Ativan on those dates. The back page of the MAR lacked documentation of administration of Ativan on 1/12, 1/13, and 1/15/15. Documentation of the administration of the Ativan for 1/20/15, lacked non pharmacological interventions attempted prior to the administration of the medication and lacked documentation of the effectiveness of the medication. The MAR for January 2015, contained initials in the column for trazodone on 1/10, 1/13, 1/16, 1/19, 1/20, 1/27, 1/30, and 1/31/15, indicating the resident was given trazodone on those dates. The back page of the MAR lacked documentation of the administration of the trazodone on 1/10, 1/13, 1/16, 1/19, 1/27, 1/30, and			

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	1/31/15, including non pharmacological interventions attempted prior to the administration of the medication, the date and time of the administration, and the effectiveness of the medication. The documentation of the dose administered on 1/20/15, lacked documentation of non pharmacological interventions attempted prior to the administration of the medication and lacked documentation of the effectiveness of the medication. A review of the MAR for February 2015, contained initials in the column for trazodone on 2/1, 2/3, 2/6, two initials on 2/9, 2/14, 2/19, and 2/20/15, indicating the resident was given the medication on those dates. The back page of the MAR lacked documentation of the administration of the trazodone on 2/1, 2/6, 2/14, and 2/19/15, including non pharmacological interventions attempted prior to the administration of the medication, the date and time of the administration, and the effectiveness of the medication. The documentation of the administration of the trazodone on 2/3/15, indicated the medication was administered at 2300 (11:00 p.m.), one hour later than the medication was ordered to be given. A dose of trazodone was documented as given on 2/9/15 at 0015 (12:15 a.m.), two			

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	hours and 15 minutes later than the medication was ordered to be given, and another dose was documented as given at 2250 (10:50 p.m.), 50 minutes later than the medication was ordered to be given. The dose documented as given on 2/20/15 indicated the dose was given at 2300 (11:00 p.m.), one hour later than the medication was ordered to be given. The documentation lacked non pharmacological interventions attempted prior to the administration of the medication and lacked documentation of the effectiveness of the medication. During an interview with the Director of Nursing Services (DNS) on 2/23/15 at 11:58 a.m., the DNS indicated the facility did not have a specific policy regarding the administration of as needed medications such as antianxiety and antidepressant medications. The DNS indicated the facility did not utilize a separate form for documentation of as needed medications and the expectation was to document the administration of medications on the MAR. D. The clinical record review, completed on 2/23/15 at 10:24 a.m., indicated Resident #24 had diagnoses including, but not limited to, dementia with behavioral disturbances.			

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	A Quarterly Minimum Data Set (MDS) assessment completed 12/24/14, indicated the resident was moderately cognitively impaired and had poor decision making abilities. A review of the recapitulation of physician's orders for February 2015, indicated Resident #24 had an order hydrocodone/acetaminophen (a pain medication) 5/325 mg (milligrams) 1 tablet by mouth every 6 hours as needed for pain. A review of the Medication Administration Record (MAR) for February 2015, contained initials in the column for hydrocodone/acetaminophen on 2/3, 2/7, 2 on 2/10, 2/16, and 2/19/15, indicating the resident was given the medication on those dates. The back page of the MAR lacked documentation of the administration of the hydrocodone/acetaminophen on 2/7, 2/10, 2/16, and 2/19/15, including date and time of administration, non pharmacological interventions attempted prior to the administration of the medication, and the effectiveness of the administration of the medication. During an interview with the Director of Nursing Services (DNS) on 2/23/15 at 11:58 a.m., the DNS indicated the			

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	administration of the pain medication should have been completed on the back of the MAR. On 2/23/15 at 11:58 a.m., the DNS provided the policy Pain Management dated 9/2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...6. Documentation of administration of ordered PRN [as needed] pain medication will be initialed on the front of the Medication Administration (MAR). 7. Additional information including, but not limited to reasons for administration, interventions, and effectiveness of pain medication will be documented on the back of the Medication Administration (MAR), or on the facility specific pain management flow sheet...." 3.1-48(a)(3)			
F 431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to label and store medications according to manufactures guidelines for 1 of 1 medication cart reviewed for medication storage. (South Med Cart) Findings include: During an observation of the South Medication Cart on 2/20/15 at 3:11 p.m., a total of 44 unidentifiable medications were found loose in the bottom of the drawers of the cart along with dust and debris. The medications included 37	F 431	F431 Whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice. The medication cart was cleaned by DNS after the issues were identified Medications that required an upright position wererelocated to another drawer. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken. All residents have the potential tobe	03/11/2015

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	tablets, 6 capsules, and 1 gel capsule. The top drawer of the cart contained 2 bottles of fluticasone nasal spray, each packaged in separate plastic bags and each laying flat on the bottom of the drawer. Bottle #1 had a fill date of 2/7/15, and the label indicated the medication should be stored in an upright position. Bottle #2 had a fill date of 1/15/15, and the label lacked instructions to store in an upright position. During an interview with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #2 on 2/20/15 at 3:15 p.m., RN #1 indicated the medication cart had been cleaned approximately 2 weeks ago but was not on a routine schedule for cleaning. Both nurses indicated they were not aware of any special storage instructions for nasal sprays. On 2/20/15 at 1:56 p.m., the Director of Nursing Services (DNS) provided the policy Medication Storage Requirements dated 2/2014, and indicated the policy was the one currently used by the facility. The policy indicated, " Purpose:To ensure drugs and biologicals are stored in safe and secure manner in accordance to all manufacture's recommendations...." 3.1-25(j)		affected. Inservices on medication cart cleaning and storage ofmedications were provided by the DNS/Designee by 3/11/15. What measures will be put in place or what systemic changeswill be made to ensure that the deficient practice does not recur: The medication cart was placed on aschedule for routine cleaning by the night shift nurse daily. DNS/designee will inspectmedication cart to ensure cleanliness and proper order. Inserviceson medication cart cleaning and storageof medications were provided by the DNS/Designee by 3/11/15 How the corrective action will be monitored to ensure thedeficient practice will not recur… DNS/designee will complete theContinuous Quality Improvement tool on MedicationCart and Storage of Medications weeklytimes 4 weeks, and monthly times 6. These results will be reviewed by the CQIcommittee overseen by the ED. Ifthreshold of 90 % is not achieved anaction plan will be developed.	

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F 441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread			

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	of infection. Based on interview and record review, the facility failed to ensure a resident with an active infection caused by a multi drug resistant organism was isolated to prevent the spread of infection. (Resident # 22) Findings include: The closed clinical record review, completed on 2/25/15 at 11:30 a.m., indicated Resident #22 had diagnoses including, but not limited to, dementia with delusional disorder. The resident was admitted to the facility on 10/3/15. A physician's order dated 10/6/14, indicated the resident was to have a chest x-ray to rule out pneumonia and an urinalysis with a culture and sensitivity to rule out an urinary tract infection (UTI). The resident was seen by the nurse practitioner on 10/8/14, and was started on Doxycycline (an antibiotic) 100 mg (milligrams) twice a day for pneumonia. The progress note written by the nurse practitioner indicated the resident had dysuria (pain, burning, or discomfort when urinating) and the urinalysis indicated the bacteria was too numerous to count.	F 441	F441 Whatcorrective action will be accomplished for those residents found to have beenaffected by the deficient practice. The resident had been dischargedfrom the facility at the time of the survey. All other residents with known or suspected infections were evaluatedfor the need for isolation. No otherresidents were identified. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken. All residents have the potential tobe affected. . All other residents withknown or suspected infections were evaluated for the need for isolation. No other residents were identified. Inservices on isolation,infection control, and multi drug resistant organisms were completed by the DNS/Designee by 3/11/15 What measures will be put in place or what systemic changeswill be made to ensure that the deficient practice does not recur: All residents with a known orsuspected infection will be discussed in the clinical meeting to determine ifisolation is required per Infection Control policy and CDC guidelines.	03/11/2015

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	The results of the urine culture with the sensitivity was sent from the laboratory to the facility on 10/10/14 at 2:38 p.m. The results indicated the resident had Klebsiella pneumonia ESBL (extended spectrum beta-lactamase), a multi-drug resistant organism. The laboratory report indicated the organism was CRE (carbapenem resistant Enterobacteriaceae, indicating the organism was resistant to multiple antibiotics) and consultation with an infectious disease practitioner was recommended. A review of the nursing progress notes from 10/6/14 through 10/14/14, indicated the resident was incontinent of urine and the documentation lacked any special precautions observed by the staff in regard to the urine culture results. The Precautions Section of an Infection Control Report dated 10/8/14, lacked documentation of precautions to be followed by the staff or resident including Standard, Droplet, Airborne, and Contact. The nursing progress notes indicated on 10/14/14 at 3:05 a.m., the physician's office was notified of a decline in condition of the resident and an order was received to send the resident to the Emergency Room (ER) for evaluation		Residents who require isolation perphysician orders/infection control policy/CDC guidelines will beevaluated/monitored to ensure thatInfection Control policy is followed by conducting rounds every shift by theDNS/designee. Inservices on isolation,infection control, and multi drug resistant organisms were completed by the DNS/Designee by 3/11/15 How the corrective action will be monitored to ensure the deficientpractice will not recur… DNS/designee will complete theContinuous Quality Improvement tool on InfectionControl weekly times 4 weeks, and monthly times 6. These results will bereviewed by the CQI committee overseen by the ED. If threshold of 90 % is not achieved an action plan will be developed.	

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	and treatment. The resident was admitted to the hospital with Klebsiella pneumonia UTI with bacteremia (bacteria into the blood stream). The resident was readmitted from the hospital on 10/20/14, with IV (intravenous) antibiotic treatment for the multi-drug resistant UTI. On 12/12/14, the resident complained of burning with urination and an urinalysis with culture and sensitivity was ordered by the nurse practitioner. The culture results were sent to the facility from the laboratory on 12/15/14 at 2:36 p.m. The results indicated the resident had an UTI with Klebsiella pneumonia CRE confirmed as ESBL. On 12/16/14 at 12:30 a.m., the resident was started on doxycycline 100 mg twice a day by mouth for the UTI. On 1/3/15, the resident complained of pain with urination and a urinalysis with culture and sensitivity was ordered. The specimen was collected on 1/7/15. The results were sent to the facility on 1/10/15 at 3:09 p.m. The resident was again diagnosed with UTI related to Klebsiella oxytoca ESBL. During an interview with the Director of Nursing Services (DNS) on 2/25/15 at			

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	11:59 a.m., the DNS indicated Resident #22 was not placed in isolation at any time while in the facility and contact precautions were not utilized when the resident was symptomatic and then when treated for multiple UTIs. On 2/25/15 at 2:32 p.m., the DNS provided the policy Multi-drug Resistant Organisms (MDRO) dated September 2014, and indicated the policy was the one currently used by the facility. The policy indicated, "The facility shall utilize proper infection control and prevention when dealing with resident(s) with Multiple Drug Resistant Organisms (MDRO) infection(s)...MDROs are transmitted from one person to another via direct and indirect contact...." On 2/25/25 at 2:32 p.m., the DNS provided the policy Transmission Based Precautions Guidelines dated April 2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...In addition to Standard Precautions, Transmission-Based Precautions should be used for resident(s) with documented or suspected infection(s) or colonization with highly transmissible or epidemiological pathogen(s) for which additional precautions are needed to prevent the spread of infection(s). CONTACT			

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	PRECAUTIONS: Use for the resident(s) with known or suspected infection(s) or evidence of symptom(s) related to infection(s) that have not been confirmed but may be associated with the spread of infection(s)...." 3.1-18(a)			